



**University of  
Nottingham**

UK | CHINA | MALAYSIA

***“I don't have to be perfect; I can just do my best and I have noticed that it's  
enough”*: A Mixed Methods Study Exploring the Effectiveness of a Parenting  
Intervention for Parents with Anxiety in Reducing Parental Perceptions of Child  
Anxiety**

by Isabel Williams

Thesis submitted to the University of Nottingham for the degree of Doctor of  
Applied Educational Psychology

May 2024

Word Count (including Figures): 39989

## Contents Page

<b>Abstract.....</b>	<b>6</b>
<b>List of Figures.....</b>	<b>7</b>
<b>List of Tables.....</b>	<b>8</b>
<b>List of Key Abbreviations.....</b>	<b>10</b>
<b>Acknowledgements.....</b>	<b>12</b>
<b>1 Chapter 1: Introduction.....</b>	<b>13</b>
1.1 Personal Interest in the Research .....	13
1.2 Thesis Structure .....	14
<b>2 Chapter 2: Literature Review .....</b>	<b>15</b>
2.1 Aim and Structure .....	15
2.2 Mental Health.....	15
2.2.1 <i>Defining Mental Health Needs</i> .....	16
2.2.2 <i>Current Context of Child Mental Health Needs</i> .....	17
2.3 Childhood Anxiety.....	19
2.3.1 <i>Defining Anxiety</i> .....	19
2.3.2 <i>Current Context of Childhood Anxiety</i> .....	19
2.3.3 <i>Impact of Childhood Anxiety</i> .....	20
2.3.4 <i>Challenges of Identifying Childhood Anxiety</i> .....	20
2.3.5 <i>Forms of Childhood Anxiety</i> .....	21
2.3.6 <i>Cognitive Theory of Anxiety</i> .....	21
2.4 Risk Factors for Childhood Anxiety.....	23
2.4.1 <i>Child Factors</i> .....	24
2.4.2 <i>Psychosocial Factors</i> .....	25
2.4.3 <i>Attachment</i> .....	25
2.4.4 <i>Parenting Factors</i> .....	26
2.4.5 <i>Summary of Risk Factors</i> .....	27
2.5 Intergenerational Transmission of Anxiety.....	27
2.5.1 <i>Current Context of Parental Anxiety</i> .....	27
2.5.2 <i>Genetic versus Environmental Contribution</i> .....	27
2.5.3 <i>From Parental Cognitions to Parenting Behaviours</i> .....	28
2.5.4 <i>Considerations</i> .....	31
2.5.5 <i>Summary of the Intergenerational Transmission of Anxiety</i> .....	32
2.6 Anxiety Interventions.....	32
2.6.1 <i>Role of Indicated Interventions for Parents with Anxiety</i> .....	33
2.6.2 <i>Parenting Interventions for Parents with Anxiety</i> .....	33
2.7 Role of Educational Psychologists .....	37
2.8 Summary and Rationale .....	38
2.9 Systematic Literature Review .....	39
2.9.1 <i>Introduction to the Systematic Literature Review</i> .....	39
2.9.2 <i>Objectives</i> .....	39

2.9.3	Method.....	39
2.9.4	Results .....	44
2.9.5	Discussion.....	54
2.9.6	Summary of the Systematic Literature Review.....	57
2.10	Current Study.....	58
2.10.1	Summary and Rationale .....	58
2.10.2	Research Question .....	59
<b>3</b>	<b>Chapter 3: Methodology.....</b>	<b>60</b>
3.1	Aim and Structure .....	60
3.2	Philosophical Paradigms.....	60
3.2.1	Terminology .....	60
3.2.2	Positivism .....	61
3.2.3	Postmodernism .....	62
3.2.4	Mixed-Methods.....	63
3.3	Chosen Paradigm of the Current Study: Mixed Methods .....	64
3.4	Research Designs .....	65
3.4.1	Evaluation Research .....	65
3.4.2	Quantitative Designs .....	66
3.4.3	Qualitative Designs.....	68
3.4.4	Mixed Methods .....	69
3.5	Chosen Research Design of the Current Study: Mixed Methods .....	71
3.6	Characteristics of the Current Study.....	73
3.6.1	Stakeholders.....	73
3.6.2	Sample.....	73
3.7	Quantitative Research Design of the Current Study.....	77
3.7.1	Overarching Quantitative Research Question .....	77
3.7.2	Quantitative Research Design .....	78
3.7.3	Quantitative Measures .....	78
3.7.4	Quantitative Research Procedure .....	80
3.7.5	Quality of Quantitative Design.....	84
3.7.6	Quantitative Data Analysis .....	86
3.8	Embedded Qualitative Research Design of the Current Study .....	87
3.8.1	Embedded Qualitative Research Question .....	87
3.8.2	Embedded Qualitative Research Design .....	87
3.8.3	Embedded Qualitative Research Procedure .....	87
3.8.4	Quality of Embedded Qualitative Design.....	91
3.8.5	Qualitative Research Analysis: Reflexive Thematic Analysis .....	93
3.8.6	Reflexive Thematic Analysis Process.....	96
3.9	Ethical Considerations .....	98
3.10	Method Summary .....	98
<b>4</b>	<b>Chapter 4: Results.....</b>	<b>100</b>
4.1	Aim and Structure .....	100
4.2	Overarching Research Question: Planning Quantitative Data Analysis .....	100
4.2.1	Objective of the Data Analysis .....	100
4.2.2	Scale of the Data .....	101
4.2.3	Non-Parametric versus Parametric Data .....	101
4.2.4	Statistical Tests of Difference .....	102
4.2.5	Statistical Significance, Statistical Power and Effect Size .....	102

4.3	Overarching Research Question: Results of Quantitative Data Analysis.....	105
4.3.1	<i>Preparing the Raw Data</i> .....	105
4.3.2	<i>Descriptive Statistics and Statistical Tests of Difference</i> .....	106
4.3.3	<i>Overarching Quantitative Results Summary</i> .....	121
4.4	Embedded Qualitative Results.....	121
4.4.1	<i>Thematic Map</i> .....	122
4.4.2	<i>Theme 1: “Oh, okay, I’m not alone” – Valuing Peer Support</i> .....	124
4.4.3	<i>Theme 2: “I’m doing this course for them” – For the Child</i> .....	127
4.4.4	<i>Theme 3: Journeying Towards Reducing Anxiogenic Parenting</i> .....	128
4.4.5	<i>Theme 4: Getting More ‘Good and Brave’ Behaviour</i> .....	129
4.4.6	<i>Theme 5: Wanting Personalised Support</i> .....	131
4.4.7	<i>Theme 6: Facilitating Engagement</i> .....	132
4.5	Embedded Qualitative Results Summary .....	135
4.6	Results Summary .....	135
5	<b>Chapter 5: Discussion.....</b>	<b>136</b>
5.1	Aim and Structure .....	136
5.2	Overarching Research Question: Quantitative Findings and Interpretations..	136
5.2.1	<i>Overall Anxiety</i> .....	137
5.2.2	<i>Subtests of Anxiety- Findings, Interpretations and Previous Research</i> .....	139
5.2.3	<i>Summary of Quantitative Findings and Interpretations</i> .....	142
5.3	Embedded Qualitative Themes and Interpretations .....	142
5.3.1	<i>Positive Impact: The Child</i> .....	143
5.3.2	<i>Positive Impact: The Parent</i> .....	145
5.3.3	<i>Improving the Intervention</i> .....	147
5.3.4	<i>Summary of Qualitative Findings and Interpretations</i> .....	149
5.4	Mixed Methods Integration.....	149
5.4.1	<i>Meta-inferences</i> .....	150
5.4.2	<i>Summary of Mixed Methods Integration</i> .....	154
5.5	Methodological Review: Strengths and Limitations .....	154
5.5.1	<i>Quantitative Review</i> .....	155
5.5.2	<i>Qualitative Review</i> .....	157
5.5.3	<i>Mixed Methods Review</i> .....	158
5.5.4	<i>Review of the Research Focus</i> .....	159
5.6	Implications of Findings.....	159
5.6.1	<i>Implications for Policy</i> .....	160
5.6.2	<i>Implications for Educational Psychologists</i> .....	161
5.6.3	<i>Implications for Future Research</i> .....	162
5.7	Conclusion and Reflections.....	162
	<b>References.....</b>	<b>165</b>
	<b>Appendices .....</b>	<b>191</b>
	Appendix A Search Strategy Terms and Results per Database .....	191
	Appendix B Eligibility Criteria - Full Text Screen.....	195
	Appendix C Application of Weight of Evidence Framework to Included Studies for Review.....	200
	Appendix D Key Study Characteristics of Included Studies .....	204
	Appendix E Recruitment Poster .....	214

<b>Appendix F Demographics Questionnaire .....</b>	<b>215</b>
<b>Appendix G Session Plans .....</b>	<b>218</b>
<b>Appendix H Participant Information Sheet .....</b>	<b>234</b>
<b>Appendix I Participant Consent Form .....</b>	<b>237</b>
<b>Appendix J PWA (Cartwright, 2021) Intervention Handouts .....</b>	<b>238</b>
<b>Appendix K Emotion Coaching Handout 1 .....</b>	<b>272</b>
<b>Appendix L Emotion Coaching Handout 2.....</b>	<b>273</b>
<b>Appendix M Reflexivity Boxes .....</b>	<b>274</b>
<b>Appendix N Familiarisation Doodle.....</b>	<b>277</b>
<b>Appendix O RTA Phase Four Image .....</b>	<b>278</b>
<b>Appendix P RTA Phase Four Thematic Map .....</b>	<b>279</b>
<b>Appendix Q Ethical Approval .....</b>	<b>280</b>
<b>Appendix R Additional Illustrative Quotes for Themes.....</b>	<b>281</b>

## **Abstract**

**Aim:** To explore the effectiveness of an adapted parenting intervention, *Parenting with Anxiety: Helping Anxious Parents Raise Confident Children (PWA)*, delivered by a Trainee Educational Psychologist (TEP), in reducing parental perceptions of child anxiety. Subsidiary to this, the research aimed to explore parental perceptions of the intervention.

**Design:** Following a pragmatic ontology, an embedded, mixed-methods design was employed. Quantitative data was gathered to answer the overarching research question. A one group pre-test post-test design was used, with child anxiety measured before and after the intervention. Qualitative data was gathered using a focus group, to explore the subsidiary research question. Reflexive Thematic Analysis (RTA) was used to analyse the data.

**Research Purpose:** To address a gap in the research, offering Educational Psychologists (EPs) evidence regarding the effectiveness of a parenting intervention for parents with anxiety, in reducing Intergenerational Transmission of anxiety when delivered by a TEP, in schools. In line with the aims of evaluation research, it hopes to offer insight into how the intervention may have worked (or not), and how it may be improved to reduce child anxiety.

**Findings:** Quantitative findings showed a reduction in overall child anxiety scores pre- versus post-intervention. Meta-inferences were given, using qualitative findings to support a more complete understanding of quantitative results. Generated themes suggested parents experienced a decrease in anxiogenic parenting behaviours, and an increase in 'good and brave' child behaviours, following the intervention. Parents suggested intervention improvements. The findings from this mixed-methods study are critically reviewed and considered alongside existing research. Implications for government policy, future research and the work of EPs is discussed considering the novel findings. Importantly, it is suggested that EPs may deliver the adapted PWA intervention to reduce child anxiety.

## List of Figures

<b>Figure 2.1</b> Seven Confident Thoughts .....	16
<b>Figure 2.2</b> Negative Cognitive Triad (Beck, 1976) .....	23
<b>Figure 2.3</b> Figure Demonstrating Transmission of Parental to Child Anxiety.....	30
<b>Figure 2.4</b> PRISMA Flow Chart (Page et al., 2021) Demonstrating the Selection Process Used for the Review.....	45
<b>Figure 3.1</b> Comparison of Deductive versus Inductive Reasoning .....	61
<b>Figure 3.2</b> The Continuum of Research Approaches and their Common Characteristics .....	65
<b>Figure 3.3</b> Stages of the Embedded Mixed-Methods Design Used .....	72
<b>Figure 3.4</b> Flow Chart Demonstrating Recruitment Process and Retention .....	76
<b>Figure 3.5</b> One-group Pre-test Post-test Design Used in this Study .....	78
<b>Figure 3.6</b> Research and Intervention Summary .....	82
<b>Figure 3.7</b> Focus Group Seating Arrangement.....	88
<b>Figure 3.8</b> Flow Chart Showing the Structure and Content of the Focus Group .....	90
<b>Figure 3.9</b> Variations of RTA (Braun & Clarke, 2022) .....	94
<b>Figure 4.1</b> The Null Hypotheses and Hypotheses for The Current Study .....	103
<b>Figure 4.2</b> Raincloud Plot Demonstrating Pre- and Post-Intervention SCAS-P (Spence, 1998) Scores .....	108
<b>Figure 4.3</b> Raincloud Plot Demonstrating Pre- and Post-Intervention SCAS (Spence et al., 2001) Scores .....	109
<b>Figure 4.4</b> Raincloud Plots Demonstrating Pre- and Post-Intervention SCAS-P Subtest Scores .....	113
<b>Figure 4.5</b> Raincloud Plots Demonstrating Pre- and Post-Intervention SCAS (Spence et al., 2001) Subtest Scores.....	116
<b>Figure 4.6</b> Thematic Map .....	123

## List of Tables

<b>Table 2.1</b> Table Defining Externalising versus Internalising Behaviours .....	17
<b>Table 2.2</b> Summary of the Central Principles of the Cognitive Model of Anxiety (Clark & Beck, 2011) .....	22
<b>Table 2.3</b> Table Detailing Anxiogenic Parenting Behaviours (Flessner et al., 2016; Murray et al., 2009) .....	29
<b>Table 2.4</b> Inclusion and Exclusion Criteria used for this SLR.....	40
<b>Table 2.5</b> Review Search Terms Used .....	42
<b>Table 2.6</b> Characteristics of Interventions Included in Review.....	49
<b>Table 3.1</b> Experimental Designs.....	67
<b>Table 3.2</b> Core Mixed Methods Designs .....	70
<b>Table 3.3</b> Study Exclusion and Inclusion Criteria .....	74
<b>Table 3.4</b> Management of Possible Threats to Validity within this Research .....	85
<b>Table 3.5</b> Trustworthiness Criteria for Qualitative Research (Lincoln & Guba, 1985; Nowell et al., 2017) .....	92
<b>Table 3.6</b> Definitions of Key Terms within RTA (Braun & Clarke, 2022) .....	93
<b>Table 3.7</b> Six Phases of RTA (Braun & Clarke, 2022) .....	94
<b>Table 4.1</b> Scales of Data (Cohen et al., 2017) .....	101
<b>Table 4.2</b> Parametric Versus Non-parametric Data (Cohen et al., 2017) .....	101
<b>Table 4.3</b> Parametric Versus Non-Parametric Statistical Tests of Difference (Goss- Sampson, 2022).....	102
<b>Table 4.4</b> Type I versus Type II Errors (Cohen et al., 2017).....	103
<b>Table 4.5</b> Wilcoxon Signed Rank Effect Sizes .....	105
<b>Table 4.6</b> Participant Data Analysed .....	106
<b>Table 4.7</b> Descriptive Statistics for Total SCAS-P Scores (Spence, 1998) Pre- and Post-Intervention .....	107
<b>Table 4.8</b> Descriptive Statistics for Total SCAS (Spence et al., 2001) Scores Pre- and Post-Intervention .....	109
<b>Table 4.9</b> Descriptive Statistics for Total SCAS-P Scores (Spence, 1998) Pre-, Post-, and Six-Months-Post-Intervention.....	110

<b>Table 4.10</b> Descriptive Statistics for Total SCAS Scores (Spence et al., 2001) Pre-, Post-, and Six-Months-Post-Intervention .....	110
<b>Table 4.11</b> Descriptive Statistics for Subtest SCAS-P Scores (Spence, 1998) Pre- and Post-Intervention .....	112
<b>Table 4.12</b> Descriptive Statistics for Subtest SCAS (Spence et al., 2001) Scores Pre- and Post-Intervention .....	115
<b>Table 4.13</b> Descriptive Statistics for Subtest SCAS-P Scores (Spence, 1998) Pre-, Post and Six-Months-Post-Intervention.....	118
<b>Table 4.14</b> Descriptive Statistics for Subtest SCAS (Spence et al., 2001) Scores Pre-, Post- and Six-Months Post-Intervention.....	120
<b>Table 4.15</b> Subthemes within the Valuing Peer Support Theme.....	125
<b>Table 4.16</b> Illustrative Quotes within the For the Child Theme .....	127
<b>Table 4.17</b> Illustrative Quotes within the Journeying Towards Reducing Anxiogenic Parenting Theme .....	128
<b>Table 4.18</b> Illustrative Quotes within the Getting More ‘Good and Brave’ Behaviour Theme .....	130
<b>Table 4.19</b> Illustrative Quotes within the Wanting Personalised Support Theme .	131
<b>Table 4.20</b> Subthemes within the Facilitating Engagement Theme .....	133

## List of Key Abbreviations

<b>ANOVA</b>	Analysis of Variance
<b>BI</b>	Behavioural Inhibition
<b>BPS</b>	British Psychological Society
<b>CAMHS</b>	Child and Adolescent Mental Health Services
<b>CBA</b>	Cognitive Behavioural Approach(es)
<b>CBT</b>	Cognitive Behavioural Therapy
<b>DSM-IV</b>	Diagnostic and Statistical Manual of Mental Disorders
<b>EAL</b>	English as and Additional Language
<b>EP</b>	Educational Psychologist
<b>EPS</b>	Educational Psychology Service
<b>ERI</b>	Emotion-Related Impulsivity
<b>GAD</b>	Generalised Anxiety Disorder
<b>HCPC</b>	Health and Care Professional Council
<b>IGT</b>	Intergenerational Transmission
<b>JASP</b>	Jeffrey's Amazing Statistics Program
<b>NA</b>	Negative Affect
<b>NHS</b>	National Health Service
<b>OCD</b>	Obsessive Compulsive Disorder
<b>PD</b>	Panic Disorder
<b>PWA</b>	Parenting with Anxiety: Helping Anxious Parents Raise Confident Children
<b>RCT</b>	Randomised Control Trial
<b>RMANOVA</b>	Repeated Measures Analysis of Variance
<b>RTA</b>	Reflexive Thematic Analysis
<b>SAD</b>	Separation Anxiety Disorder
<b>SCAS</b>	Spence Pre-school Anxiety Scale-Parent Report
<b>SCAS-P</b>	Spence Children's Anxiety Scale-Parent Report
<b>SDT</b>	Self-Determination Theory
<b>SEMH</b>	Social Emotional Mental Health
<b>SFBT</b>	Solution-Focussed Brief Therapy

<b>SLR</b>	Systematic Literature Review
<b>TA</b>	Thematic Analysis
<b>TaMHS</b>	Targeted Mental Health in Schools
<b>TEP</b>	Trainee Educational Psychologist
<b>UK</b>	United Kingdom
<b>UoN</b>	University of Nottingham
<b>WoE</b>	Weight of Evidence

## **Acknowledgements**

I would first like to thank the parents for embracing this intervention with the positivity, kindness, bravery, and commitment that they did. Research into ways to reduce child anxiety would not be possible without such parents. Thank you. I would also like to thank the school who hosted this project. Creating a warm, safe environment was important for the running of this project and the individuals in the reception did just that. Thank you to Sam Cartwright-Hatton for allowing me to use her intervention for this research project.

I extend thanks to the tutor team at the University of Nottingham for their support. Thank you to my research tutor, Sarah Godwin, for your containment, encouragement, and guidance. I thank all the fellow Trainee Educational Psychologists within 'Cohort 16' for their friendship and laughter. Finally, I would like to thank my family and friends for their unwavering support, interest, and encouragement. Thank you to my boy, Gilly, for always being there to make me laugh, for all the cuddles and for forcing me out for daily walks even when neither of us really wanted to go. I know you'd rather a treat than me write this for you – you can have both.

## **Chapter 1: Introduction**

### **1.1 Personal Interest in the Research**

Through my roles prior to, and whilst becoming, a TEP, I have worked with children who experience anxiety. I have enjoyed learning about and implementing direct interventions to support such young people. Still, considering EPs aim to work not only with the child but those around them, a systemic approach to supporting children with anxiety was seemingly lacking. Despite statistics indicating that 15% of parents experience anxiety (Joint Commissioning Panel for Mental Health, 2012), there was scarce research outlining the ways in which parents with anxiety may be supported using parenting interventions to reduce Intergenerational Transmission (IGT) of anxiety. Through further research, I realised that this gap in research was not only lacking within the field of educational psychology but beyond. This gap in systemic approaches to reducing child anxiety seemed to exist despite growing levels of child anxiety and waiting lists for direct intervention.

My initial research into systemic interventions for IGT of anxiety led me to Sam Cartwright-Hatton. Sam had designed the first parenting intervention for parents with anxiety in the UK, which she trialled in 2018. In 2023, Sam shared that she had designed an online version of this intervention that was yet to be trialled in a school setting, delivered by a TEP. Sam kindly allowed me to do this.

My interest in anxiety also relates to my own experience of anxiety. I relate to the children and parents who experience anxious thinking as part of their daily routine. I also relate to wanting to ensure I do not transmit such thinking. My hope is that EPs can begin to offer an avenue for parents to learn about how their anxiety may be managed in a way that reduces the likelihood of their children developing anxiety.

Together, this research offers an investigation into the effectiveness of a parenting intervention for parents with anxiety in reducing parental perceptions of child anxiety. In addition, it will explore parental views of the intervention.

## 1.2 Thesis Structure

This thesis is comprised of three chapters outlined below:

### **Chapter 1**      **Introduction**

This chapter outlined the researcher's personal journey towards the research topic, along with the purpose of the study. It summarised the structure of the thesis.

### **Chapter 2**      **Literature Review**

This chapter introduces the context of child anxiety. It details theories of and risk factors for child anxiety. IGT of anxiety is explored, alongside interventions which aim to reduce this. A systematic literature review is conducted, exploring the effectiveness of parenting interventions in reducing child internalising behaviours.

### **Chapter 3**      **Methodology**

Philosophical paradigms underpinning research are explored. Attention is then directed towards quantitative, qualitative and mixed-methods research designs. The current mixed-methods research design is outlined. The overarching quantitative, and subsidiary qualitative research questions, designs, procedures and analyses are detailed. The quality and ethics of the study are considered.

### **Chapter 4**      **Results**

This chapter outlines the findings from the quantitative data analysis, including descriptive statistics and inferential statistics. The themes generated from the qualitative data are defined and illustrated.

### **Chapter 5**      **Discussion**

Side-by-side inferences are made for both the quantitative and qualitative data, as well as meta-inferences. A review is given of the methodology. Implications for policy, EPs and future research are given. A conclusion to the research study is provided.

## Chapter 2: Literature Review

### 2.1 Aim and Structure

The current study aims to explore the effectiveness of an adapted parenting intervention, *Parenting with Anxiety: Helping Anxious Parents Raise Confident Children (PWA)* (Cartwright-Hatton, 2021), delivered by a Trainee Educational Psychologist (TEP), in reducing parental perceptions of child anxiety. Subsidiary to this, the research will explore parental perceptions of the intervention.

This literature review will first define mental health needs and anxiety. It will then explore the cognitive model of anxiety (Beck, 1985) and risk factors for the development of childhood anxiety. This review will summarise research regarding the Intergenerational Transmission (IGT) of anxiety. It will explore how parental anxiety may lead to the development of their child's anxiety through a cycle of anxious cognitions and anxiogenic parenting behaviours (Alloy, 2001). Interventions to reduce the risk of IGT will be considered. Thought will be given to the role of Educational Psychologists (EPs) for reducing this risk.

A Systematic Literature Review (SLR) is conducted, investigating, and summarising current research into the effectiveness of parenting interventions in reducing child internalising behaviours and its implications for EP practice.

Finally, this chapter will present the rationale and original contribution of the current research project along with the research questions that this research aims to answer.

### 2.2 Parenting with Anxiety: Helping Anxious Parents Raise Confident Children

The PWA intervention (Cartwright-Hatton, 2021) is a parenting intervention for parents with anxiety. It is underpinned by the cognitive theory of anxiety detailed in section 2.4.6. The intervention aims to challenge anxious parental cognitions and support parents to identify and adapt anxiogenic parenting behaviours. In addition, it aims to guide parents to challenge their child's anxious cognitions, and increase the presence of protective factors including, as high self-concept (Mammarella et al., 2021). The PWA intervention frames the aims of the intervention using the 'Seven Confident Thoughts' framework, shown in Figure 2.1, which is introduced to parents in session 1, and revisited throughout the intervention.

## Figure 2.1

*Seven Confident Thoughts (Cartwright-Hatton, 2021)*

**THE SEVEN CONFIDENT THOUGHTS**

We know that confident children and anxious children think differently about the world. In fact, there are seven key differences. This course is all about getting your children to think like confident children. We call this the Seven Confident Thoughts, and this is what they look like:

- The world is a fairly safe place.
- I can cope with most things.
- Bad things don't usually happen to me.
- Bad things don't usually pop up out of the blue.
- I have some control over my life.
- Other people are okay.
- Other people respect me.

This course is all about different ways to get your child thinking about **The Seven Confident Thoughts**.

*Note:* Figure demonstrating the Seven Confident Thoughts Framework.

Figure taken from the PWA session 1 handout (Cartwright-Hatton, 2021)

To support the parents to instil the 'Seven Confident Thoughts' within their children, the intervention uses draws on psychological theory. For instance, parents are taught relational approaches such as, Emotion Coaching (Gottman et al., 1997) to reduce anxiogenic parenting behaviours such as, reduced warmth, and increase child self-concept.

## 2.3 Mental Health

### 2.3.1 *Defining Mental Health Needs*

*"Problems of living" - Borsboom (2017, p.1)*

Mental health may be conceptualised as a position of well-being whereby the individual realises their abilities, copes with daily stressors, works productively, and contributes to the community (World Health Organization, 2004b). Mental health needs may be defined as the opposite of such a position (Dawson et al., 2010) and are commonly further grouped into internalising or externalising behaviours, outlined in Table 2.1 (Achenbach, 1978; National Health Service, 2018a; Schleider et al., 2015).

**Table 2.1***Table Defining Externalising versus Internalising Behaviours*

<b>Category</b>	<b>Definition</b>
Externalising behaviours	Disinhibited, externally-projected behaviours such as, aggression and hyperactivity (Willner et al., 2016)
Internalising behaviours	Depressive symptoms, social withdrawal, anxiety and somatic complaints (Pinquart, 2017)

Still, the definition of mental health remains a topic of debate, with some theorists suggesting it should simply be deemed the absence of “mental illness” (Carter, 1959) and others suggesting it should be expanded (World Health Organization, 2004b). Alternatively, Borsboom (2017) suggests mental health needs are inappropriately conceptualised as “diseases” with discrete “symptoms” and they should instead be considered the result of interacting risk factors and presentations.

### **2.3.2 Current Context of Child Mental Health Needs**

#### **2.3.2.1 Prevalence**

Mental health needs that occur within childhood have been associated with enduring impairments in social, educational and relational development, as well as adulthood mental health needs (Morales-Muñoz et al., 2023; Pollard et al., 2023; Sellers et al., 2019). In 2023, 1 in 5 young people aged 8 – 25 years old had a “probable mental health disorder” (NHS Digital, 2023).

The number of children with a “probable mental health disorder” has been on the rise from 2017- 2022 (NHS England, 2023). From 2019-2022, the likelihood of children experiencing mental health needs is reported to have risen by 50% (The Children’s Society, 2023). The number of children in contact with mental health services increased by 335, 000 from 2018-2022 (NHS Digital, 2023). A specific rise in internalising behaviours has been observed. Currently, internalising behaviours are suggested to pose the greatest risk to the health of children and young people (Stockings et al., 2016). Of such internalising behaviours, anxiety is considered the most prevalent (Pahl et al., 2012).

### **2.3.2.2 Explaining the Rise in Child Mental Health Needs**

The State of the Nation annual report concluded an “inconsistent recovery of children’s wellbeing” in England from September 2021 to July 2022, following the coronavirus pandemic (gov.uk, 2023). School pressures, social media use, social inequalities, climate change and the Ukrainian war are also cited as possible reasons for the rise in child internalising behaviours (Daly et al., 2022; gov.uk, 2023; Lessof et al., 2016; YoungMinds, 2020).

Recent research suggests that increased mental health awareness in the UK media and schools, may have contributed to the rise in recorded mental health needs (Foulkes & Andrews, 2023). Foulkes and Andrews (2023) present a “prevalence inflation hypothesis”, suggesting that awareness strategies may enhance accurate recognition of mental health needs but may also lead to overinterpretation of mild or transient distress, as mental health needs resulting in a self-fulfilling prophecy (Creswell & O’Connor, 2006). Whilst research on this topic is in its early stages, it highlights the need for sensitivity regarding the language used when discussing mental health needs.

### **2.3.2.3 Government Response**

National mental health services are reportedly struggling to meet the need of the rising number of young people who require mental health support; 34% of children referred to NHS services for mental health support are reportedly not provided with treatment (The Health Foundation, 2022). YoungMinds report that 76% of parents suggest that the waiting time for Child and Adolescent Mental Health Services (CAMHS) support lead to a decline in their children’s wellbeing (YoungMinds, 2018). Schools and professionals working with children in education have a statutory role to ensure best outcomes for child wellbeing (Department for Education, 2023b). Within the State of the Nation report, the Government reports that supporting children’s wellbeing is central to the Department for Education’s plans for post-pandemic recovery (gov.uk, 2023). The Department for Education (2023a) outline aims to support the mental health of young people through offering funding to schools and increasing access to early, specialist mental health support within education. Public Health England (2021b) suggest support, such as parenting

interventions, should be given to families to reduce risk factors associated with child mental health needs.

## **2.4 Childhood Anxiety**

### **2.4.1 Defining Anxiety**

*Anxiety* has been defined as a state of unease, worry or fear ranging from mild to severe (National Health Service, 2018b). An *anxiety disorder* may be defined as an excessive and consistent state of anxiety or fear which is linked to maladaptive behaviours (American Psychiatric Association, 2022). The term *anxiety disorder* is commonly used within the literature. However, this research aligns with the view that categorising children as having an anxiety disorder may be harmful to their well-being, suggesting that the challenges the child is facing is situated within-child, which may reduce the efforts of those around the child to support them (Billington, 2012; Mills, 2016). Parents of children experiencing anxiety express mixed views on the use of this label, with some suggesting that it may lead to the child feeling that they will be “stuck with it for life” (Davey et al., 2022). To minimise the possible harm that the label may cause, this study will describe such experiences as: *anxious behaviours, cognitions, or anxiety*.

### **2.4.2 Current Context of Childhood Anxiety**

*“Generation anxiety”- Zurich (2022, p.1)*

In Britain, it is reported that almost 300,000 young people have a pathological anxiety disorder (NHS Inform, 2023). In the UK, up to 19% of children and young people are estimated to have anxiety disorder (NHS Inform, 2023). The State of the Nation report found that anxiousness in primary and secondary aged children has worsened from 2021-22 (gov.uk, 2023). Recent research found that, of 1,130 school staff surveyed, 95% observed a rise in child anxiety levels in school, following the pandemic (NAHT & Place2Be, 2022). The rise in child anxiety has been associated with the coronavirus pandemic (Zurich, 2022) and the rise in the cost of living (Hingley et al., 2022), alongside the risk factors outlined in section 2.2.2.

Statistics may still underestimate the number of young people experiencing anxiety; they are often based on children who have been diagnosed with an “anxiety disorder” which may mean that the figures are biased towards those able

to afford mental health services or been in a position to be referred to them (Albano et al., 2003). It is suggested that cultural biases may influence whether children from minority background are referred to such services, suggesting that they may be underrepresented within the statistics (Albano et al., 2003).

#### **2.4.3 *Impact of Childhood Anxiety***

Children who experience anxiety may be at risk of not meeting the developmental milestones needed for positive adult functioning such as, completing school and securing employment (Albano et al., 2003; Pollard et al., 2023). Childhood anxiety has also been associated with increased likelihood of peer victimisation and social withdrawal, and reduced prosocial behaviours (Erath et al., 2007; Van Ameringen et al., 2003). Anxiety has been named a “gateway disorder” for several adult mental health needs (Ginsburg et al., 2014). Albano et al. (2003) highlight “disturbing” findings that childhood anxiety has been associated with the development of secondary disorders including, emotional disorders, substance abuse and possible suicide.

#### **2.4.4 *Challenges of Identifying Childhood Anxiety***

Determining “typical” versus “pathological” anxiety in children can be challenging. Serving an adaptive function to alert a child to threats in order for them to flee or confront such danger, anxiety is an important part of normal development towards independence (Albano et al., 2003; Beesdo-Baum & Knappe, 2012). Through experience of novel situations, children learn to habituate to scenarios which may have initially caused anxiety (Albano et al., 2003). For instance, it is typical for children to experience anxiety on their first day at nursery but with further attendance, this anxiety soon subsides.

Contrastingly, pathological child anxiety may be identified when fear and avoidance is pervasive; the child experiences distress and anxiety that is intractable and interferes with their day-to-day functioning (Albano et al., 2003). An additional challenge to recognising childhood anxiety is its high comorbidity with externalising behaviours or depression (Albano et al., 2003) which may lead to anxiety becoming overshadowed (Albano et al., 2003).

#### **2.4.5 *Forms of Childhood Anxiety***

The most common form of anxiety is suggested to be Generalised Anxiety Disorder (GAD) (Mammarella et al., 2021). Other forms of childhood anxiety include Separation Anxiety Disorder (SAD), social phobia, Obsessive Compulsive Disorder (OCD) and Panic Disorder (PD) (Albano et al., 2003). Anxiety is the predominant aspect of each disorder, however, this anxiety may be expressed via different physiological, behavioural and cognitive reactions (Albano et al., 2003). For instance, children with OCD may experience intrusive thoughts (obsessions) which may generate compulsions (NHS, 2013). Children with SAD may experience excessive fear in response to imagined or real caregiver separations (Pincus et al., 2008).

#### **2.4.6 *Cognitive Theory of Anxiety***

Anxiety is most commonly understood using cognitive paradigms (Stallard, 2009). Integral to most cognitive theories of anxiety in adults and children are interpretation biases (Creswell & O'Connor, 2006) – tendencies to interpret ambiguous stimuli as threatening (Ollendick & Benoit, 2012). One of the best-known theories of anxiety comes from Beck (Beck et al., 1985). The central principles of Beck's cognitive model of anxiety (Beck et al., 1985) are shown in Table 2.2 (Clark & Beck, 2011). In summary, Beck et al. (1985) suggests that those with anxiety experience cognitive distortions at three levels: cognitive processing distortions, cognitive content, and a negative self-schema.

Together, such cognitions lead to behaviours such as, maladaptive coping strategies which may maintain and reinforce feelings of anxiety (Creswell et al., 2006). These maladaptive coping strategies include avoidance and Excessive Reassurance Seeking (ERS) (Rector et al., 2019). ERS may be defined as repetitive seeking of safety-associated information from others despite having already received such information (Parrish & Radomsky, 2010). ERS provides a short-term decrease in anxiety but an increased urge to seek reassurance over time, maintaining anxiety through reaffirming the individual's inability to cope (Parrish & Radomsky, 2010; Rector et al., 2011). Low levels of reassurance seeking may be seen in the general population whilst higher levels may be seen in those with anxiety (Rector et al., 2019).

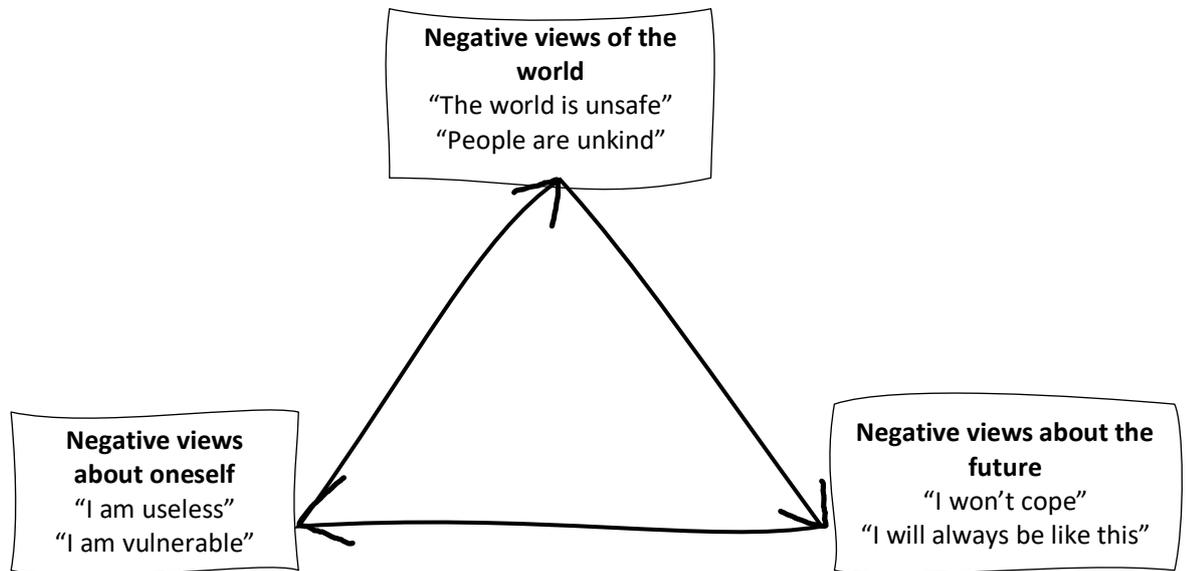
**Table 2.2**

*Summary of the Central Principles of the Cognitive Model of Anxiety (Clark & Beck, 2011)*

Central principle	Explanation
	A person with anxiety may...
1. Overactive threat perception	Have an attentional bias towards threatening or dangerous stimuli
2. Underestimated ability to cope	Experience increased feelings of helplessness and a reduced sense of their ability to cope
3. Restricted processing of safety information	Experience inhibited or restricted processing of safety information or cues that may reduce their sense of danger
4. Impaired reflective thinking	Find it challenging to appraise experiences, logically and therefore do so less
5. Automatic cognitive processing	Experience automatic cognitive processes leading to feelings of anxiety
6. Self-perpetuating cycle	Have a heightened self-awareness of the symptoms and signs of anxiety which may increase distress
7. Cognitive primacy	Misperceive stimuli as dangerous due to the initial cognitive processing of threat and secondary sense of personal vulnerability, leading to behavioural and physiological responses to threat being inappropriately activated
8. Cognitive vulnerability to anxiety	Experience increased anxiety due to core beliefs (schemas) about the person's perceived helplessness and overestimation of threat. Schemas are cognitive structures which process and add meaning to experiences and activate connected psychobiological systems (Beck & Haigh, 2014). An anxious person's schemas are suggested to be a negative view of themselves, a negative view of the future and the world – together, these schemas may be termed the negative cognitive triad, depicted in Figure 2.2.

**Figure 2.2**

*Negative Cognitive Triad (Beck, 1976)*



## **2.5 Risk Factors for Childhood Anxiety**

According to Bronfenbrenner and Morris' (2007) bioecological model of human development, child development is influenced by five nested systems: the microsystem (e.g., parents and teachers), mesosystem (relationship between those in the microsystem), the exosystem (e.g., the school board), the macrosystem (e.g., societal views) and the chronosystem (system changes over time). Bronfenbrenner and Morris (2007) propose a bidirectional relationship between the child's characteristics and those in their immediate environment (proximal processes) as well as bi-directional influences between the child and systems beyond the microsystem (distal processes).

Such ecological models of development have been used to understand the development of childhood anxiety beyond the cognitive model, alone (Mian et al., 2011). Current theorists present integrative models of childhood anxiety, highlighting the role of factors which encompass both psychological and biological vulnerabilities of the child, along with environmental and conditioning factors (e.g., Barlow, 2002; Chorpita & Barlow, 1998; Kerns & Brumariu, 2014).

One integrative model of child anxiety comes from Barlow (2002). The Triple Vulnerability Model (Barlow, 2002) suggests that three risk factors may interact to lead one to experience anxiety. Barlow (2002) suggests children may experience biological vulnerabilities to developing anxiety such as, variations in temperamental characteristics. Another vulnerability may be disorder-specific; children may learn to experience particular internal states in particular contexts which results in the expression of subtypes of anxiety. For instance, Thought-action fusion (TAF) is suggested to be a specific risk factor for the development of OCD; children may believe that just thinking about a distressing event is morally comparable to having experienced it, and it increases the chances of it occurring (Shafran et al., 1996). The Triple Vulnerability Model (Barlow, 2002) suggests psychosocial factors such as, poverty, may also pose a risk to the development of anxiety. In line with the cognitive model of anxiety, Barlow (2002) emphasise that psychological vulnerabilities, namely a reduced perceived sense of control (Gallagher et al., 2014) may contribute to the maintenance of anxiety.

Although detailed examination of integrative models of anxiety, including the Triple Vulnerability Model (Barlow, 2002), is beyond the scope of this review, the following section will briefly outline elements within the child's system which may act as risk factors to the development of anxiety. Subsequently, the review will examine, more closely, the unique influence of parental anxiety on the development of child anxiety.

### **2.5.1 Child Factors**

Genetics may play a key role in the development of anxiety (Barlow, 2002). Research emphasises two temperamental characteristics that serve as risk factors for anxiety (Mian et al., 2011). First, it is suggested that Behavioural Inhibition (BI) may pose a risk for the development of anxiety across developmental stages (Ollendick & Benoit, 2012; Pahl et al., 2012). BI may be defined as a biologically routed tendency to show fear, distress, avoidance, reticence, or quiet restraint when exposed to novel situations, objects and persons (Kagan et al., 2017). A second temperamental characteristic implicated in the development of anxiety is Negative Affect (NA) (Mian et al., 2011). NA is a temperamental construct typified by negative mood, intensive negative emotional reactions, irritability and difficulty

being soothed (Sanson et al., 2004). However, it should be noted that the measurement of temperamental constructs remains controversial within the literature (Mian et al., 2011). For instance, it has been suggested that as NA may be associated with a range of child mental health needs, measures of anxiety *symptomology* such as, fearful responses, are better predictors of child anxiety (Shaw et al., 1997). Nevertheless, research suggests temperamental characteristics and anxiety symptomology are both strong predictors of child anxiety (Mian et al., 2011).

### **2.5.2 Psychosocial Factors**

In line with the Triple Vulnerability Model (Barlow, 2002), psychosocial factors may also pose a risk to the development of anxiety. It is suggested that stressful life events such as, experience of family conflict or poverty can increase the risk of anxiety development (Mian et al., 2011). Chorpita and Barlow (1998) propose that the influence of such events may be mediated by a complex interplay of child factors such as, the child's perceived control and the temperamental characteristics outlined above. Still, research linking life events and the development of child internalising behaviours remains limited (Mian et al., 2011)

### **2.5.3 Attachment**

The attachment between the child and their caregiver has also been found to be a risk factor for the development of anxiety (Kerns & Brumariu, 2014). Attachment may be understood as a person's method of connecting in caregiving and receiving relationships with one's caregiver or parent (Bowlby, 1969). It is suggested that children who develop insecure attachments with their caregiver may develop a maladaptive approach to developing relationships with others and regulating their emotions due to possible early experiences of their caregiver being untrustworthy, unreliable, and uncommunicative (Ollendick & Benoit, 2012). Reflecting on the negative cognitive triad (Beck, 1976), it makes sense that such experiences may lead to negative thoughts about the world, self, and others. It is suggested that, as predicted by the cognitive theory of anxiety (Beck, 1985), such maladaptive thoughts may lead to behaviours that reinforce such beliefs (Ollendick & Benoit, 2012).

Yarbro et al. (2013) found that attachment anxiety partly mediated the interaction between neglectful and cold parenting and the development of child perfectionism and threat estimation— obsessive beliefs associated with OCD. It was proposed that through an anxious attachment, the child develops maladaptive cognitions about themselves and others in ways that may serve as “cognitive vulnerabilities” for the development of OCD (Yarbro et al., 2013). Yarbro et al. (2013) suggest that a child of a parent who demonstrates reduced warmth may become hypervigilant of threats due to an uncertainty as to the caregiver support available to them. They may also develop perfectionism which may manifest as striving for perfect interpersonal behaviours or performances to feel accepted by others (Yarbro et al., 2013). Perfectionism relates to individuals setting unrealistically high expectations for themselves and others (Lewis & Cardwell, 2020)

In line with the theory of proximal processes (Bronfenbrenner & Morris, 2007), it is suggested that the attachment relationship itself may be influenced not only by the parent but the characteristics of the child. Ollendick and Benoit (2012) propose a model highlighting how child anxiety may be developed through a complex interplay of child temperament, attachment security, parenting factors and life stress.

However, it should be considered that the concept of attachment has been criticised. It is suggested that categorising children in this way is reductionist (Mercer & Main St, 2011). The profile of a child with an “insecure attachment” may be similar to a child with alternative needs (Moran, 2010).

#### **2.5.4 Parenting Factors**

It is proposed that parenting factors are a significant risk factor for the development and maintenance of child anxiety (Casline et al., 2021), with parenting being one of the primary systems within which the child is nested (Ollendick & Benoit, 2012). Research suggests parenting behaviours (Ollendick & Benoit, 2012), parenting stress (Pahl et al., 2012), parenting psychopathology (Pahl et al., 2012) and parental anxiety are associated with child anxiety (Chapman et al., 2022). It is reported that parental anxiety increases the chances of a child developing anxiety two-fold (Lawrence et al., 2019). Given the purpose of this literature review, the next section will consider, in further detail, the ways in which parental anxiety may

lead to the development of child anxiety. Within this, parenting behaviours will be referenced.

### **2.5.5 Summary of Risk Factors**

Several risk factors are implicated in the development and maintenance of childhood anxiety. Child factors such as, temperament may play a role in the development of anxiety (Barlow, 2002). Considering proximal processes, child factors may interact with aspects of their environment or experiences such as, stressful life events, leading to the development of anxiety (Albano et al., 2003; Ollendick & Benoit, 2012). Parenting factors, particularly parental anxiety, are presented as a significant risk factors for the development and maintenance of child anxiety (Casline et al., 2021).

## **2.6 Intergenerational Transmission of Anxiety**

### **2.6.1 Current Context of Parental Anxiety**

*“A large number of adults access treatment for anxiety, and a substantial proportion of these adults will have children” - Chapman et al. (2022, p.5)*

It is suggested that 57% of men and 68% of women who experience mental health needs are parents (The Royal College of Psychiatrists, 2016). Approximately 15% of parents experience anxiety or depression (Joint Commissioning Panel for Mental Health, 2012). Anxiety is one of the most common mental health needs affecting mothers (Joint Commissioning Panel for Mental Health, 2012). Given that parental anxiety has been associated with child anxiety (e.g., Casline et al., 2021), research emphasises that the support of parents experiencing anxiety should be a priority when considering childhood anxiety prevention (Chapman et al., 2022).

### **2.6.2 Genetic versus Environmental Contribution**

The association between parental and child anxiety is widely accepted within the literature (Ahmadzadeh et al., 2019). However, knowledge of the mechanisms driving this IGT is still developing (Ahmadzadeh et al., 2019). As previously mentioned, research indicates the role of genetics in this transmission (Barlow, 2002). However, it is suggested that genes account for up to just half of individual risk factors for childhood anxiety (Ahmadzadeh et al., 2019). Much of the

IGT is believed to be attributable to the environmental influence of parenting processes (Cartwright-Hatton et al., 2018).

### **2.6.3 From Parental Cognitions to Parenting Behaviours**

According to the cognitive model of anxiety, adults with anxiety experience cognitive distortions which can generate and maintain feelings of anxiety (Beck, 1985). It is suggested that these cognitive patterns in parents may be transferred to their children thus increasing the chances of the child experiencing anxiety (Alloy, 2001). Creswell et al. (2006) found that when mothers with anxiety expected their children to experience high levels of distress, their child's threat perception, over time, also increased. Likewise, Mammarella et al. (2021) found that in parents with anxiety, their threat perception and distress expectations significantly predicted their children's threat perceptions. This interpretation bias has frequently been cited in research connecting parental and child anxious cognitions (Ollendick & Benoit, 2012).

The transmission of anxious cognitive patterns may occur via parental behaviours which teach their children about their self-competency and "appropriate" cognitive processing of situations – information transfer (Alloy, 2001; Murray et al., 2009). Creswell et al. (2008) showed that parents with negative beliefs about their child completing an activity (overprotection) were less likely to allow their child to complete the activity independently versus those with positive beliefs. This overprotection may reduce the child's beliefs that they can cope in the face of challenges (Chorpita & Barlow, 1998). These behaviours have been labelled *anxiogenic (anxiety enhancing) parenting* behaviours (Flessner et al., 2016; Murray et al., 2009).

Table 2.3 outlines several anxiogenic parenting behaviours (Flessner et al., 2016; Murray et al., 2009). In line with the social learning theory (Bandura, 1986), anxiogenic parenting may teach anxious behaviours via modelling (e.g., parent screaming when they see a dog). Direct communication from parents (e.g., parent telling the child the dog is scary) may also teach anxious responses. Figure 2.3 shows how anxiogenic parenting may lead to child anxiety.

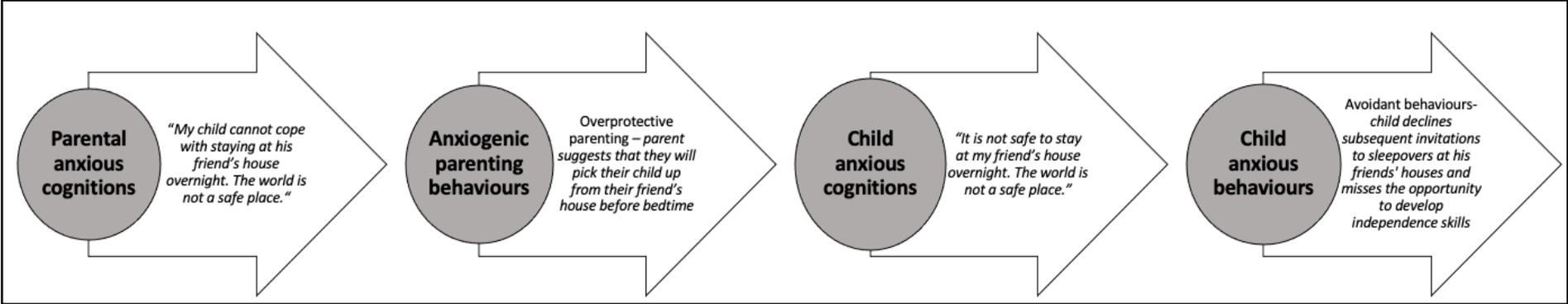
**Table 2.3**

*Table Detailing Anxiogenic Parenting Behaviours (Flessner et al., 2016; Murray et al., 2009)*

<b>Behaviour</b>	<b>Definition</b>	<b>Impact on Child</b>
Overcontrolling parenting	Unnecessary restrictions and instructions on the child's behaviour	<ul style="list-style-type: none"> <li>• Indicates the world is unsafe</li> <li>• Encourages avoidant behaviours</li> </ul>
Overprotective parenting	Superfluously warm and supportive parenting (Chorpita & Barlow, 1998)	<ul style="list-style-type: none"> <li>• Reduces chances to independently cope with developmentally suitable challenges which would enhance their skills and confidence (Chorpita &amp; Barlow, 1998)</li> </ul>
Accommodation of anxiety and modelling of avoidant coping behaviours	Parental behaviours which assist the child in avoiding potentially distressing situations (Lebowitz et al., 2014) and demonstrate their own anxiety	<ul style="list-style-type: none"> <li>• Suggests fearful situations should be avoided (Adelman &amp; Lebowitz, 2012)</li> </ul>
Reduced warmth	Reduced praise, support and affection (Kirkham et al., 2018)	<ul style="list-style-type: none"> <li>• Child believes the world is unsafe, reducing their sense of competence and worth (Bögels &amp; Tarrier, 2004)</li> </ul>

**Figure 2.3**

*Figure Demonstrating Transmission of Parental to Child Anxiety*



Anxiogenic parenting practices may be reinforced by the parent avoiding observing their child experience anxiety in the short term, creating an anxiety feedback cycle which may lead to greater child anxiety in the long term (Emerson et al., 2019). Drawing on cognitive risk factors at the heart of emotional regulation theories of anxiety, Casline et al. (2021) found that parental Distress Intolerance (DI), the perceived difficulty in coping with negative emotions (McHugh & Otto, 2012), was associated with child anxiety. Parents with anxiety may struggle to observe their child experiencing anxiety (DI) and thus engage in avoidant coping behaviours (Casline et al., 2021). Parental Emotion-Related Impulsivity (ERI), the tendency to behave impulsively when responding to emotions (Johnson et al., 2013), was also indirectly associated with child anxiety (Casline et al., 2021). Parents with anxiety may struggle to inhibit compensatory behaviours in response to their child's anxiety (Casline et al., 2021).

Research has explored the association between anxiogenic parenting behaviours and forms of childhood anxiety. Thompson-Hollands et al. (2014) found that although parental accommodation is frequently associated with OCD, accommodation was most strongly associated with child SAD, phobias, and GAD. It was also shown that such parental accommodation was higher when maternal distress was increased (Thompson-Hollands et al., 2014). This may suggest, in line with Casline et al. (2021)'s findings, that anxiogenic parenting behaviours may vary depending on the parents' emotional capacity given their personal levels of distress.

Schneider et al., (2009) found that mothers with panic disorder demonstrated reduced sensitivity and increased criticism and verbal control towards their children versus mothers without mental health needs. Children of mothers who exhibited increased levels of parental control experienced reduced self-efficacy (Schneider et al., 2009) and increased anxiety. Schneider et al., (2009) suggest child self-efficacy as a mediating factor between anxiogenic parenting behaviour, over control, and child anxiety.

#### **2.6.4 Considerations**

In line with the bioecological model of development (Bronfenbrenner & Morris, 2007) and the integrative models outlining risk factors for the development of childhood anxiety (Barlow, 2002), IGT is thought to be a complex interplay

between parental and child factors (Drew, 2015). Parental cognitions may be responsive to their children's anxious cognitions (Creswell et al., 2006). Protective factors such as high parental emotional regulation skills are also suggested to reduce the chances of the parent using anxiogenic parenting styles (Chapman et al., 2022). It should also be considered that a large majority of research into the influence of parental anxiety is conducted with single mothers (Ahmadzadeh et al., 2019; Pahl et al., 2012). Research indicates that paternal anxiety may influence child anxiety differently (Pahl et al., 2012). For example, paternal DI and child anxiety did not predict anxiogenic parenting, whereas maternal DI and child anxiety did (Casline et al., 2021). Casline et al. (2021) suggest that this may relate to gender differences in coping mechanisms in response to distress; women may be more likely to avoid the negative emotion whilst men may problem-solve.

### **2.6.5 Summary of the Intergenerational Transmission of Anxiety**

A suggested mechanism of IGT of anxiety is through anxious cognitions (Alloy, 2001). It is suggested that parental anxious cognitions may lead to anxiogenic parenting behaviours which may encourage their children's development of anxious cognitions (Murray et al., 2009). This cycle may be maintained by the parents reducing the distress that they may experience should they witness their children experience short-term anxiety (Casline et al., 2021; Emerson et al., 2019). However, this cycle may foster greater anxiety in their children, long-term (Emerson et al., 2019). Together it is suggested that breaking this cycle could be critical to the prevention of childhood anxiety (Chapman et al., 2022) – the way in which this may be achieved is explored further in the next section of this review.

## **2.7 Anxiety Interventions**

There are multiple interventions that aim to reduce childhood anxiety. Interventions may be given at three levels: universal (delivered to the entire populations), selective (for those at risk of anxiety) and indicated (for those who demonstrate anxiety) (Lawrence et al., 2022). Selective and universal interventions may be thought of as preventative. It is suggested that preventative measures, for instance those which may reduce IGT, are preferable and should be used to mitigate the need for direct child interventions (World Health Organization, 2004a).

Despite increasing demands for direct child interventions, such interventions are often unavailable to those who need them (Jewell et al., 2023). Many children experiencing anxiety do not meet the threshold for services such as, CAMHS which may mean that their anxiety goes unsupported (Jewell et al., 2023).

### **2.7.1 Role of Indicated Interventions for Parents with Anxiety**

Indicated interventions such as, Cognitive Behavioural Therapy (CBT) are frequently recommended to adults and children experiencing anxiety (Creswell & Cartwright-Hatton, 2007). Associated with the cognitive model of anxiety (Beck, 1985), CBT aims to highlight and challenge the maladaptive cognitions that may lead to feelings of anxiety and anxious behaviours, whilst providing coping strategies (Stallard, 2009).

It makes sense that treating parental anxious cognitions may serve to break the cycle in which parental anxious cognitions generate anxiogenic parenting behaviours which in turn, encourage child anxious cognitions (Chapman et al., 2022). However, research suggests that this may not be the case; merely treating parental anxiety alone may not be effective in reducing the risk of IGT (Chapman et al., 2022). Schneider et al. (2002) found that children of parents who underwent CBT for panic disorder showed no reduction in anxiety following parental CBT compared to the control group.

This lack of reduction in IGT of anxiety following treatment of parental anxiety may be due to the emotional regulation strategies required for *parenting* being different to those utilised when one targets their own needs (Rutherford et al., 2015). It is also suggested that CBT does not support parents in altering anxiogenic parenting behaviours which may encourage the development of childhood anxiety (Challacombe et al., 2017).

### **2.7.2 Parenting Interventions for Parents with Anxiety**

*“Anxiety disorders run in families but we currently do little to help anxious parents to raise confident children” - Cartwright-Hatton et al., (2018, p.1)*

#### **2.7.2.1 Content**

Emerging research supports the use of parenting interventions for parents with anxiety to prevent IGT of anxiety through positive shaping of parenting cognitions *and* behaviours (Brendel & Maynard, 2013; Cartwright-Hatton et al.,

2018). Following a Cognitive Behavioural Approach (CBA), it is suggested that the content of such interventions may focus on challenging anxious parental cognitions *and* reducing anxiogenic parenting behaviours whilst guiding parents to challenge the anxious cognitions that their child may develop (Cartwright-Hatton, 2021).

Hirshfeld-Becker et al. (2007) suggests that interventions which are attended by parents with anxiety may focus on reducing child avoidant behaviours and supporting a graduated exposure to fear-inducing stimuli. Silk et al. (2013) found that children of parents who encouraged approach-orientated behaviours showed a greater reduction in anxiety, in conjunction with CBT, versus children who completed CBT alone. Sperling et al. (2021) suggest this may be due to children of encouraging parents developing feelings of mastery and capability.

Parents may also be supported to recognise areas in which their own anxieties (e.g., social anxiety) may cause gaps in the developmental experiences of their children (e.g., social activities) (Dadds & Barrett, 2001). Wood et al. (2006) suggests that parenting interventions aimed at prevention of childhood anxiety should also support parents to reduce overprotection, granting their children age-appropriate levels of autonomy. Possibly countering the reduced warmth associated with anxiogenic parenting, research indicates the benefits of parents using relational approaches, encouraging positive change via trusting relationships and collaborative problem solving (Rose et al., 2019) to reduce child anxiety (Brumariu & Kerns, 2015). Parenting interventions for parents with anxiety may include teaching of relational strategies such as, Emotion Coaching (Hurrell et al., 2017). Emotion Coaching (Gottman et al., 1997) consists of parents using their children's experiences of adverse emotions as opportunities for connection and teaching so that the child may problem-solve similar feelings in the future (Gottman et al., 1997). Interventions for parents with anxiety may also offer parents ways to encourage factors that protect against the development of childhood anxiety, such as high resilience and self-concept (Mammarella et al., 2021).

Research suggests that parental interventions may need to be tailored to the family's needs to reduce and/or prevent child anxiety (Pincus et al., 2008). Pincus et al. (2008) adapted the Parent-Child Interaction Therapy (PCIT) (Brinkmeyer & Eyberg, 2003) intervention for children with SAD. The PCIT supports parents with

behaviour management and enhancing the parent-child relationship (Pincus et al., 2008). Adapting the PCIT, Pincus et al. (2008) included a Bravery Directed Interaction (BDI) phase. This phase taught parents to create a Bravery Ladder with the child, identifying gradual steps for the child to take in exposing themselves to their fear of separation – a graduated exposure approach. Children whose parents took part in the SAD-adapted PCIT, versus PCIT alone, showed further reductions in separation anxiety (Pincus et al., 2008).

Reflecting on the intervention, Pincus et al. (2008) suggested parents needed coaching to ensure they were not “overdoing it” with the use of taught strategies such as, praise. Pincus et al. (2008) also suggested that some parents may not have been motivated to use some of the taught techniques, either due to feeling that they already use them, or due to secondary gains such as, feeling needed by the child (Pincus et al., 2008).

Inclusion of a peer support element to interventions for parents with anxiety may also be important for reducing IGT of anxiety. Facilitation of peer support has been associated with a reduction in parental anxiety (Preyde & Ardal, 2003; Sharma et al., 2022) which may work to reduce IGT of anxiety through a reduction in anxiogenic parenting (e.g., Alloy, 2001). The Self Determination Theory (SDT) (Ryan & Deci, 2000) may explain the relationship between enhanced peer support and the reduction of anxiety (Kearns, 2017; Wu & Lee, 2022). The SDT indicates that humans need three dimensions for positive wellbeing: autonomy, competence, and relatedness (Ryan & Deci, 2000). Relatedness may be defined as the need to interact and build connections with others and having reciprocal and caring relationships (Ryan & Deci, 2000). An important element of relatedness is a sense of belonging – being valued, encouraged, and included by others (Calp, 2020). It may be proposed that feelings of relatedness may challenge the thoughts outlined in the Negative Cognitive Triad, suggesting – “people are kind, I can cope and I am valued”, reducing anxiety (Beck, 1976).

#### **2.7.2.2 Possible Barriers and Facilitators to Attendance**

Using semi-structured interviews, Lawrence et al. (2022) explored what young people, 14-17 years old, and their mothers with previous or existing anxiety

disorders perceived as facilitators and barriers to attending anxiety prevention programmes.

Barriers to mothers attending an anxiety prevention programme included: a lack of knowledge as to what anxious behaviours looked like and therefore whether the intervention would be beneficial to them, fear of stigmatisation and being unaware of the evidence underpinning the intervention (Lawrence et al., 2022).

Facilitators to parents accessing such interventions included schools signposting support and promoting the importance of anxiety prevention (Lawrence et al., 2022). Mothers felt that in-person interventions would facilitate their attendance, and the young people indicated that online sessions would be preferable (Lawrence et al., 2022). Of note, all mothers in this study are from the same cohort, suggesting their views may differ from those in other cohorts. Indeed, recent research suggests parents prefer parental interventions which use a blended approach of remote and in-person aspects (Hall & Bierman, 2015; Kenworthy et al., 2022). Such blended interventions have been associated with increased participant engagement and positive child outcomes due to facilitation of peer support (Hall & Bierman, 2015; Kenworthy et al., 2022).

Additional barriers to parents with anxiety attending interventions have been cited to be anxiety itself, lack of childcare and work commitments (Cartwright-Hatton et al., 2018).

### **2.7.2.3 Evidence Base**

There is scarce research into the effectiveness of parental interventions for parents with anxiety, in reducing their child anxiety. Recently, Chapman et al. (2022) reported an “empty systematic literature review” on the topic, finding no research exploring the impact of parenting interventions for parents with anxiety on child anxiety. However, as this review included Randomised Control Trials (RCTs) only, research conducted using alternative research designs may have been overlooked (Chapman et al., 2022). Nevertheless, this generated a request for action and research (Chapman et al., 2022).

At a broader level, there are similarly few SLRs and indeed studies (Mendez et al., 2013), exploring the effectiveness of parenting interventions informed by psychological theory in reducing child internalising behaviours (Burke et al., 2021).

Of the available reviews, Petrenko (2013) highlighted two studies that found parenting interventions to be effective in reducing child internalising symptoms. Similarly, Brendel and Maynard (2013) found parent-child interventions to be successful in reducing anxiety symptoms beyond child-only interventions. Differently, Gardner et al. (2017) found the Incredible Years parenting programme did not reduce child internalising behaviours more in parents who attended the intervention versus those who did not. Although, this intervention allowed parents to create their own parenting strategies, which may not be supported by psychological theory, reducing validity of findings.

## **2.8 Role of Educational Psychologists**

Considering the rising levels of child internalising behaviours, including anxiety (NHS Digital, 2018), the UK Government are calling on professionals such as, EPs to support children with mental health needs and highlight the importance of doing so through work with parents (Public Health England, 2021).

EPs have a valuable role to play in supporting the Social, Emotional and Mental Health (SEMH) of children and young people (Dunsmuir & Cobbald, 2016). This may be achieved through working at the various systemic levels outlined by Bronfenbrenner and Morris (2007) (Scottish Executive Education Department, 2002). However, to the researcher's knowledge, despite indications that interventions for parents with anxiety may reduce the IGT of anxiety (Chapman et al., 2022), such interventions are not currently delivered by EPs. This may owe to a lack of existing evidence for their effect (Cartwright-Hatton et al., 2018); as scientist-practitioners, EPs must be able to justify their delivery of interventions, with research evidence (Evidence Based Practice, EBP) (Robson & McCartan, 2015). Barriers to parents accessing preventative programmes may also be a reason for the lack of delivery (Lawrence et al., 2022).

Nonetheless, EPs may be well positioned to help overcome such barriers (Department for Education & Department of Health, 2015). Using their skills in systemic working, EPs may work with both schools and parents, giving psychology away to support their understanding of what anxiety may look like, the importance of anxiety prevention and how interventions may work to support this (Lawrence et al., 2022; Lee & Woods, 2017).

Although, another barrier to EPs delivering parenting interventions may be working within a traded context. Traded models refer to EP services which generate income from education settings to meet some or the entirety of their costs (Woods, 2014). Working within a traded model, EP involvement may be restricted to the desires of the schools (Lee & Woods, 2017). Nevertheless, interventions have been found to be one of the EP contributions deemed valuable to schools (Lee & Woods, 2017). In a survey of five schools in the researcher's Local Authority (LA), two shared that they would like EP involvement regarding the impact of parental mental health on their children's wellbeing, indicating a possible interest in parenting interventions to support children with their mental health.

## **2.9 Summary and Rationale**

A rising number of children in the UK are experiencing anxiety which has been linked to negative child outcomes (Van Ameringen et al., 2003). Research indicates parental anxiety as a key risk factor for the development of childhood anxiety (Cartwright-Hatton et al., 2018). Anxiety is thought to transmit through generations via parental anxious cognitions, leading to anxiogenic parenting behaviours which may foster anxious child cognitions (Alloy, 2001). Interventions for parents with anxiety, focussed on challenging maladaptive anxious cognitions, reducing anxiogenic parenting, and enhancing child protective factors may be used to prevent the development of child anxiety (Cartwright-Hatton, 2021; Chapman et al., 2022). EPs may be well placed to deliver such interventions (Dunsmuir & Cobbald, 2016).

A recent SLR which aimed to explore the effectiveness of interventions for parents with anxiety on child anxiety outcomes reported an "empty review" (Chapman et al., 2022). Even at a broader level, there remain few SLRs which explore the effectiveness of parenting interventions, underpinned by psychological theory, in reducing child internalising symptoms. The existing SLRs on this topic explore specific interventions (Gardner et al., 2017), present inconsistent findings, and are up to 10 years old, indicating the need for an updated review.

With national calls for EPs to deliver evidence-based interventions to reduce child internalising behaviours, including anxiety (Dawson et al., 2010), yet a lack of reviews summarising such evidence, EPs may benefit from the synthesis of evidence

exploring the effectiveness of parenting interventions in reducing child internalising symptoms. This may support EPs in deciding whether to recommend or deliver such interventions to reduce child internalising behaviours (Dawson et al., 2010).

## **2.10 Systematic Literature Review**

### **2.10.1 Introduction to the Systematic Literature Review**

#### **2.10.2 Objectives**

The objective of this SLR is to answer the question: “**Are parenting interventions effective in reducing child internalising behaviours?**”. In reference to the Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) guidelines (Page et al., 2021), this SLR will search, synthesise and evaluate articles in line with defined eligibility criteria.

#### **2.10.3 Method**

A SLR was conducted due to its suitability for exploring emerging research topics (Mertens, 2005) through summarising existing findings and highlighting avenues for future research (Mertens, 2005). SLRs are also proposed to be useful for exploring the effectiveness of interventions through summarising and appraising findings from more than one study (Petticrew & Roberts, 2008). A critique of SLRs is their potential to present studies without critically appraising their methodology, leading to misleading findings (Petticrew & Roberts, 2008). All studies included in this review will be quality appraised.

##### **2.10.3.1 Eligibility Criteria**

Table 2.4 outlines the inclusion and exclusion criteria used to identify articles for review. This criteria was created in reference to the Population Intervention Comparison Outcomes (PICO) strategy (Petticrew & Roberts, 2008).

**Table 2.4***Inclusion and Exclusion Criteria used for this SLR*

Criteria	Inclusion Criteria	Exclusion Criteria	Rationale
1. Population	<ul style="list-style-type: none"> <li>a. Parents and caregivers (biological, kinship, foster or adoptive) of children aged 0-25 years</li> <li>b. Children aged 0-25 years</li> </ul>	<ul style="list-style-type: none"> <li>a. School staff or parents and caregivers of children over the age of 25 years old</li> <li>b. Young people over the age of 25 years old</li> </ul>	<ul style="list-style-type: none"> <li>a. This review is exploring the effectiveness of <i>parenting</i> interventions in reducing their children's internalising behaviours.</li> <li>b. The findings of this review are to be relevant to EPs who work with children 0-25 years old</li> </ul>
2. Intervention	<ul style="list-style-type: none"> <li>a. A focus of the intervention is parenting practices and/or the parent-child relationship</li> <li>b. The intervention is based on a psychological paradigm or theory</li> </ul>	<ul style="list-style-type: none"> <li>a. There is no intervention focus on parenting practices and/or the parent-child relationship</li> <li>b. The intervention is not based on a psychological approach, paradigm or theory</li> </ul>	<ul style="list-style-type: none"> <li>a. This review is exploring the effectiveness of parenting interventions in reducing their children's internalising behaviours. Therefore, the aim of the parenting intervention must be related to this outcome</li> <li>b. The findings of this review are to be relevant to the profession of EP</li> </ul>
3. Context	The research was conducted in the UK	The research was not conducted in the UK	The findings of this review are to be generalisable to UK schools
4. Outcomes	The research explores the effectiveness of parenting interventions in reducing their children's internalising behaviours	The research does not explore the effectiveness of parenting interventions in reducing their children's internalising behaviours	This review is exploring the effectiveness of parenting interventions in reducing their children's internalising behaviours

Criteria	Inclusion Criteria	Exclusion Criteria	Rationale
5. Design	<p>The research uses RCTs whereby participants have been randomly allocated to the intervention or control group* or Quasi-experimental designs or Pre-experimental designs (e.g., pre- and post-measures)</p> <p><i>*The intervention condition relates to participants taking part in the parenting intervention. The control group will receive no intervention, an alternative intervention or be on an intervention waiting list.</i></p>	The research does not use RCTs whereby participants have been randomly allocated to the intervention or control group nor does it use a quasi- or pre-experimental design	This review is exploring the <i>effectiveness</i> of an intervention; according to the hierarchy of evidence, RCTs are the most internally valid measure of this (Petticrew & Roberts, 2008). To allow for the review of a sufficient number of studies, quasi- and pre-experimental designs will also be used (Petticrew & Roberts, 2008), however the weight of such evidence will be reduced in comparison to RCTs (Gough, 2007).
6. Language	The research is presented in English	The research is presented in a language other than English	The review must be understood by the reviewer
7. Date of publication	The study was published up to 2023	The study was published after 2023	To allow for the review of a sufficient number of studies
8. Type of publication	<ul style="list-style-type: none"> <li>a. The publication has been peer-reviewed</li> <li>b. Journal research articles</li> </ul>	<ul style="list-style-type: none"> <li>a. The publication has not been peer-reviewed</li> <li>b. Books, book reviews or opinion pieces</li> </ul>	<ul style="list-style-type: none"> <li>a. To ensure that the research methodology has been assessed, ensuring its validity and high quality.</li> <li>b. For feasibility of the small-scale review</li> </ul>
9. Review topic	The research is investigating the effectiveness of parenting interventions in reducing their children's internalising behaviours	The research is not exploring this topic	This review is investigating the effectiveness of parenting interventions in reducing their children's internalising behaviours

### 2.10.3.2 Search Strategy

Electronic databases, EBSCO, Web of Science and PsychINFO were searched for this review in November 2023. The search terms applied to the abstract, title and key words are outlined in Table 2.5. The following limits were applied: Peer Reviewed, United Kingdom, Journal Articles, and available in the English language. See Appendix A for further details.

**Table 2.5**

*Review Search Terms Used*

Main Search Term	Variations	Truncations
Parenting	parent-child	parent*
Intervention	training, programme	program*, session*
Child	adolescent, teenager, infant, young person	child*, adolescen*, teen*, inf*,
Internalising	internalizing, anxiety, depression, somatic, social withdrawal	despressi*, anx*

### 2.10.3.3 Selection Process

The selection of articles for synthesis and review was completed independently by the reviewer. Articles resulting from the database searches were first exported to the bibliographic database software, Mendeley. Mendeley automatically removed duplicate articles. The title and abstracts of the remaining articles were then manually screened by the reviewer, according to the topic of the article. Finally, the remaining full articles were screened using the eligibility criteria (see Appendix B). Two articles were manually exported into Mendeley; this article was found during a previous SLR search and was deemed relevant to be title and abstract screened.

### 2.10.3.4 Data Collection Process

The reviewer will independently extract and summarise the following key characteristics from each article for the review: aim, participants, design, outcome measure, follow-up and findings (Petticrew & Roberts, 2008). Additionally, the

intervention name, provider, content, and frequency will be extracted and tabulated (Hoffmann et al., 2014).

#### **2.10.3.5 Synthesis Methods**

A narrative synthesis will be performed using the articles found from the systematic search. This method of synthesis is found to be appropriate for quantitative data (Moher et al., 2015). Due to the expected variety of interventions synthesised, a meta-analysis is deemed inappropriate (Petticrew & Roberts, 2008). Given the few studies predicted to be available for review (Burke et al., 2021), an overall versus grouped, narrative synthesis will be performed (Moher et al., 2015). Study heterogeneity will be explored through a narrative comparison of study characteristics (Petticrew & Roberts, 2008).

#### **2.10.3.6 Quality Appraisal**

Prior to synthesis, the reviewer will independently appraise the quality of research to ensure the evidence used for synthesis is relevant and of sufficient quality (Gough, 2007). This will be completed using the Weight of Evidence (WoE) framework (Gough, 2007). This framework allows the reviewer to assess both the methodological quality of the research as well as its suitability for answering the review question (Gough, 2007).

The WoE framework consists of three criteria (*A*, *B* and *C*) which are used by the reviewer to appraise the studies included in the review (Gough, 2007). WoE criteria *A* requires the reviewer to judge the integrity and coherence of the research evidence (Gough, 2007). This judgement is non-review-specific and may be made through use of a criteria for appraising the quality of the type of evidence used in the research by those who commonly generate or use it (Gough, 2007). Gersten et al. (2005)'s quality indicators for experimental and quasi-experimental designs informed the WoE *A* criteria.

WoE *B* is review-specific; it asks the reviewer to judge the appropriateness of the research methodology in answering the specific review question (Gough, 2007). Gough (2007) indicates that RCTs are appropriate for answering questions relating to the effectiveness of interventions. The criteria for WoE *B* was informed by both the quality indicators outlined by Gersten et al. (2005) and the hierarchy of evidence outlined by Petticrew and Roberts (2008).

WoE C consists of a review-specific appraisal of the relevance of the evidence in relation to the research question such as, the sample used (Gough, 2007).

The specific criteria used within WoE A, B and C is defined by the reviewer (see Appendix C) as the WoE tool is intended for flexible use, in line with the review aims and methods and overall research question (Gough, 2007). Each study will be rated per criteria as *high*, *low* or *medium* quality (*A*, *B* and *C*) (Gough, 2007). Ratings will be combined to generate an overall quality judgement (*D*) for each study (Gough, 2007). See Appendix C for further information.

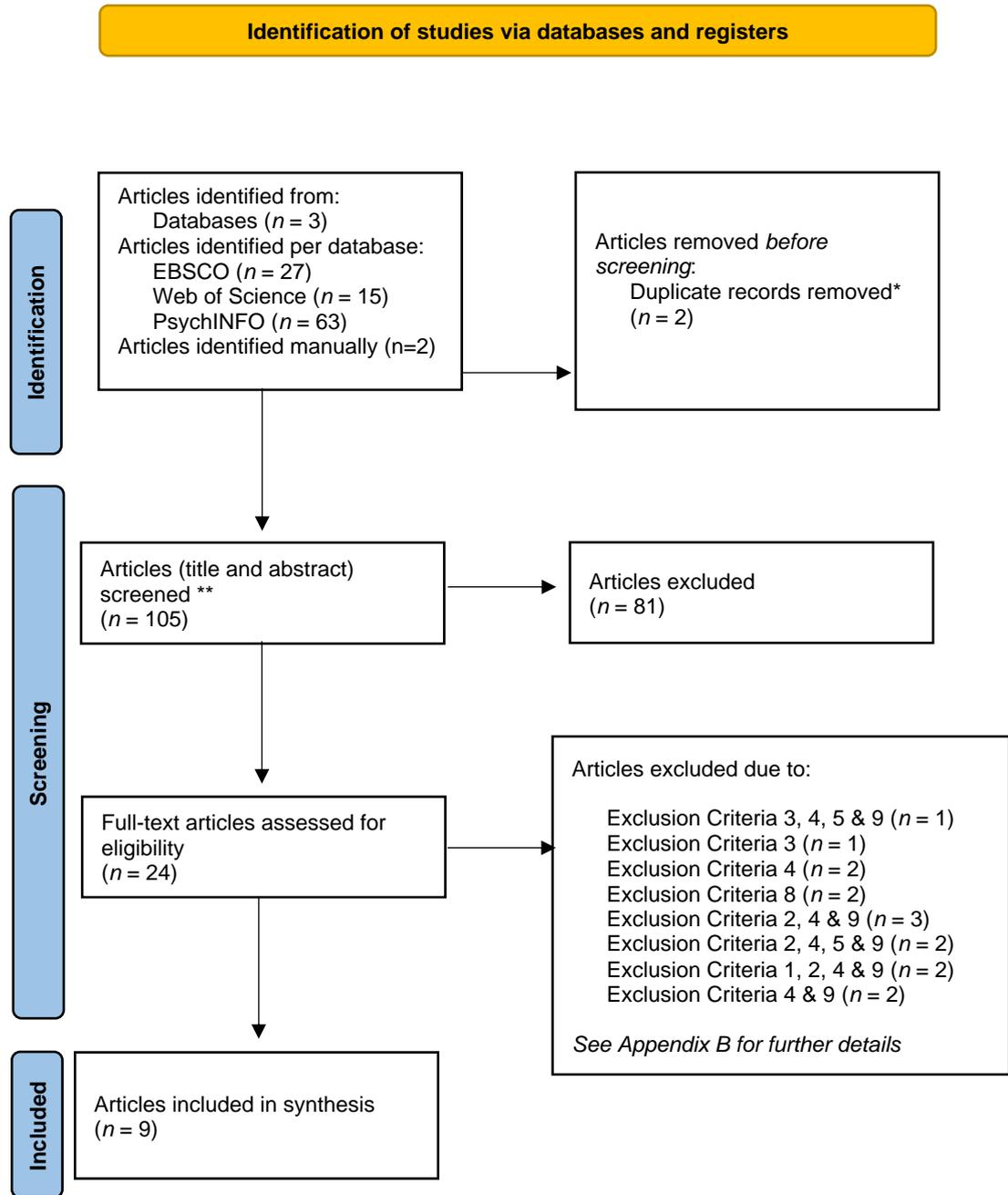
#### **2.10.4 Results**

##### **2.10.4.1 Study Selection**

A flow chart showing the results of the selection process is shown in Figure 2.4. Nine articles (Cartwright-Hatton et al., 2005, 2018; Davis & Spurr, 1998; Evangelou & Sylva, 2007; Gobrial & Raghavan, 2018; Jewell et al., 2023; McConachie et al., 2014; Palmer et al., 2023; Pillay et al., 2011) were included in the synthesis following screening.

**Figure 2.4**

*PRISMA Flow Chart (Page et al., 2021) Demonstrating the Selection Process Used for the Review*



\* Automatically using Mendeley

\*\* Manually

#### **2.10.4.2 Study Characteristics and Synthesis**

For review transparency (Petticrew & Roberts, 2008), key study characteristics are tabulated in Appendix D. The WoE scores for included studies are outlined in Appendix C.

##### **2.10.4.2.1 Participants**

The number of parents and children who participated in the interventions was outlined in each study (WoE A). Altogether, the numbers of parents and children who participated in the interventions included in this review were 438 and 417, respectively. Each study included parents of children and children, aged 0-25 years, as per WoE C. Children ranged from 15 months – 18 years old. Of the 9 studies included in the review, only four (Cartwright-Hatton et al., 2018; Davis & Spurr, 1998; Gobrial & Raghavan, 2018; Jewell et al., 2023) reported the ages and genders of the parents who participated in the interventions, aiding them a higher WoE A score. Together, the ages of the parents included in these studies (Cartwright-Hatton et al., 2018; Davis & Spurr, 1998; Gobrial & Raghavan, 2018; Jewell et al., 2023) ranged from 24-66 years old; 146 parents were mothers, 1 was a grandmother and 15 were fathers. Of note, Davis and Spurr (1998) included mothers and partners in the interventions however it is understood that the parents who completed the outcome measures, “main caregivers”, were all mothers apart from one grandmother; they do not specify the gender of “partners”. Just three studies (Cartwright-Hatton et al., 2018; Jewell et al., 2023; Palmer et al., 2023) outlined the sociodemographic characteristics of the parents (WoE A); each reported the majority ethnicity as White British or Irish (85-94.7%), reducing reliability of findings.

All parents included in the study by Cartwright-Hatton et al., (2018) and Palmer et al. (2023), experienced anxiety. This may reduce the generalisability of the findings, as children of parents with anxiety are at heightened risk of generating anxiety (Cartwright-Hatton et al., 2018) suggesting the findings may not apply to children of parents without anxiety. Likewise, all children in Gobrial and Raghavan (2018), McConachie et al. (2014) and Pillay et al. (2011)’s studies were diagnosed with autism, reducing generalisability of findings.

All studies outlined their sampling methods and offered sufficient information to confirm that participants showed the difficulties presented (WoE A). However, four studies (Davis & Spurr, 1998; Evangelou & Sylva, 2007; Gobrial & Raghavan, 2018; Pillay et al., 2011) did not declare their inclusion and exclusion criteria for participant recruitment, reducing their WoE A score.

#### **2.10.4.2.2 Design**

Cartwright-Hatton et al. (2018), Harrington et al. (2000) and McConachie et al. (2014) used an RCT design. This aided a high WoE B score, as per the hierarchy of evidence (Petticrew & Roberts, 2008). Two studies used a quasi-experimental design (Davis & Spurr, 1998; Evangelou & Sylva, 2007) and five employed pre-experimental designs (Cartwright-Hatton et al., 2005; Gobrial & Raghavan, 2018; Jewell et al., 2023; Palmer et al., 2023; Pillay et al., 2011). Follow-up measures were used in five studies (Cartwright-Hatton et al., 2005, 2018; Davis & Spurr, 1998; McConachie et al., 2014; Palmer et al., 2023), increasing the reliability of the results and thus their WoE B score. Follow up points ranged from 8 weeks after baseline measures were taken (Palmer et al., 2023) to 12 months post-intervention (Cartwright-Hatton et al., 2018).

#### **2.10.4.2.3 Intervention**

Intervention details are tabulated in Table 2.6. Six interventions were run by trainee and/or clinical psychologists (Cartwright-Hatton et al., 2005, 2018; Jewell et al., 2023; McConachie et al., 2014; Palmer et al., 2023; Pillay et al., 2011). The *Parent Survival Course* was additionally run by mental health professionals (Cartwright-Hatton et al., 2005). *ASCEND* was also run by child and adolescent psychiatrists (Pillay et al., 2011). One intervention was run by Paediatric Clinical Medical Officers and Health Visitors, supervised by a Clinical Psychologist (Davis & Spurr, 1998). The length of intervention across studies ranged from two, two-hour sessions across two weeks (Palmer et al., 2023) to 11 weekly sessions (Pillay et al., 2011). Davis and Spurr (1998) report that parents attended from 2 -25 sessions.

Although interventions differed per study, all interventions included an aim to reduce child internalising behaviours, meeting criteria 3 of WoE C. Second, each intervention was underpinned by psychological theory, in line with criteria 4 of WoE C. All interventions incorporated elements of behaviourist principles such as,

positive reinforcement (praise and rewards). Many of the interventions (Cartwright-Hatton et al., 2018; Evangelou & Sylva, 2007; Palmer et al., 2023) draw upon the social learning theory (Bandura, 1986), exploring behavioural modelling. Behaviour management strategies are covered across several of the interventions (Cartwright-Hatton et al., 2005, 2018; Davis & Spurr, 1998; Palmer et al., 2023; Pillay et al., 2011).

CBA are utilised within several of the interventions (Cartwright-Hatton et al., 2018; Jewell et al., 2023; McConachie et al., 2014; Palmer et al., 2023). For example the *Parent Workshop* (Cartwright-Hatton et al., 2018) encourages parents to support children to challenge maladaptive anxious cognitions (Beck, 1985) and negative cognitive triad (Beck, 1976), encouraging the use of “seven confident thoughts”. This may also act as a protective factor against child anxiety, enhancing self-concept (Mammarella et al., 2021).

Relational approaches such as Emotion Coaching (Gus et al., 2015), are incorporated into most interventions (Cartwright-Hatton et al., 2005, 2018; Gobrial & Raghavan, 2018; Jewell et al., 2023; McConachie et al., 2014; Palmer et al., 2023; Pillay et al., 2011).

Five interventions included information about anxiety and offered specific strategies to counter anxiogenic parenting (Cartwright-Hatton et al., 2018; Gobrial & Raghavan, 2018; Jewell et al., 2023; McConachie et al., 2014; Palmer et al., 2023). For example, the *Parent Workshop* (Cartwright-Hatton et al., 2018) includes sessions on how to reduce overprotection and modelling of avoidant behaviours (Murray et al., 2009).

Davis and Spurr (1998) offer limited information as to what the intervention content included, referring readers to a manual which is not widely accessible. This reduced their WoE A score.

**Table 2.6***Characteristics of Interventions Included in Review*

Reference	Intervention Name	Content Summary	Delivered by	Frequency
Cartwright-Hatton et al. (2005)	Parent Survival Course	Derived from the Webster Stratton programme (Webster-Stratton, 1990) <ol style="list-style-type: none"> <li>1. Giving rewards</li> <li>2. Appropriate times and ways to give attention</li> <li>3. Managing destructive and dangerous behaviours</li> </ol>	Mental health professionals (clinical psychology or nursing backgrounds)	8 weekly, 90-minute sessions
Cartwright-Hatton et al. (2018)	Parent Workshop	<ol style="list-style-type: none"> <li>1. Introduction</li> <li>2. Understanding anxiety</li> <li>3. Child anxiety statistics</li> <li>4. Behavioural management skills</li> <li>5. Parenting for parents with anxiety</li> <li>6. Managing early indications of child anxiety</li> </ol>	Clinical child psychologist	One day (09:30-15:00)
Davis and Spurr (1998)	Parent Adviser Service	Parents are supported to explore perceived "problems" and to develop behaviour management strategies	Paediatric Clinical Medical Officers and Health Visitors, supervised by a clinical psychologist	Average of 7.8 sessions, ranging from 2 -25 sessions
Evangelou & Sylva (2007)	Peers Early Education Partnership (PEEP)	Opportunities, Recognition, Interaction and Modelling framework (Hannon, 1995)  Each session contained: circle and story time, talking between parents, book sharing, borrowing time and home activities. PEEP leaders model how to develop children's skills in areas such as reading.	PEEP leaders (qualifications not stated)	Not stated

Reference	Intervention Name	Content Summary	Delivered by	Frequency
Gobrial & Raghavan (2018)	Calm Child Programme (CCP)	Parents are supported to recognise child anxiety levels. Three categories of strategies to support child anxiety are taught: reactive, communicative, and proactive	Not stated	Three-month implementation period. Parents to record strategies used daily.
Jewell et al. (2023)	Brief Cognitive Behavioural Online Intervention	<ol style="list-style-type: none"> <li>1. What is anxiety</li> <li>2. Building on formulation and developing strategies</li> <li>3. Review</li> </ol>	Trainee Clinical Psychologist (TCP) and author trained and supervised by psychologist and author	Three online sessions (total 5.5 hours) delivered fortnightly across six weeks
McConachie et al. (2014)	Exploring Feelings (Attwood, 2004)* <i>*Ran as parallel children and parent groups</i>	<ol style="list-style-type: none"> <li>1. Introductory session</li> <li>2. Exploring Feelings activities (adapted for UK use) - how to identify relaxed, anxious, and happy emotions, and generating individualised strategies to manage child anxiety</li> </ol>	TCPs supervised by clinical psychologists	7 two-hour weekly sessions
Palmer et al. (2023)	Adapted* online version of the Parent Workshop (Cartwright-Hatton et al., 2018)  <i>*Delivered online and for parents of children 1-3 years old</i>	<ol style="list-style-type: none"> <li>1. Welcome and introductions</li> <li>2. Risk factors for anxiety</li> <li>3. "Seven confident thoughts" about the self, world, and others</li> <li>4. Emotion coaching</li> <li>5. Child play</li> <li>6. Praise and boundary setting</li> <li>7. Avoidance</li> <li>8. Parenting hotspots</li> <li>9. Over-protection</li> <li>10. Modelling anxiety/confidence</li> <li>11. Compensation</li> <li>12. Perfectionism</li> </ol>	TCP	Two, two-hour sessions across two weeks

Reference	Intervention Name	Content Summary	Delivered by	Frequency
Pillay et al., (2011)	Autism Spectrum Conditions Enhancing Nurture and Development (ASCEND)	<ol style="list-style-type: none"> <li>1. Autism information and its parenting implications</li> <li>2. How to maximise child development</li> <li>3. Behaviour management skills</li> <li>4. Sharing experiences and expertise</li> </ol>	<ol style="list-style-type: none"> <li>1. Chief therapists - consultant child psychologist and child and adolescent psychiatrist</li> <li>2. Co-therapists - clinical psychologists, child psychiatrists, a speech and language therapist and community mental health nurses</li> </ol>	11 weekly sessions

#### **2.10.4.2.4 Outcome Measures**

All studies used scales as outcome measures of internalising behaviours. Cartwright-Hatton et al. (2005) and Davis and Spurr (1998) used the CBC (Achenbach, 1992b, 1992a) which measures internalising behaviours as per the definition offered in Table 2.1. The DBC (Einfeld & Tonge, 1995) used by Pillay et al. (2011) explores anxiety, social and emotional needs. The ASBI (Hogan et al., 1992) explores social withdrawal only. Cartwright-Hatton et al. (2018), Gobrial and Raghavan (2018), Jewell et al. (2023) and McConachie et al. (2014) used anxiety-specific outcome scales. All measures other than the ASBI (Hogan et al., 1992) and GAS-ID (Mindham & Espie, 2003) were reported to have good validity and reliability. The reliability and validity of the ASBI (Hogan et al., 1992) and GAS-ID (Mindham & Espie, 2003) was not mentioned, lowering the WoE A score for the studies of Evangelou and Sylva (2007) and Gobrial and Raghavan (2018).

The DBC (Einfeld & Tonge, 1995), CBC (Achenbach, 1992b, 1992a) and SCAS(P) (Spence, 1998; Spence et al., 2001), BITSEA (Briggs-Gowan & Carter, 2002), GAS-ID (Mindham & Espie, 2003) and ADIS (Silverman & Albano, 1996) were completed by parents. This may reduce validity of findings as parental perceptions of change may differ from real change (Cartwright-Hatton et al., 2005). Indeed, Sperling et al. (2021) found that higher levels of parental distress at the end of a parental intervention was associated with higher levels of parent-reported child anxiety. Sperling et al. (2021) suggest this may be due to parental struggles in managing their own and child's emotions or due to parental distress that their child may still be experiencing anxiety. Nevertheless, it is suggested that parent perceived reductions of internalising behaviours are beneficial in themselves; they are associated with more appropriate parenting and thus familial mental health benefits (Cartwright-Hatton et al., 2005). In the studies by Cartwright-Hatton et al. (2018) and McConachie et al. (2014), children over 5 years old completed the SCAS (Spence, 1998), increasing validity of results.

Several studies (Gobrial & Raghavan, 2018; Jewell et al., 2023; McConachie et al., 2014; Palmer et al., 2023; Pillay et al., 2011) also included qualitative outcome measures, supporting the understanding of usefulness, impact, and acceptability of the interventions, offering useful implications for practice and

research (Petticrew & Roberts, 2008). This enhanced their WoE A score. The qualitative measures included a focus group (Gobrial & Raghavan, 2018), interviews (Jewell et al., 2023; McConachie et al., 2014) and questionnaires (Palmer et al., 2023; Pillay et al., 2011).

#### **2.10.4.2.5 Results**

Seven of nine studies reported a reduction in scores of internalising behaviours from pre- to post-intervention (Cartwright-Hatton et al., 2005, 2018; Davis & Spurr, 1998; Gobrial & Raghavan, 2018; Jewell et al., 2023; McConachie et al., 2014; Palmer et al., 2023; Pillay et al., 2011), suggesting a decrease in internalising behaviours following intervention.

The reduction in CBC (Achenbach, 1992b, 1992a) scores in the intervention group was found to be significant ( $p < .001$ ) in the studies by Cartwright-Hatton et al. (2005) and Davis and Spurr (1998). Cartwright-Hatton et al. (2005) also report the number of children that scored over the clinical cut-off for internalising behaviours as per the CBC (Achenbach, 1992b, 1992a) reduced substantially from pre- ( $n=17$ ) to post-intervention ( $n=2$ ), suggesting a reduction in internalising behaviours associated with the parental intervention. Cartwright-Hatton et al. (2005) reported no significant change in reduction of internalising behaviours at the 6-month follow up, suggesting stability of this reduction over time.

Gobrial and Raghavan (2018) found a significant reduction in child anxiety scores pre-post intervention as measured by the GAS-ID (Mindham & Espie, 2003). Similarly, Jewell et al. (2023) found that parent and child-rated anxiety reduced from session one to three of the parenting intervention. Jewell et al. (2023) report moderate to large effect sizes in terms of parent-reported child anxiety outcomes and a small effect size for child-reported anxiety and behavioural outcomes as measured using CAPES (Morawska et al., 2020). A reduction in child “emotional problems” (Morawska et al., 2020) showed a moderate-large effect size. Parental confidence and efficacy were also reported to increase (Morawska et al., 2020). In Pillay et al. (2011)’s study, the reduction in anxiety scores as measured by the DBC (Einfeld & Tonge, 1995) were reported to almost meet significance.

Cartwright-Hatton et al. (2018) indicate that their study did not have sufficient power to detect statistically significant differences thus this is not

reported. However, they do state that children from the parent intervention group showed a greater reduction in anxiety and fear measures versus the control group, immediately after and 12 months post-intervention, suggesting a decrease in internalising behaviours (Cartwright-Hatton et al., 2018).

McConachie et al. (2014) found that parents in the intervention group were significantly more likely to report a reduction in child anxiety scores versus those in the control group ( $p=.045$ ). Anxiety severity was found to reduce in 76% of children in the intervention group following intervention versus 33% of those in the control (McConachie et al., 2014). The rate of change in child-reported SCAS (Spence, 1998) scores from baseline to 9 month follow-up showed a rate of change of -1.4 for the intervention and -1.16 for the control group – these were not significantly different (McConachie et al., 2014).

Evangelou and Sylva (2007) report no significant differences between the intervention and control group regarding their ASBI (Hogan et al., 1992) scores, suggesting the parent intervention did not reduce internalising behaviours. Likewise, Palmer et al. (2023) found no significant changes in BITSEA (Briggs-Gowan & Carter, 2002) scores pre to post intervention. However, they report that 40% (pre-intervention), 46.7% (immediately post-intervention) and 63.3% (8 week follow up) of parents stated that they felt “not at all worried” about their child.

### **2.10.5 Discussion**

#### **2.10.5.1 Findings**

##### **2.10.5.1.1 All Interventions**

This SLR aimed to answer the research question: “Are parenting interventions effective in reducing child internalising behaviours?”. As previously found (e.g., Burke et al., 2021), there was limited research on the effectiveness of parenting interventions in reducing child internalising behaviours; just nine articles were synthesised in this review. Just two of which explored the effectiveness of interventions for parents with anxiety in reducing IGT of anxiety (Cartwright-Hatton et al., 2018; Palmer et al., 2023).

These studies may not have been incorporated into the “empty” SLR completed by Chapman et al. (2022) as Cartwright-Hatton et al. (2018) used a *feasibility* RCT and Palmer et al. (2023)’s research was published a year later.

In line with previous findings (Brendel & Maynard, 2013; Petrenko, 2013), seven of the nine studies synthesised found parental interventions to be effective in reducing child internalising behaviours (Cartwright-Hatton et al., 2005, 2018; Davis & Spurr, 1998; Gobrial & Raghavan, 2018; Jewell et al., 2023; McConachie et al., 2014; Palmer et al., 2023; Pillay et al., 2011). Four studies found this reduction to be significant, one found results approached significance and two did not report significance, suggesting emerging support for the use of parenting interventions for reducing child internalising behaviours. Strengthening reliability, such results were found for children across ages 2-18 years. Moreover, the reduction in internalising behaviours was shown to be maintained over time (Cartwright-Hatton et al., 2005, 2018).

Contrastingly, Evangelou and Sylva (2007) did not find significant differences between the intervention and control group in regard to measures of social behaviours. The outcome measure used by Evangelou and Sylva (2007) explored social-withdrawal only. This differs from Cartwright-Hatton et al. (2018) and Pillay et al. (2011) who measured anxiety symptoms only, suggesting parenting interventions may be effective in reducing specific internalising behaviours only (i.e. anxiety but not social withdrawal). That said, Cartwright-Hatton et al. (2005) found a significant reduction in internalising behaviours using a measure that explored anxiety, somatic symptoms, social withdrawal and depression, indicating that parenting interventions may be effective in reducing a range of internalising behaviours.

Considering this, the differing findings presented by Evangelou and Sylva (2007) may instead be explained by the absence of teaching of relational strategies within the PEEP intervention (Evangelou & Sylva, 2007). Notably, five of the seven interventions associated with a reduction in child internalising behaviours stated that they included supporting parents to use relational approaches with their children. As previously mentioned, reduced warmth is suggested to be an anxiogenic parenting behaviour associated with the development of child anxiety

(Murray et al., 2009), thus it is intuitive that relational approaches that enhance affection and support may result in a reduction of child internalising behaviours.

#### **2.10.5.1.2 Interventions for Parents with Anxiety**

Two studies explored the effectiveness of a parenting intervention for parents with anxiety in reducing their children's anxiety (Cartwright-Hatton et al., 2018; Palmer et al., 2023). Cartwright-Hatton et al. (2018) found that children from the parental intervention group showed more of a reduction in anxiety versus the control group, immediately after and 12 months following the intervention. Contrastingly, Palmer et al., (2023) found no significant changes in emotional and behavioural concerns pre- to post-intervention.

Interestingly, both studies implemented the *Parenting Workshop* intervention devised by Cartwright-Hatton et al. (2018). However, several differences between the studies are noted. Palmer et al., (2023) adapted the intervention for online delivery across two, two hour sessions whilst Cartwright-Hatton et al. (2018) delivered the intervention as designed, in-person as a one-day workshop. Moreover, Palmer et al., (2023) had adapted the intervention for younger children (Cartwright-Hatton et al., 2018).

Comparing designs, Cartwright-Hatton et al. (2018) used a feasibility RCT whilst Palmer et al. (2023) used a pre-experimental design, suggesting enhanced validity of the results presented by Cartwright-Hatton et al. (2018) as per the hierarchy of evidence (Petticrew & Roberts, 2008).

Palmer et al. (2023)'s lack of significant change in child emotional and behavioural concern scores could be explained by a short-follow up period. Palmer et al. (2023) highlight the primary outcome measure of their study was parental mental health outcomes. They found that parental anxiety reduced significantly from pre- to post-intervention (Palmer et al., 2023). Palmer et al. (2023) also found that anxiogenic parenting behaviours reduced. They indicate an expectation that, in line with theories of IGT of anxiety (e.g., Emerson et al., 2019), over time, this decrease in parental anxiety and anxiogenic parenting will reduce the risk of IGT of anxiety but that they did not expect to see this change so soon after the intervention.

### **2.10.5.2 Limitations**

Due to the limited research on this topic, a small number of studies were reviewed, reducing reliability of findings. Moreover, as this study used only published journal articles, there is a risk of reporting bias, threatening the validity of this review (Petticrew & Roberts, 2008).

Of the studies reviewed which outlined the sociodemographic characteristics of parents, three (Cartwright-Hatton et al., 2018; Jewell et al., 2023; Palmer et al., 2023) reported the majority ethnicity as White British or Irish (85-94.7%). This may weaken the generalisability of findings, with research suggesting that it is unclear whether parental interventions to support child mental health are similarly effective with families from minority backgrounds (Mendez et al., 2013). As EPs work with families of various ethnicities, these findings should therefore be applied with caution. Future research may investigate whether parenting interventions are effective in reducing internalising behaviours in children from majority *and* minority ethnic backgrounds, and if not, what adjustments must be made to ensure equal opportunities for families of all ethnic backgrounds.

As the objective of this review was to explore the *effectiveness* of parenting interventions on child internalising behaviours, only quantitative synthesis was conducted (Petticrew & Roberts, 2008); qualitative synthesis was deemed beyond the scope of this review. However, this may mean that useful information regarding parenting interventions for children with internalising behaviours was missed. The qualitative findings outlined by the included studies shed light on the impact and acceptability of the interventions (Petticrew & Roberts, 2008). Benefits associated with the interventions such as, improved connection with other parents and positive change regarding their child's anxiety were highlighted by parents (Gobrial & Raghavan, 2018; Jewell et al., 2023; Palmer et al., 2023; Pillay et al., 2011). Parents indicated barriers such as, difficulties of online versus face-to-face delivery of interventions (Jewell et al., 2023; Palmer et al., 2023).

### **2.10.6 Summary of the Systematic Literature Review and Implications for Educational Psychologists**

This SLR aimed to answer the research question: "Are parenting interventions effective in reducing child internalising behaviours?". Nine studies

were included in the final synthesis. Of the nine studies, seven found parental interventions effective in reducing child internalising behaviours (Cartwright-Hatton et al., 2005, 2018; Davis & Spurr, 1998; Gobrial & Raghavan, 2018; Jewell et al., 2023; McConachie et al., 2014; Palmer et al., 2023; Pillay et al., 2011). This indicates that EPs may deliver such interventions to reduce child internalising behaviours, as part of their evidence-based practice.

It was interpreted that the incorporation of relational approaches and access to peer support may be important for intervention effectiveness. This suggests that EPs should consider offering opportunities for parental peer support and supporting parents in using relational strategies to support children in reducing internalising behaviours.

Just two studies explored the influence of parental interventions for parents with anxiety in reducing IGT of anxiety. Despite use of the same intervention, Cartwright-Hatton et al. (2018) found the intervention to be effective in reducing child anxiety whilst Palmer et al. (2023) did not. This contrast may be explained by Palmer et al., (2023)'s measuring child anxiety levels shortly after the intervention, possibly leaving limited time for children to respond to the parents' reported reduced anxiogenic parenting behaviours. This finding indicates the importance of using a follow-up measure to measure the effectiveness of parenting interventions for parents with anxiety in reducing IGT of anxiety. Together, these findings offer emerging support for EP delivery of parental interventions for parents with anxiety to reduce parental perceptions of child anxiety.

## **2.11 Current Study**

### **2.11.1 Summary and Rationale**

Anxiety is presented as one of the most common internalising behaviours in children (Pahl et al., 2012). Following a rise in the prevalence of childhood anxiety (Zurich, 2022), the UK Government is calling for EPs to support child mental health through systemic working (Public Health England, 2021). It is suggested that delivery of parenting interventions that prevent the development of and reduce childhood anxiety are critical, especially in the face of increasing waiting times for direct child interventions (Jewell et al., 2023).

Emerging yet scarce research indicates that parenting interventions may be effective in reducing child internalising behaviours (e.g., Jewell et al., 2023). Two studies in the UK, known to the researcher, have investigated the effectiveness of parenting interventions for parents with anxiety in reducing the IGT of anxiety (Cartwright-Hatton et al., 2018; Palmer et al., 2023). In line with the literature (e.g., Alloy, 2001), these studies suggest that the *Parenting Workshop* intervention may reduce child anxiety, possibly through a reduction in parenting anxiety and anxiogenic parenting behaviours (Cartwright-Hatton et al., 2018; Palmer et al., 2023).

However, further research is needed. There is no current research, to the researcher's knowledge, exploring the impact of a parenting intervention, based on the *Parenting Workshop*, for parents with anxiety, on child anxiety when delivered by a TEP, in schools. Nor is there a mixed-methods study that not only explores the effectiveness of an in-person parental intervention for parents with anxiety, in reducing parental perceptions of child anxiety, but also that explores parent's views of the intervention. Parental views of the intervention may be compared to the quantitative findings to offer a fuller understanding of the effectiveness of the intervention. Parental views will be important for understanding whether the intervention met the needs of the parents and if not, why not. Their views may offer valuable insight as to how the intervention may be improved by EPs, to enhance the likelihood of reducing parental perceptions of child anxiety.

With EPs being called upon to support the mental health of children (Public Health England, 2021), this research is crucial for EPs to implement evidence-based parenting interventions to prevent IGT of anxiety.

### **2.11.2 Research Question**

The current research aims to answer the overarching question: **"Is an adapted version of the parenting intervention *Parenting with Anxiety: Helping Anxious Parents Raise Confident Children (PWA)* (Cartwright-Hatton, 2021), delivered by a Trainee Educational Psychologist (TEP), effective in reducing parental perceptions of children's anxiety?"**. Subsidiary to this, this research will explore **"How do parents perceive the intervention?"**.

## Chapter 3: Methodology

### 3.1 Aim and Structure

This chapter outlines and evaluates the methodology used within the current study. It first considers the philosophical paradigms that underpin research and outlines the paradigm that guided this study. It will explore several research designs and methodologies relevant to the research. The chosen research design and methodology for the current study will then be described including, participant characteristics, measures used and the procedure. Ethical considerations, along with possible threats to validity and reliability of the study will be considered.

### 3.2 Philosophical Paradigms

*'The 'ologies: the big scary theory' - Braun and Clarke (2022, p.166)*

Research may be defined as a systematic investigation consisting of data collection and interpretation (Mertens, 2005). It may predict, describe or control phenomenon, depending on the researcher's adopted paradigm (Mertens, 2005). Several paradigms have emerged over time, each pertaining to their own ontology, epistemology and methodology (Mertens, 2005). Understanding the philosophical underpinnings of the various paradigms has been presented as part of EP's professional duty, allowing them to align with a worldview and evaluate its impact on their research (Burnham, 2013; Moore, 2005). The following sections will outline and consider three key paradigms (Mertens, 2005) - positivism, postmodernism, and mixed-methods.

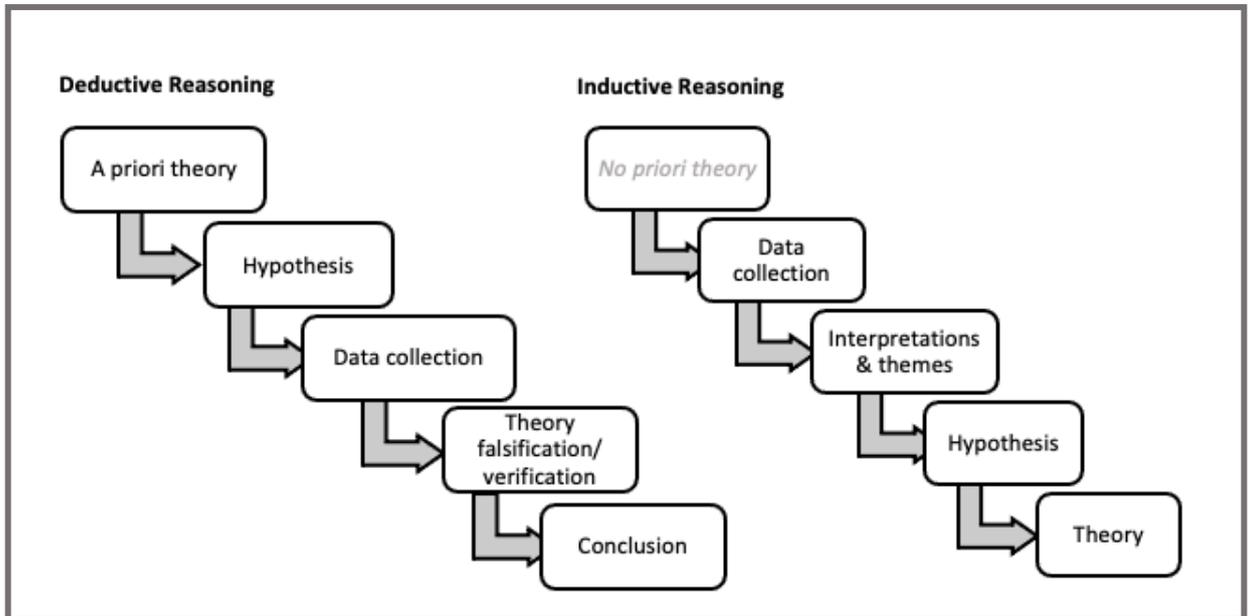
#### 3.2.1 Terminology

*'Research has its own language' - Creswell and Creswell (2023, p.3)*

*Paradigms* may be defined as a set of philosophical assumptions regarding the nature of reality, termed *ontology* (Gelo et al., 2008). The nature of knowledge about said reality may be defined as *epistemology* (Gelo et al., 2008), which directs action and thinking (Mertens, 2005). These assumptions influence *methodology*, guiding how the researcher obtains said knowledge (Mertens, 2005). Researchers may use a *deductive* or *inductive* reasoning approach as outlined in Figure 3.1 (Cohen et al., 2017) , guiding the research methods used to answer the research question – the *research design* (Gelo et al., 2008).

**Figure 3.1**

*Comparison of Deductive versus Inductive Reasoning*



*Note.* Flow chart demonstrating deductive versus inductive reasoning approaches.

Figure created by the author, showing the author's interpretation of deductive compared to inductive reasoning content taken from Cohen et al. (2018)

### **3.2.2 Positivism**

#### **3.2.2.1 Positivist Ontology and Epistemology**

Positivists believe that one, external reality exists and can be explored to find a truth (Cohen et al., 2017). In positivist thinking, objective knowledge is possible to obtain via direct experience (Robson & McCartan, 2015). The researcher is deemed an observer of social reality, independent of the researched (Mertens, 2005).

#### **3.2.2.2 Positivist Methodology**

Positivists follow a deductive reasoning approach (Cohen et al., 2017). Positivist research uses nomothetic methodology, aiming to identify causal, generalisable laws through testing theoretical predictions against observations (Gelo et al., 2008). Positivists use fixed research designs, such as, Randomised Control Trials (RCTs), in which the experimenter manipulates independent variables, measuring their impact on dependent variables (Gelo et al., 2008). Positivism is associated with the use of quantitative variables in which phenomena are

converted to numbers (Gelo et al., 2008). Validity of findings, ensuring the correct truth of reality has been identified, is key within the positivist approach (Gelo et al., 2008).

### **3.2.2.3 Criticisms of Positivism**

Positivism has been described as reductionist, ignoring human ability to express inner experiences, reducing them to measurable items (Cohen et al., 2017). It is suggested that for subject-subject versus subject-object research, human observer's perspectives and characteristics impact upon the observation of the human subject, making the observation a subjective construction versus an objective reality (Cohen et al., 2017; Robson & McCartan, 2015).

### **3.2.2.4 A Note on Post-Positivism**

The post-positivism paradigm emerged following positivism. This position may be considered a reconstructed version of positivism (Braun & Clarke, 2022). Post-positivism challenges the notion of an absolute truth (Phillips & Burbules, 2000) and accepts that when studying human behaviours, no claims of knowledge can be made with certainty (Creswell & Creswell, 2023). Still, much like positivists, post-positivists still seek an objective truth and reduce phenomenon to discrete categories or variables (Creswell & Creswell, 2023).

## **3.2.3 Postmodernism**

### **3.2.3.1 Postmodernist Ontology and Epistemology**

Postmodernism aligns to a relativist ontology, suggesting that there are multiple realities created through subjective, individual experience (Robson & McCartan, 2015). Reality is seen as socially constructed (Robson & McCartan, 2015). Subjectivity of the researcher is presented as an important element of research (Robson & McCartan, 2015). Sitting within postmodernism, social constructionism explores how societal groups construct knowledge together, looking to challenge dominant discourse in practice (Moore, 2005). Critical and emancipatory theories highlight the role of demographics in shaping multiple realities; they examine the impact of the researcher's social position and values on the researched, aiming to empower and benefit oppressed groups (Mertens, 2005). Such theories may be considered as forming their own, transformative paradigm (Mertens, 2005).

### **3.2.3.2 Postmodernist Methodology**

Postmodernists use an inductive reasoning approach (Gelo et al., 2008). Flexible research designs are often used, adapting throughout the research process (Robson & McCartan, 2015). Postmodernists typically obtain qualitative, non-numerical, and idiographic data, aiming to capture detailed descriptions of participants' experiences versus causal explanations (Gelo et al., 2008).

### **3.2.3.3 Criticisms of Postmodernism**

Generalisability (transferability) of findings is considered limited due to the typical use of small samples, reducing applicability of findings (Cohen et al., 2017). The internal validity (credibility) of the data is suggested to be vulnerable to researcher biases (Fox, 2011).

### **3.2.4 Mixed-Methods**

#### **3.2.4.1 Mixed-Methods Ontology and Epistemology**

The mixed-methods paradigm subscribes to a pragmatic ontology (Gelo et al., 2008). Pragmatists suggest that truth is whatever establishes that findings 'work' with regards to the research question, avoiding the historic deliberation over philosophy (Robson & McCartan, 2015). They suggest it is possible to employ the methods of one paradigm whilst aligning to the philosophical assumptions of another (Gelo et al., 2008). They suggest researchers should research what is of value and interest, in the way that is most appropriate and has positive systemic implications (Tashakkori & Teddlie, 1998). Researchers do not have to position themselves in relation to the researched (Tashakkori & Teddlie, 1998).

Perhaps contradictorily, a variation of this paradigm has emerged – critical realism. Critical realism is argued to be a paradigm within a paradigm that states philosophical assumptions (Robson & McCartan, 2015). Critical realists combine realist and relativist ontologies, suggesting there is an external reality to be agreed upon but that we must recognise the psychological and social mechanisms that guide our knowledge and understanding of this (Houston, 2001). Critical realists emphasise the importance of social justice (Robson & McCartan, 2015).

#### **3.2.4.2 Mixed-Methods Methodology**

Mixed methodologists use inductive-deductive reasoning (Gelo et al., 2008) and both quantitative and qualitative data (McCrudden & Marchand, 2020). Mixed-method researchers aim for valid inferences from legitimate research and it is suggested that in using both quantitative and qualitative methods, they are able to overcome the validity issues associated with each (Gelo et al., 2008).

#### **3.2.4.3 Criticisms of Mixed-Methods**

It is suggested by some that quantitative and qualitative approaches are incompatible, studying different phenomena (Cohen et al., 2017) thus destroying the philosophical grounding of both (Gelo et al., 2008). However, it is suggested that such differences are exaggerated, with both approaches sitting on a continuum with several commonalities (Robson & McCartan, 2015). Another criticism of this approach is its complexity, requiring additional time and a range of researcher skills (Cohen et al., 2017). Still, it is presented that the richer understanding of the research phenomena offered outweighs such costs (McCrudden & Marchand, 2020). Mixed-methods research fits in the real world of the EP, with researchers who are eager to answer important problems without spending time debating philosophy (Robson & McCartan, 2015).

### **3.3 Chosen Paradigm of the Current Study: Mixed Methods**

The current research study aligns to the mixed-methods paradigm, following a pragmatic ontology. In addition to the strengths outlined above, this paradigm and ontology was chosen for the current study as it:

- Explores how theory may be translated into effective practice (Robson & McCartan, 2015). This corresponds with the position of EPs as *scientist practitioners* (British Psychological Society, 2002; Fallon et al., 2010).
- Allows for flexibility to study what is of interest and value (Mertens, 2005). The research may be conducted in ways that 'make sense', and results may be used to generate positive outcomes relating to our value system (Mertens, 2005). In this respect, mixed-methods research, following a pragmatic ontology may become transformative.

A risk of conducting a study which follows a pragmatic ontology is that without clarity regarding research purpose, it may become incoherent and lead to questionable validity (Robson & McCartan, 2015). Clear research questions and methodologies will therefore be outlined in the following sections.

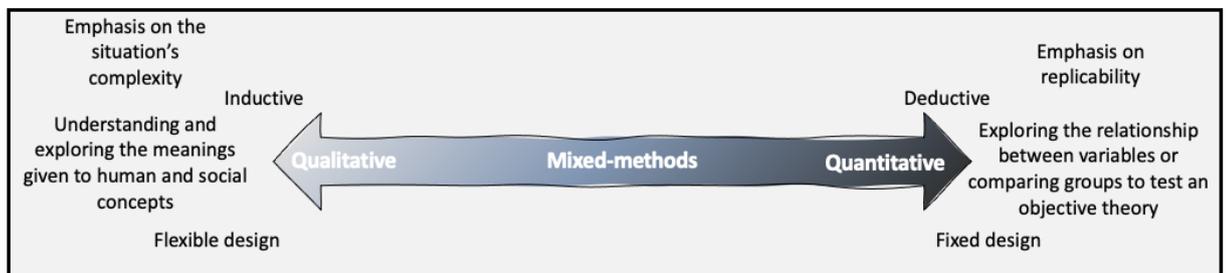
### 3.4 Research Designs

*'If you don't give serious attention to the design of a research project, you are likely to end up with a mess' - Robson and McCartan (2015, p.3)*

The research design may be understood as the research methods used to answer the research question (Gelo et al., 2008). Research designs may be organised under three research approaches: quantitative, qualitative, and mixed-methods. Such approaches may not be conceptualised as distinct categories but instead placed among a continuum as depicted in Figure 3.2 (Creswell & Creswell, 2023).

**Figure 3.2**

*The Continuum of Research Approaches and their Common Characteristics*



#### 3.4.1 Evaluation Research

*"Their hope and intention is that the research and its findings will be used in some way to make a difference to the lives and situations of those involved in the study and/or others." - Robson and McCartan (2015, p. 187)*

The current study primarily aims to explore the effectiveness of an intervention. In addition, it will explore participants' perceptions of the intervention. This study may be conceptualised as evaluation research (Robson & McCartan, 2015). Evaluation research is not a distinct research approach but indicates the purpose of the study – to examine the effectiveness of a practice, service, policy or intervention (Robson & McCartan, 2015). Evaluation research may seek to understand the way in which an intervention may be improved, how it

operates, whether it meets the needs of the people experiencing it and what makes it effective, or not (Robson & McCartan, 2015). It may be formative, concentrating on developing the focus of the evaluation (e.g., intervention), or summative, exploring the effectiveness of the focus of the evaluation (Robson & McCartan, 2015). It may concentrate on the process or outcome of the evaluation focus (Robson & McCartan, 2015).

There is thought to be a rising expectation for real-world researchers to conduct evaluation research (Robson & McCartan, 2015). Still, within educational research, it is presented that evaluation and politics are often intertwined and perhaps in conflict (Mertens, 2019). Lindsay (2007) suggests government bodies may favour the use of fixed designs which focus on intervention outcomes, over the use of flexible designs which may best evaluate intervention process.

The following sections will outline and evaluate research designs which may be used across quantitative, qualitative, and mixed methods approaches, before outlining the research design chosen for the current study.

### **3.4.2 Quantitative Designs**

As will be illustrated, definitions of the different research approaches may differ throughout the literature. Typically, quantitative research uses fixed designs; they deductively examine objective theories through comparing groups or variable relationships (Creswell & Creswell, 2023; Robson & McCartan, 2015).

Creswell and Creswell (2023) identify two popular quantitative research designs- survey and experimental designs. In an experimental design, one or more independent variables are systemically manipulated and this influence of this manipulation on the outcomes is measured (Creswell & Creswell, 2023). Essentially, in an experimental design, all other variables are held constant to isolate the effect of the variable that has been manipulated (Creswell & Creswell, 2023). Given that this study will explore the influence of introducing an intervention on anxiety outcomes, experimental designs will be explored in further detail. Table 3.1 outlines key characteristics of pre-experimental, quasi-experimental and true-experimental designs (Creswell & Creswell, 2023; Robson & McCartan, 2015).

**Table 3.1***Experimental Designs*

<b>Experimental Design</b>	<b>Summary</b>	<b>Example Designs</b>	<b>Strengths</b>	<b>Weaknesses</b>
True experimental	Control and experimental groups are used. The experimental group receives treatment or an intervention whilst the control does not. Participants are randomly assigned to conditions.	RCTs	RCTs are presented as the 'gold standard' of research into intervention effectiveness (Fox, 2011). The use of a control group enhances the researcher's ability to make claims of causation.	It may be deemed unethical to withhold treatment from the control group. It can be impractical to randomly assign participants in real world research.
Quasi-experimental	Control and experimental groups are used. There is partial or no random assignment of participants to conditions.	Pre-test and Post-test Control-Group Design	Quasi-experimental designs are viewed as the next best choice following true experiments	Selection bias may occur
Pre-experimental	A single group is studied, and an intervention is implemented during the experiment. No control group is used.	One-Group Pre-test Post-test	Treatment is not withheld from participants, reducing risk of harm.	Without a control group, the researcher is less able to make claims of causation

### **3.4.3 Qualitative Designs**

Typically using inductive reasoning and flexible designs, qualitative research may be defined as an approach for understanding and exploring the meaning, given by groups or individuals, to human and social issues (Creswell & Creswell, 2023). Numerous types of qualitative research designs are used within psychological and educational research (Mertens, 2005). Indeed Tesch (1990) identifies 26 types. Narrowing this down, Mertens (2005) highlights seven key qualitative strategies:

1. Case study
2. Grounded theory
3. Ethnographic research
4. Clinical research
5. Participatory research
6. Phenomenological research
7. Focus groups

Focus groups are interviews which rely on the interaction between group members (Krueger & Casey, 2000). A moderator introduces topics, and a small group discusses them under moderator guidance (Morgan, 1997b). Mertens (2005) include focus groups as one of the seven qualitative design types as it is considered an increasingly important strategy using within evaluation research. Focus groups are suggested to be useful when the researcher is interested in learning from individuals' perspectives (Mertens, 2005). They are particularly useful when exploring topics that are scantily understood, offering the individuals the opportunity to raise what is of importance to them (Morgan, 1997b).

Alternatively, individual interviews may be used as data collection method within qualitative and evaluative research; the researcher asks participants questions and, hopefully, gains answers (Robson & McCartan, 2015). Interviews range from unstructured to structured depending on the depth of questions (Robson & McCartan, 2015). In comparison to individual interviews, focus groups reduce the pressure or discomfort that certain individuals may feel when being interviewed alone and may encourage individuals to open up about sensitive topics (Kitzinger, 1995; Morgan, 1997b).

#### **3.4.4 *Mixed Methods***

Not dissimilar to the research designs discussed so far, a range of terminologies, typologies, procedures and processes are described within the mixed-methods literature (Teddlie & Tashakkori, 2010). Greene (2008) suggests that mixed-methods designs are distinguishable by: the priority given to one methodology over another, the degree to which methodologies are implemented interactively or independently and whether methodologies are implemented sequentially or concurrently. Designs also differ in terms of how data types are integrated (Creswell & Creswell, 2023). Table 3.2 summarises three key mixed-methods designs (Creswell & Creswell, 2023; Niederberger et al., 2018).

**Table 3.2***Core Mixed Methods Designs*

<b>Design</b>	<b>Purpose</b>	<b>Integration</b>	<b>Priority</b>	<b>Implementation</b>	<b>Notation</b>
Convergent	Enhance	Merged	Equal	Data is collected in parallel	QUAN + QUAL
		Embedded	One method is given priority	One set of data is embedded within the other. The embedded data may be collected before, during or following collection of the main data.	QUAN (qual) or QUAL (quan)
Explanatory Sequential Design	Explain	Connected	One method (quantitative) is given priority	Quantitate data is first collected. Qualitative data is next collected to build upon and explain quantitative results.	QUAN → qual
Exploratory Sequential Design	Build upon	Connected	One method (qualitative) is given priority	Qualitative data is first collected followed by quantitative. This design may be used to support the development of quantitative measures.	QUAL → quan

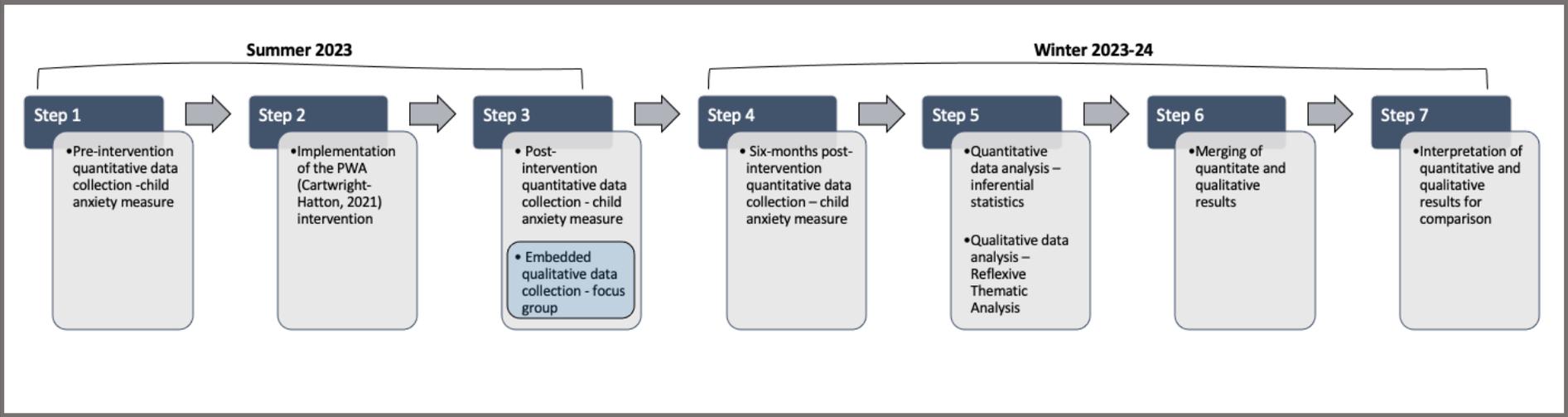
It is suggested that mixed-methods designs are compatible with evaluation research particularly in complex real world research (Teddlie & Tashakkori, 2010). They can provide qualitative data to explain and “back up the numbers” (Creswell & Creswell, 2023). Robson and McCartan (2015) suggest the strongest evaluation studies incorporate both an experimental strategy as well as a method of exploring whether the intervention met participants’ needs.

### **3.5 Chosen Research Design of the Current Study: Mixed Methods**

This research study used a convergent, embedded mixed-methods design to answer the research questions outlined in section 2.10.2. An embedded mixed-methods design was chosen to enhance and develop the findings gathered from the quantitative data and to expand the data, exploring parental perspectives of the intervention including how it may be improved. This is in line with the purposes of evaluation research (Robson & McCartan, 2015). To answer the overarching research question, quantitative data was gathered using child anxiety measures pre- and post-intervention. A one group pre-test post-test design was used. A focus group was conducted following the intervention to answer the embedded qualitative research question. Figure 3.3 demonstrates the stages of the research. The following section of this chapter will explore each stage in further detail.

**Figure 3.3**

*Stages of the Embedded Mixed-Methods Design Used*



### **3.6 Characteristics of the Current Study**

#### **3.6.1 Stakeholders**

As per legislation from The British Psychological Society (2018), the interests of stakeholders, outlined below, will be respected.

- The University of Nottingham; the completion of this research is in line with the requirements of the Doctorate in Applied Educational Psychology course. It will be supervised by a university tutor who will support the researcher to adhere to University research guidelines (University of Nottingham, 2021)
- The researcher's funding LA and EPS; consideration will be given to the benefit of this research to EP work, and how findings may inform subsequent practice.
- The creator of the PWA intervention (Cartwright-Hatton, 2021) supported the researcher by sharing their intervention. Cartwright-Hatton (2021) will be referenced as the original PWA intervention creator. The researcher will send Cartwright-Hatton (2021) the research proposal and findings.
- Participating schools, parents, and children; schools will be involved in the recruitment of parents, and hosting of the intervention. Parents and their children are key stakeholders, as the intervention aims to benefit their mental health. Parents and the host school will be given copies of the research findings.
- EPs and Mental Health Professionals; this research aims to contribute to the practice of EPs and professionals supporting child and parent mental health, offering an intervention to reduce IGT of anxiety.

#### **3.6.2 Sample**

##### **3.6.2.1 Sample Selection**

This study used a purposive homogenous sampling strategy. The researcher selected participants with similar characteristics specific to the purpose of the project, allowing the researcher to answer the research question. Inclusion and exclusion criteria were employed to ensure that the participants partaking in the study possessed characteristics relevant to the research question. The inclusion and

exclusion criteria are demonstrated in Table 3.3. Parents self-selected their participation in the study.

**Table 3.3**

*Study Exclusion and Inclusion Criteria*

Inclusion Criteria	Exclusion Criteria	Justification
Parents and caregivers (biological, kinship, foster or adoptive) of at least one child aged 2-11 years	Adults who are not parents and caregivers of at least one child aged 2-11 years old	This study is exploring the effectiveness of an intervention aimed at reducing anxiogenic parenting in <i>parents</i> with anxiety in reducing their children's anxiety
Parents who identify themselves as anxious person	Parents who do not identify as an anxious person	
Children aged 2-11 years	Children aged below 2 years or over 11 years old	Treatment fidelity - the intervention used has been designed for children aged 2-11 years old

**3.6.2.2 Sample Size**

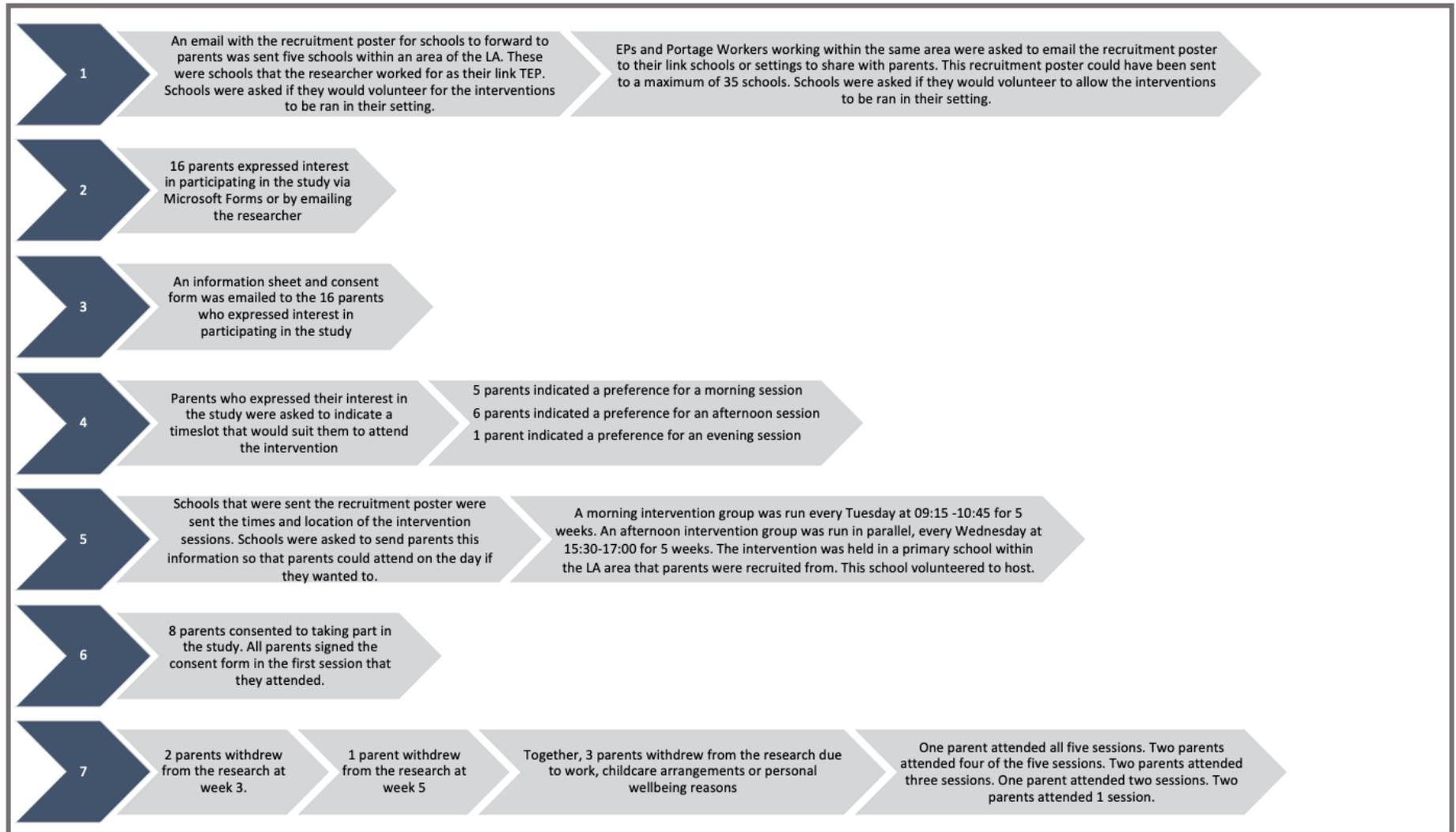
Quantitative designs and statistical tests require a minimum sample size (Robson & McCartan, 2015). For experimental designs and use of parametric statistical tests, it is suggested that 15 observations per group is required (Mertens, 2005; Minitab, 2023). Considering the embedded qualitative design of the study, the minimum group size suggested for a focus group ranges across the literature, from 4 to 14 participants (Then et al., 2014). The group needs to be large enough to offer diversity of views but small enough to encourage participation of all group members (Then et al., 2014). This highlights a possible challenge of conducting mixed-methods research – recruiting a sample small enough for qualitative data collection and analysis but large enough for quantitative data collection and analysis. In line with a pragmatic ontology, it is suggested that when conducting research in the real world, sample size is decided by the situation (Robson & McCartan, 2015). Sample size is discussed further throughout the remainder of this chapter.

### **3.6.2.3 Recruitment**

The recruitment process is outlined in Figure 3.4. The recruitment poster can be found in Appendix E.

**Figure 3.4**

*Flow Chart Demonstrating Recruitment Process and Retention*



#### **3.6.2.4 Parents**

Eight parents consented to taking part in the study. Three withdrew from the study. In sum, five parents took part in this research project. Two parents were aged between 25-34 years old; three parents were aged between 35-44 years old. All parents identified as women. All participants identified their ethnicity as 'White'. All parents spoke English fluently. One parent also spoke Latvian and Russian fluently – this parent shared that she was Latvian. One parent also spoke Spanish, Italian, French and Romanian – this parent shared that she was Romanian. For three parents, their highest level of education was a foundation degree, diploma, or apprenticeship (levels 1-5). One parent held a bachelor's degree. One parent attended secondary school as their highest level of education. Two parents were employed part-time. Two parents were seeking opportunities or unemployed. One parent was employed full-time but was currently on maternity leave. Three parents described their relationship status as 'married', one was 'single' and one was 'cohabiting'. Two parents had three children, one parent had one child and one parent had two children. The final parent had five children including a foster child. All parents lived in the same area of the county.

Three parents attended the morning session, 09:15 – 10:45 and two parents attended 15:30 – 17:00. Three of the five parents took part in a follow-up data collection session which was offered to all five parents in the final intervention session.

#### **3.6.2.5 Children**

Altogether, the parents who participated in the study had 14 children. Of those 14 children, 9 met the inclusion criteria for the study. Children were aged between 3 - 11 years old with a mean age of 6.5 years old. 7 children were male and 2 were female. At follow up, measures of anxiety were completed for 5 children aged between 3-11 years old. 4 were male and 1 was female.

### **3.7 Quantitative Research Design of the Current Study**

#### **3.7.1 Overarching Quantitative Research Question**

The quantitative design element of this mixed-methods research aimed to answer the overarching research question: **“Is an adapted version of the parenting**

**intervention PWA (Cartwright-Hatton, 2021), delivered by a TEP, effective in reducing parental perceptions of children’s anxiety?”**

### **3.7.2 Quantitative Research Design**

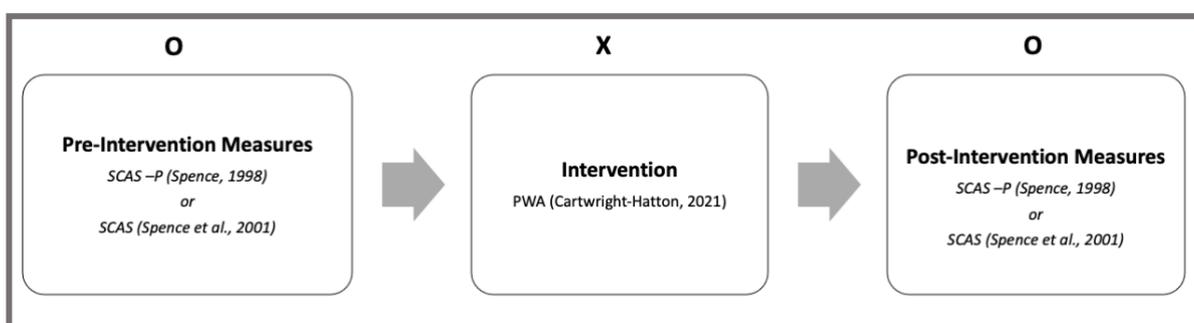
To answer the overarching quantitative research question, a pre-experimental research design was used. Using a pre-experimental design, the intervention was not withheld from eligible parents, offering equal opportunities for all children to receive wellbeing support. Suited to real-world research, pre-experimental designs can be used with smaller groups of participants (Creswell & Creswell, 2023) - this matched the research topic as it was unclear how many participants would take part in the intervention given that it was the first time it had been delivered in schools by a TEP.

A one-group pre-test post-test design was used. A single group of parents completed pre-test measures (O1), took part in the PWA intervention (Cartwright-Hatton, 2021) (X) and completed post-test measures immediately after the intervention (O2). This is depicted in the Figure 3.5. Three parents also completed the post-test measures six months post-intervention.

The independent variable was the intervention and the dependent variable was child anxiety scores as measured by the Spence Children’s Anxiety Scale-Parent Report (SCAS-P) (Spence, 1998) or the Spence Pre-school Anxiety Scale-Parent Report (SCAS) (Spence et al., 2001).

**Figure 3.5**

*One-group Pre-test Post-test Design Used in this Study*



### **3.7.3 Quantitative Measures**

As measures of child anxiety, parents completed either the SCAS-P (Spence, 1998) or the SCAS (Spence et al., 2001) questionnaires. As per the manuals for the

measures, the SCAS-P was completed for children aged 7-13 years old (Spence, 1998) and the SCAS was completed for children aged 3-6 years old (Spence et al., 2001).

The SCAS-P (Spence, 1998) consists of 38 statements about their child which parents rate as “never”, “sometimes”, “often” and “always”. For the SCAS (Spence et al., 2001), parents rate 28 statements about their child as “not true at all”, “seldom true”, “sometimes true”, “quite often true” and “very often true”. An overall score of anxiety as well as subscale scores relating to specific aspects of child anxiety are generated from the ratings.

The SCAS-P (Spence, 1998) was used as it shows good internal reliability and validity and has been designed for use with non-clinical samples of children, such as those in the current study (Nauta et al., 2004; Orgilés et al., 2019; Spence, 1998). Unlike measures such as the CBC (Achenbach, 1992b), subscales within the SCAS-P (Spence, 1998) explore symptoms associated with specific anxiety disorders outlined in the DSM-IV (Bell, 1994) namely: panic, separation anxiety, social phobia, physical injury fears, obsessive-compulsive and generalised anxiety. As the PWA intervention (Cartwright-Hatton, 2021) used in this study incorporated strategies to reduce symptoms such as, specific fears, the use of this measure allowed for a detailed evaluation of the impact of the intervention on child anxiety. The SCAS (Spence et al., 2001) was used as it shows good internal consistency (Edwards et al., 2010). Like the SCAS-P (Spence, 1998), subscale scores can be generated for symptoms related to: separation anxiety, social anxiety, physical injury fears, obsessive-compulsive and generalised anxiety (Spence et al., 2001).

Teacher-report measures of child anxiety were not used as the research was interested in parent views of their child’s anxiety. Child-report measures were not used as it can be challenging to gather meaningful data from these (Cartwright-Hatton et al., 2018). It was also considered unethical to seek child views due to the selective nature of the intervention. Moreover, this research was interested in exploring *parental* perceptions of child anxiety, hence a parental report measure was used.

Parents also completed a demographics questionnaire - see Appendix F.

#### **3.7.4 Quantitative Research Procedure**

A summary of the procedure is given in Figure 3.6. The research was conducted across six weeks. Six months post-intervention, three parents completed follow-up measures of child anxiety.

#### **3.7.4.1 *Session Setting***

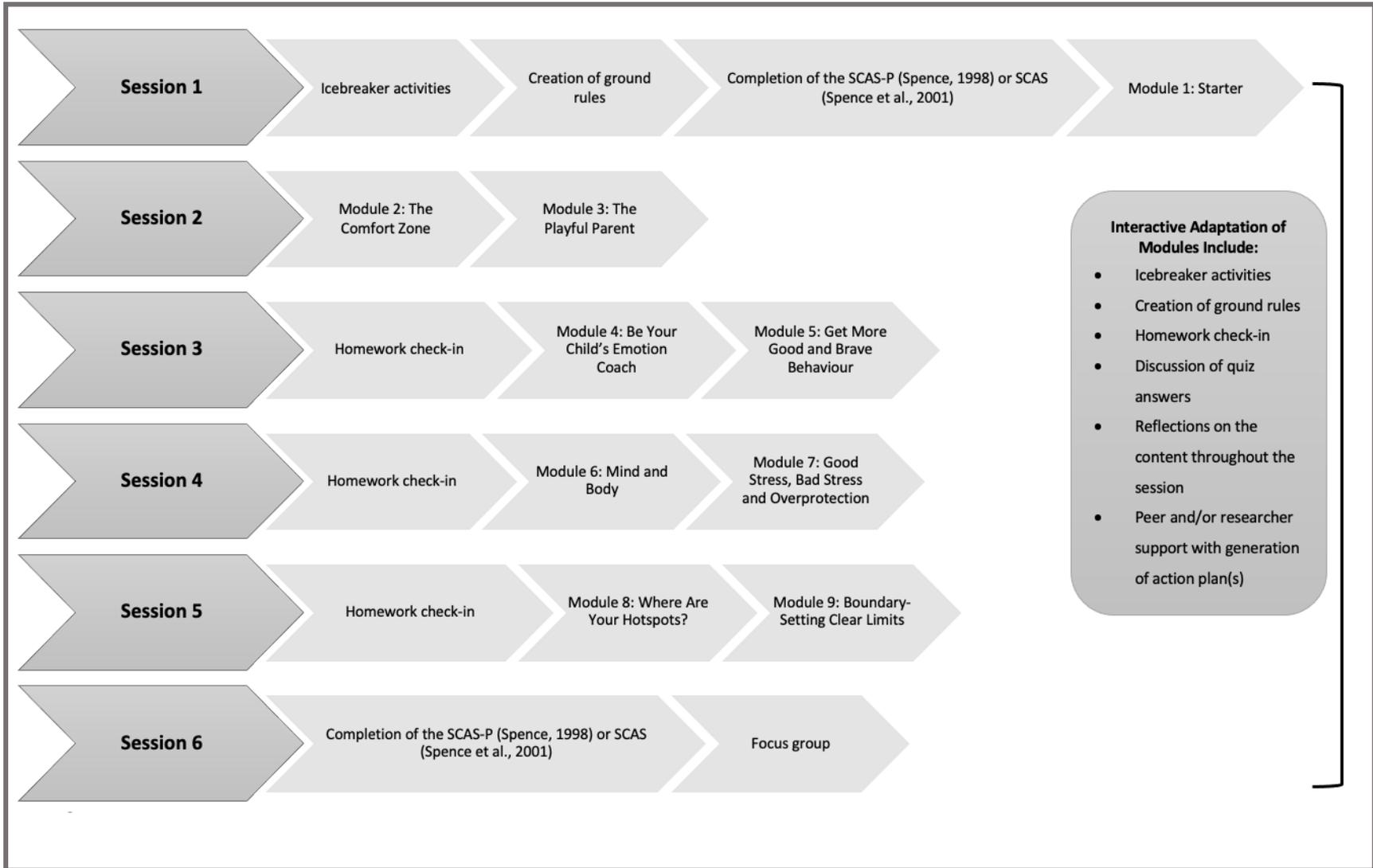
The research was conducted in a primary school local to participants. The morning sessions were conducted in the empty school hall. Participants sat around a table and the intervention was played via the researcher's laptop. The afternoon sessions were conducted in a meeting room; the intervention was played through a screen. For session 6, all five parents attended at 09:15 – 10:45 to participate in the focus group, held in a meeting room. As only two parents attended the afternoon session, if one was unable to attend, the other was offered to complete the session with the researcher, virtually, via Microsoft Teams. This was to reduce possible anxiety that they parent may experience from an in-person 1:1 session. Sessions 4 and 5 were delivered to one parent virtually. In session 3, one parent attended the intervention in-person whilst the other attended virtually as they were unable to attend in person due to work constraints. The follow-up data collection session was conducted in a local café at the request of the parents.

#### **3.7.4.2 *Session Content and Materials***

Figure 3.6 demonstrates the content of each session. The modules referenced are those from the PWA intervention (Cartwright et al., 2021). Further detail including a script that was approximately followed, by the researcher, can be found in Appendix G.

**Figure 3.6**

*Research and Intervention Summary*



In session 1, the information sheet (see Appendix H) was presented again to participants and consent forms (see Appendix I) were given to parents to sign if they had not already done so. Parents also completed the demographics questionnaire. One parent was unable to attend the initial session and therefore completed the SCAS (Spence et al., 2001) and SCAS-P (Spence, 1998) over the phone with the researcher.

As the researcher-adapted version of the intervention included opportunities for group interaction, effective group work was desirable to support intervention engagement. The icebreaker activity consisted of asking parents to share their name and who was at home with them. This aimed to highlight the common identity of group members, as parents, to enhance group harmony and effective working (Allport, 1954; Dovidio et al., 2017). Parents were also asked to rate how they were feeling, using scaled photos of sheep (Wan, 2020) or squirrels (Class Critters, 2020). This drew upon psychodynamic assumptions which suggest that when the emotions of the group are brought to the conscious, group functioning is improved (McLeod & Kettner-Polley, 2004). At the end of each session, parents were offered to take a “token” representing what they needed such as, “fun” or “connection” (Treisman, 2020) to enhance their wellbeing.

Participants in the morning and afternoon sessions were provided with the same materials in sessions 1-5 including the PWA intervention handouts (see Appendix J), an Emotion Coaching ‘cheat sheet’ (see Appendix K) and Emotion Coaching scripts (see Appendix L). The Emotion Coaching handouts were created by the researcher to support the participants with embedding the content delivered in the Be Your Child’s Emotion Coach module.

#### **3.7.4.3 Intervention and Treatment Fidelity**

Treatment fidelity relates to whether the independent variable was implemented as per the treatment procedures outlined by the researcher (Gall et al., 2003). The PWA intervention was created by Cartwright et al. (2021), covering content similar to that used in the Parent Workshop (Cartwright-Hatton et al., 2018; Palmer et al., 2023). Differently to the prior versions of the Parent Workshop, the PWA intervention (Cartwright et al., 2021) was designed to be completed online, independently by parents. However, for this research study, parents were

played the online modules, in-person, in a school setting. This decision was made in light of Lawrence et al. (2022)'s findings that mothers felt that school support, and in-person parenting interventions would facilitate their attendance. Additional interactive elements incorporated into the intervention sessions are shown in Figure 3.6. If parents were unable to attend a session, they were emailed the module handouts.

### **3.7.5 *Quality of Quantitative Design***

The quality of quantitative research designs may be considered in terms of internal and external validity. Weak treatment fidelity is one possible threat to validity. Table 3.4 offers additional examples of how possible threats to external and internal validity were addressed within the current study.

**Table 3.4***Management of Possible Threats to Validity within this Research*

<b>Validity</b>	<b>Possible Threat</b>	<b>Explanation</b>	<b>Measures Taken to Reduce Threat</b>
	History	Events that may occur throughout the study, other than the intervention, which may influence findings	Events that the participants experienced and shared with the researcher will be considered within data analysis.
Internal Validity	Instrumentation	Different results at pre- versus post-test may relate to changes in the measurement instrument used	The same standardised measured were used at pre- and post-test. The qualitative strand of the research design offered parents a second way to express the influence of the intervention which could be compared with the quantitative findings
	Hawthorne Effect	The mere participation in an intervention may influence the participants' behaviour	Through use of mixed methods, the qualitative strand of the research design allows this to be explored further as parents were asked <i>how</i> the intervention may have influenced their behaviours.
External Validity	Time of Measurement and Treatment Interaction	The timing of the post-test may influence findings	A follow-up data collection point at 6 months post-intervention was incorporated into the design so that results immediately after, and 6 months post-intervention could be compared

### 3.7.6 Quantitative Data Analysis

*“Nonparametric tests are designed for real data: skewed, lumpy, having a few warts, outliers, and gaps scattered about”- Smalheiser (2017, p.157)*

The demographic data was inputted into Microsoft Excel (Microsoft, 2024); Microsoft Excel was used to generate descriptive statistics from this data.

The quantitative data from the SCAS (Spence, 1998) and SCAS-P (Spence et al., 2001) pre-, post- and six-months post-intervention was inputted into Microsoft Excel. Total scores and subscale scores were derived from the SCAS (Spence, 1998) and SCAS-P (Spence et al., 2001). As per the SCAS (Spence, 1998) manual, responses were scored 0 for “never”, 1 for “sometimes”, 2 for “often” and 3 for “always”. As per the SCAS-P (Spence et al., 2001) manual, responses were scored 0 for “not true at all”, 1 for “seldom true”, 2 for “sometimes true”, 3 for “quite often true” and 4 for “very often true”. Missing data values due to participants writing “not sure” or not responding to an item, were left blank. The data from one child was removed from the analysis as the parent completed 25% (>75%) of the measure for the child; as the child was pre-verbal, the parent felt unable to answer most questions on the SCAS (Spence, 1998). Such decisions were in line with previous research using the SCAS (Spence, 1998) (e.g., Reardon et al., 2018).

A Wilcoxon Signed-Rank Test was performed in Jeffrey’s Amazing Statistics Program (JASP) version 0.16 (JASP, 2018) to compare total and subtest SCAS (Spence, 1998) and SCAS-P (Spence et al., 2001) scores, pre-and post-intervention. A Wilcoxon Signed-Rank Test compares dependent variable means across two related groups, when data is non parametric (Goss-Sampson, 2022). Non-parametric data does not meet parametric assumptions of normal distribution (Goss-Sampson, 2022). A non-parametric test was used as the sample was classed as extremely small,  $N < 16$  meaning tests of normality may be inappropriate and thus normality cannot be assumed (Dwivedi et al., 2017).

A Friedman’s Repeated Measures ANOVA (RMANOVA) was also performed in JASP. Friedman’s RMANOVAs investigate whether there is a difference in mean scores across more than two time points using the same participants each time, when data is non-parametric (Goss-Sampson, 2022). A Friedman’s RMANOVA was

conducted to compare pre-, post- and six-months post-intervention total and subtest scores on the SCAS (Spence, 1998) and SCAS-P (Spence et al., 2001).

### **3.8 Embedded Qualitative Research Design of the Current Study**

#### **3.8.1 Embedded Qualitative Research Question**

The embedded qualitative design element of this mixed-methods research aimed to answer the subsidiary research question: **“How do parents perceive the adapted version of the parenting intervention PWA (Cartwright-Hatton, 2021)?”**.

#### **3.8.2 Embedded Qualitative Research Design**

A focus group qualitative design was implemented in the sixth intervention session to explore parental perspectives of the PWA intervention (Cartwright et al., 2021) and how it may be improved. A focus group was chosen due to its aligned with evaluation research (Mertens, 2005). It offered the opportunity to learn from parental perspectives of the intervention which has been scantily investigated as yet (Morgan, 1997b).

#### **3.8.3 Embedded Qualitative Research Procedure**

##### **3.8.3.1 Group Size**

*“Size matters” - Morgan (1997a, p.70)*

A delicate balance should be achieved when deciding focus group size; enough people are needed to generate discussion but the group should not be so big that individuals voices are overpowered (Morgan, 1997a). Then et al. (2014) report research that use focus group sizes of 4-14 people (Then et al., 2014). Typically six-ten participants is recommended although smaller groups may be used if deemed most appropriate (Morgan, 1997a). For this research, five parents attended a singular homogenous focus group. This group size decision was pragmatic; only five participants took part in the study and thus were suitable to attend. Moreover, smaller groups are recommended for emotive interview topics, like child anxiety, allowing the moderator to attend to the needs of the participants and offer a safe space for expression (Morgan, 1997a; Then et al., 2014).

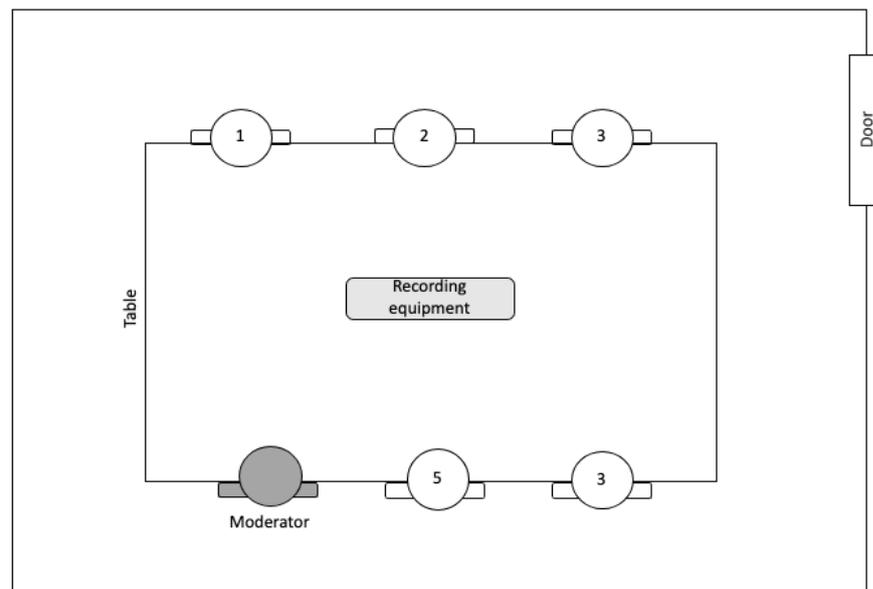
##### **3.8.3.2 Setting**

Considering the negative cognitive triad (Beck, 1976), it was deemed important that the focus group location was pleasant and felt safe to parents

(Morgan, 1997a). It was decided that the school meeting room met these requirements, offering predictability, for instance. Figure 3.7 demonstrates the seating arrangements used.

**Figure 3.7**

*Focus Group Seating Arrangement*



### **3.8.3.3 Moderator Role**

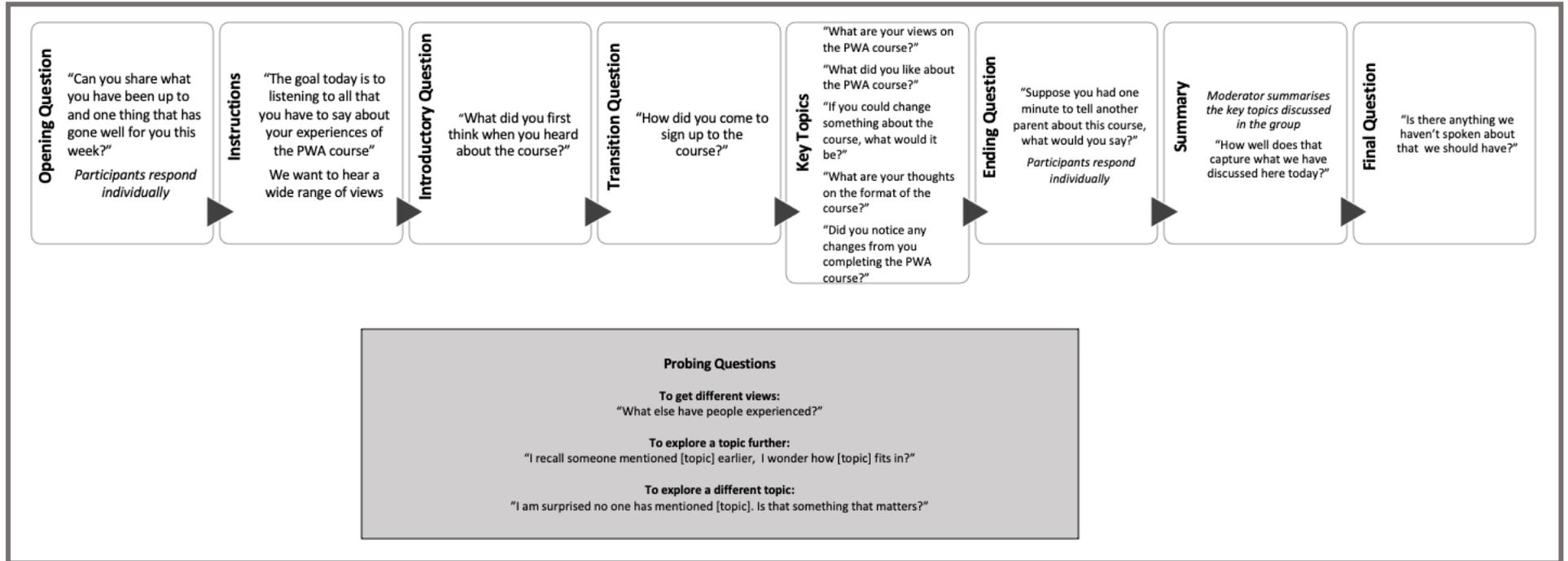
The moderator introduces topics for the focus group to discuss and is typically the researcher, as in this study (Morgan, 1997c). Moderator involvement consists of managing group dynamics; whether conversation within the group is relatively free flowing (low moderator involvement) or controlled (high moderator involvement) (Morgan, 1997c). This research used low moderator involvement as recommended for exploratory research, allowing the researcher to learn from participants views (Morgan, 1997c). Topics were loosely presented to the group and the moderator probed where necessary, following new topics that arose and skipping pre-covered topics (Morgan, 1997c). Topics introduced to the group for discussion were informed by existing literature and the researcher's intervention experience (Krueger & Casey, 2000). The focus group was recorded using the researcher's laptop via the Voice Recorder Application. The moderator also made brief notes.

#### **3.8.3.4 Phases**

Figure 3.8 demonstrated the phases followed within the focus group and topics introduced. The focus group took place for a recommended duration of 1.5 hours (Robson & McCartan, 2015).

**Figure 3.8**

*Flow Chart Showing the Structure and Content of the Focus Group*



#### **3.8.4 Quality of Embedded Qualitative Design**

*“Qualitative research apologising for lack of statistical generalisability is problematic” - Braun and Clarke (2022, p.143)*

Traditional quantitative ambitions for generalisability, reliability and validity are mismatched with qualitative research (Creswell & Creswell, 2023). Researchers may idealise quality aspects such as, empirical and statistical generalisability (Maxwell & Chmiel, 2014). This ideology can seep into the world of qualitative research which, as Braun and Clarke (2022) suggest, may be problematic, devaluing contextualised voices as well as the value of researcher interpretations for generating meaning. Indeed, some qualitative researchers suggest that generalisability, in any form, is irrelevant for qualitative research (Braun & Clarke, 2022).

Nevertheless, reference should be made to characteristics of “good” qualitative research to ensure rigour and trustworthiness of findings so that they may be used to benefit society (Yardley, 2000). Lincoln and Guba (1985) offer criteria for measuring qualitative research, namely- credibility, dependability, confirmability, transferability, reflexivity, and audit trails. Table 3.5 outlines the ways in which such criteria were addressed within the current study (Braun & Clarke, 2022; Creswell & Creswell, 2023; Nowell et al., 2017).

**Table 3.5***Trustworthiness Criteria for Qualitative Research (Lincoln & Guba, 1985; Nowell et al., 2017)*

<b>Criteria</b>	<b>Explanation</b>	<b>Example of Measures Taken</b>
Credibility	Ensuring a “fit” between the researcher’s representation of participant views and the views themselves (Tobin & Begley, 2004)	<ul style="list-style-type: none"> <li>• A summary section was incorporated into the focus group, offering participants an opportunity to check the researcher’s interpretation of their views</li> <li>• ‘Prolonged engagement’ with the data was conducted through phases of Reflexive Thematic Analysis such as, familiarisation, as</li> </ul>
Transferability	A thick description of the research process is given so that readers can determine whether the findings may transfer to a different context	<ul style="list-style-type: none"> <li>• The research procedure and data analysis has been described within this chapter including details regarding participant characteristics and research settings.</li> </ul>
Dependability	The research is clearly reported and logical (Tobin & Begley, 2004)	<ul style="list-style-type: none"> <li>• The qualitative research design element of this chapter has been written in accordance with best practice outlined by those such as Braun and Clarke (2022) and Creswell and Creswell (2023).</li> </ul>
Confirmability	The researcher’s interpretations are clearly generated from the data	<ul style="list-style-type: none"> <li>• The data analysis process is outlined, and reflexive boxes are included to enhance transparency of the way in which meaning was generated by the researcher</li> <li>• Systematic coding was implemented following the RTA process, exploring the meaning of the full data set, reducing the opportunity to “cherry picking” themes (Braun &amp; Clarke, 2022).</li> </ul>
Audit Trails and Reflexivity	The researcher evidences decisions and the rationale behind them. Reflexivity is central to this.	<ul style="list-style-type: none"> <li>• A reflexive journal was kept by the researcher</li> </ul>

### 3.8.5 Qualitative Research Analysis: Reflexive Thematic Analysis

The qualitative data gathered through the focus groups was analysed using Reflexive Thematic Analysis (RTA). This section will outline what RTA is and how it was used for data analysis.

#### 3.8.5.1 Key Terms

Several key terms used within RTA are defined in Table 3.6 to support readability.

**Table 3.6**

*Definitions of Key Terms within RTA (Braun & Clarke, 2022)*

Term	Definition
Code	Analytic output and tool, representing the researcher's analytic insight generated through engagement with the data.
Code label	A phrase which summarises the data meanings and analytic ideas depicted by a code
Theme	A collection of analytic insights, connected by a shared pattern of meaning or central organising concept. Themes are made up of a cluster of codes.
Central organising concept	Meaning or idea that brings a theme together
Thematic map	Visual representation of possible themes and the relationships between them
Subtheme	A collection of shared concepts within a theme

#### 3.8.5.2 What is Reflexive Thematic Analysis

Thematic Analysis (TA) is a data analysis method which uses coding to explore patterns of meaning, guided by certain "best practice principles" underpinned by varying qualitative research values (Braun & Clarke, 2022; Clarke & Braun, 2017). One version of TA is RTA (Braun & Clarke, 2006). RTA emphasises the researcher's active and subjective role in developing codes and themes, along with researcher reflexivity (Braun & Clarke, 2022). Reflexivity may be defined as the considered practice of critically interrogating our actions, why and how we do what

we do and the influence this has on the research (Braun & Clarke, 2022). RTA is comprised of six phases shown in Table 3.7 (Braun & Clarke, 2022).

**Table 3.7**

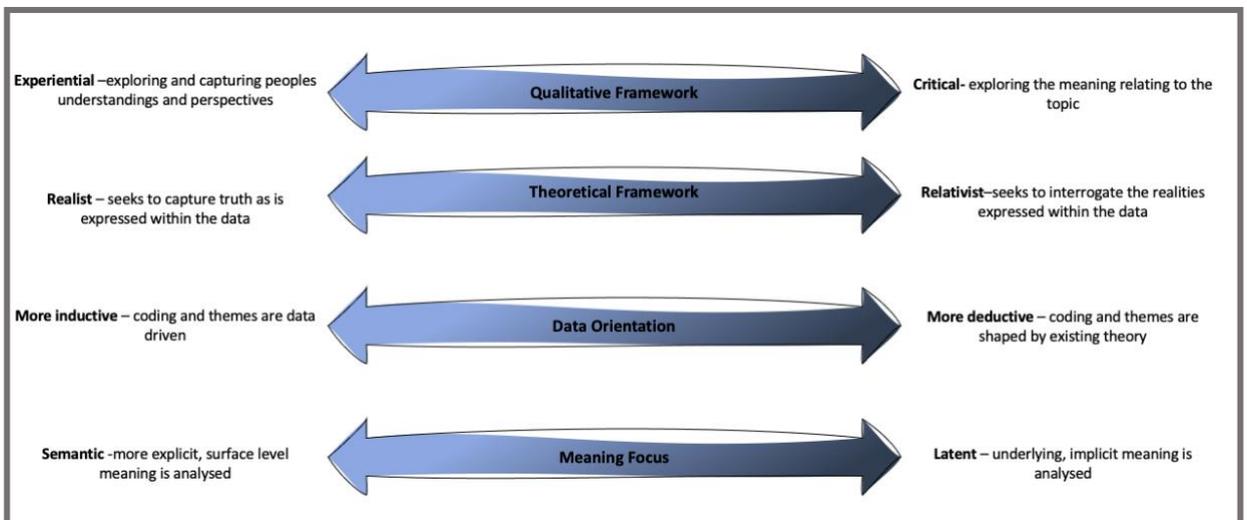
*Six Phases of RTA (Braun & Clarke, 2022)*

Phase	Description
1	Familiarisation
2	Coding
3	Theme generation
4	Theme development and review
5	Theme naming, defining, and refining
6	Write up

Figure 3.9 shows that an approach to RTA may exist along each continuum, including both semantic and latent analysis.

**Figure 3.9**

*Variations of RTA (Braun & Clarke, 2022)*



### 3.8.5.2.1 Alternative TA Versions

Alternative TA versions include Coding Reliability TA (CRTA) (Boyatzis, 1998) and Codebook TA (CTA) (King, 2012). Distinctively from RTA, within CRTA, themes are identified (not generated) and a code is not an analytic unit (Braun & Clarke, 2022). In CRTA, a codebook outlining themes and codes offers instructions on how such themes and codes may be applied to the data (Braun & Clarke, 2022). Non-

surprisingly, akin with more quantitative paradigms, within CRTA, there is a focus on using a codebook and coder 'agreement' to increase code reliability (Braun & Clarke, 2022). CTA may be seen as a midpoint between RTA and CRTA; it uses some prior theory to generate codes and centres around the use of a coding frame or book (Braun & Clarke, 2022). In comparison to CRTA, the codebook is not used to measure coding accuracy but instead to map analysis development (Braun & Clarke, 2022).

### **3.8.5.3 *Why TA and Why RTA***

TA is recommended for beginners at analysing qualitative data (Braun & Clarke, 2021). This acknowledges a key criticism of a mixed methods approach being demanding of both the researcher's quantitative and qualitative analytical skills (McCrudden & Marchand, 2020). Pragmatically, RTA was chosen as unlike versions such as CRTA, it can be performed by a single researcher. It also is compatible with a range of participant group sizes. Importantly, its flexibility meant that an inductive and/or deductive approach could be taken to data analysis which may generate new theory whilst offering evidence for pre-existing theories. This was particularly useful within this research study given that there is limited research on this area. Experiential analysis could also be used to explore parental perspectives on the anxiety intervention, in line with the embedded qualitative research question. Finally, incorporation of reflexivity corresponded with criteria for generating good quality data which may be used inform EP practice.

### **3.8.5.4 *Researcher Reflexivity***

Subjectivity (who we are and how that influences research) is viewed as integral to RTA (Braun & Clarke, 2022; Nowell et al., 2017). Still, it is suggested that that subjectivity should be interrogated (Braun & Clarke, 2022). Reflexivity requires the researcher to continuously reflect upon their choices, expectations, assumptions and actions throughout the research, and the impact this may have (Finlay & Gough, 2003). Part of such reflection includes an awareness of the researcher's epistemological standpoint, as mentioned previously (Braun & Clarke, 2022). It also includes an awareness of the researcher's personal standpoints and characteristics such as, life experiences (Braun & Clarke, 2022).

Reflexive journaling is encouraged to support the researcher's journey of reflexivity (Braun & Clarke, 2022). Reflexive journaling involves documenting thoughts for later interrogation, reflection and meaning making (Braun & Clarke, 2022). Reflexivity boxes can be found in Appendix M to demonstrate researcher reflexivity.

### **3.8.6 Reflexive Thematic Analysis Process**

The following sections will outline the ways in which the six phases of RTA were used to analyse the focus group data. My practice was informed by the guidelines outlined by Braun and Clarke (2022), peer and tutor supervision and good RTA practice examples.

#### **3.8.6.1 Phase One: Familiarisation**

Familiarisation involves the researcher immersing themselves in the data content (Braun & Clarke, 2022). The researcher must then critically engage with the data, making sense of, and challenging, the data (Braun & Clarke, 2022).

I first transcribed the audio data recorded during the focus group. The audio data was imported into Microsoft Word which automatically transcribed the audio. I then listened to the audio to ensure accurate transcription, making edits where needed. Speakers were identified and colour coded. Names were anonymised. I then read and re-read the transcription notes. To enable critical engagement with the data, I made a familiarisation doodle (see Appendix N) and considered the 'useful questions' outlined by Braun and Clarke (2022).

#### **3.8.6.2 Phase Two: Coding**

*"Codes as building blocks for analysis" - Braun and Clarke (2022, p.52)*

In RTA, coding is seen as a process; codes and their labels are process outputs (Braun & Clarke, 2022). Coding is systematic; each data item is closely read and segments of possible meaning, relevant to the research question, is given a code label (Braun & Clarke, 2022). Each code label relates to a different meaning (Braun & Clarke, 2022).

In line with good practice RTA guidelines, one coder was used (Braun & Clarke, 2022). During a peer supervision session, a second coder supported the researcher to understand the coding process and offered insights into the data

(Braun & Clarke, 2022). Codes were applied to phrases and paragraphs. These codes would sometimes adapt throughout the coding process. I was interested in understanding parents' perspectives and experiences, lending itself to an inductive orientation (Braun & Clarke, 2022). I also used theory as a lens through which to understand the data when I noticed connections to theory, following a deductive orientation (Braun & Clarke, 2022). Similarly, both semantic and latent codes were generated.

For the first round of coding, I typed possible codes into an additional column of the transcription document in Microsoft Word; I highlighted, and colour coded the text relevant to the code. I added "comments" to parts of the transcription that I was not sure whether needed a code so that I could revisit such sections in round two of coding. I followed this same process for the second round of coding, working my way through the data in a different order to ensure rigour (Braun & Clarke, 2022).

### **3.8.6.3 Phase Three Theme Generation**

*"In reflexive TA, a theme captures shared meaning, united by a central organising concept" - Braun and Clarke (2022, p.77)*

Phase three journeys into the early stages of analysis; attention moves from small units of meaning (codes) to larger patterns of meaning (themes) (Braun & Clarke, 2022). I used Microsoft Excel to group together codes with similar meanings into possible candidate themes. I discarded codes that were formed from one individual and that I felt were unimportant to the data set.

### **3.8.6.4 Phase Four: Theme Development and Review**

Phase four consists of refining and extending the initial themes generated in phase three. This phase highlights the recursive nature of RTA. This phase consisted of re-reading my initial themes and thematic map. I printed out the codes generated in phase two. I grouped the codes into their initial candidate themes and indicated their grouping using post-it notes (see Appendix O). I rearranged the codes to form new tentative themes and subthemes. These themes were formed through consideration of the 'useful review and development questions' outlined by Braun and Clarke (2022). I produced a refined thematic map (see Appendix P).

### **3.8.6.5 Phase Five: Theme Naming, Defining and Refining**

Phase five consists of further theme and analytic refinement (Braun & Clarke, 2022). Themes were first given concise, catchy and informative names (Braun & Clarke, 2022). For each theme, I wrote an abstract. This abstract offered a definition of the theme and subthemes as well as illustrations of what they consist of - the central organising concept, specific manifestations, and implications relating to the embedded research question.

### **3.8.6.6 Phase Six: Write Up**

*“Writing matters for analysis” - Braun and Clarke (2022, p.118)*

Writing is embedded throughout the RTA process from data analysis to the report, offering opportunities for refinement (Braun & Clarke, 2022). Chapter 5 will outline the conclusions drawn from the RTA story.

## **3.9 Ethical Considerations**

This research study adhered to legislations of which TEPs abide by including:

- University of Nottingham (UoN) Code of Conduct and Research Ethics (University of Nottingham, 2021)
- British Psychological Society (BPS) Code of Human Research Ethics Principles (Oates et al., 2021)
- BPS Code of Ethics and Conduct (British Psychological Society, 2018)
- Health and Care Professions Council Standard of Conduct, Performance and Ethics (Health and Care Professions Council, 2018)
- Data Protection Act (gov.uk, 2018)

The UoN Ethical Approval Submission Form including an Ethical Risks Checklist was completed to secure ethical approval which was given in May 2023 by the UoN Ethics Committee (see Appendix Q).

## **3.10 Method Summary**

This chapter began by exploring key research paradigms and why a mixed-methods paradigm and pragmatic ontology was chosen for this study. It then explored and evaluated quantitative, qualitative, and mixed-methods research designs. The embedded mixed-methods design used for this study was outlined. The quantitative and qualitative data analysis implemented was described.

Consideration was given to the quality of the quantitative and qualitative data, as well as ethics.

## Chapter 4: Results

### 4.1 Aim and Structure

This chapter will first address the overarching quantitative research question. It will outline the factors considered for the completion of the inferential statistical analyses. The results of the statistical analyses will then be reported. Second, this chapter will address the embedded qualitative research question. It will outline the themes generated from the Reflexive Thematic Analysis (RTA).

### 4.2 Overarching Research Question: Planning Quantitative Data Analysis

Cohen et al. (2017) outline three factors which should be considered prior to choosing the statistical test to be used to analyse quantitative data:

1. The object of the data analysis
2. The scale of the data
3. Whether the data is parametric or non-parametric

#### 4.2.1 Objective of the Data Analysis

The statistical test used to analyse the quantitative data should be “fit for purpose” (Cohen et al., 2017) therefore, the purpose or object of the analysis should first be ascertained. The object of this analysis was to answer the overarching quantitative research question: ***“Is an adapted version of the parenting intervention PWA (Cartwright-Hatton, 2021), delivered by a TEP, effective in reducing parental perceptions of children’s anxiety?”***.

The objective of this research question was to examine whether children’s levels of anxiety, as measured by the SCAS-P (Spence, 1998) and SCAS (Spence et al., 2001) were lowered post- compared to pre-intervention. Accordingly, an inferential statistical test to compare differences in scores between the two conditions, using the same group of participants, was needed. A statistical test was also required to compare children’s levels of anxiety, as measured by the SCAS-P (Spence, 1998) and the SCAS (Spence et al., 2001) across three time points – pre-, post- and six-months post-intervention. The statistical test used in both cases relied upon the scale of the data and whether it was parametric.

### 4.2.2 Scale of the Data

The scale of data, or kind of numbers being dealt with, has implications for the statistical analyses which may be performed. Cohen et al. (2017) highlight four scales of data shown in Table 4.1.

**Table 4.1**

*Scales of Data (Cohen et al., 2017)*

Scale	Variable Type	Description
Nominal	Categorical	Numbers represent discrete categories and may be thought of as labels, with no quantitative significance. For instance, a '1' may represent a gender category.
Ordinal	Categorical	Numbers represent orders. This scale of data typically results from rating scales. For instance, a '1' may represent strongly disagree.
Interval	Continuous	Numbers have equal distances (intervals) between them. There is no true zero. These scales are rarely used.
Ratio	Continuous	This scale incorporates the same features of interval data but includes a true zero.

The data used in the present study was ordinal - derived from the ratings given by parents using the SCAS-P (Spence, 1998) or the SCAS (Spence et al., 2001).

### 4.2.3 Non-Parametric versus Parametric Data

Different statistical tests may be used to analyse quantitative data depending on whether the data is parametric or non-parametric. Table 4.2 offers a comparison between parametric and non-parametric data.

**Table 4.2**

*Parametric Versus Non-parametric Data (Cohen et al., 2017)*

Data	Typical Scales	Description
Parametric	Ratio or interval	Assumes data is normally distributed, following a 'bell-shaped curve', peaking at the mean of the data
Non-parametric	Ordinal or nominal	Does not assume normal distribution of data

A non-parametric statistical test was used to analyse the data in the current study. This was due to the use of ordinal data generated from the SCAS-P (Spence, 1998) and the SCAS (Spence et al., 2001). Also, as previously outlined, the sample size was extremely small (Dwivedi et al., 2017) meaning that tests normality could not be assumed (Dwivedi et al., 2017).

#### 4.2.4 Statistical Tests of Difference

Several tests explore whether differences exist between two or more groups, examples of which are shown in Table 4.3. The test chosen depends on whether the data is parametric, the number of groups compared and whether the groups are related or unrelated (Cohen et al., 2017) . Parametric tests require continuous data whilst non-parametric tests require ordinal data.

**Table 4.3**

*Parametric Versus Non-Parametric Statistical Tests of Difference (Goss-Sampson, 2022)*

Group Type	Number of Groups	Parametric Test	Non-Parametric Equivalent Test
Independent	2	Independent T-test	Mann-Whitney U
Related		Paired Samples T-test	Wilcoxon’s Signed Rank
Independent	≥3	ANOVA	Kruksall-Wallis
Related		Repeated Measures ANOVA (RMANOVA)	Freidman’s RMANOVA

The data used in this study was ordinal, non-parametric and compared differences between two related groups. Therefore, a Wilcoxon’s Signed Rank test was performed. To compare anxiety scores across three timepoints, pre-, post-, and six-months-post-intervention, a Freidman’s RMANOVA was performed.

#### 4.2.5 Statistical Significance, Statistical Power and Effect Size

*“Statistical significance, effect size and statistical power. These are essential ingredients of statistics.” - Cohen et al. (2017, p.739)*

Once a statistical test of difference has been conducted, it is important to explore whether possible differences between groups are likely due to chance (significance), as well as the magnitude of this difference (effect size) (Cohen et al., 2017) .

#### 4.2.5.1 Statistical Significance and Power

*“A Type I error is deemed the worst error to make in statistical analyses” - Goss-Sampson (2022, p.173)*

Statistical significance tests the null hypotheses – there is no relationship between the independent and dependent variable, any difference in groups is due to chance (Cohen et al., 2017) . The null hypotheses and alternative hypotheses for this study are shown in Figure 4.1.

**Figure 4.1**

*The Null Hypotheses and Hypotheses for The Current Study*

<p><b>Null hypothesis 1 (H<sub>0</sub>)</b> – There is no difference between child anxiety scores pre- versus post-intervention.</p> <p><b>Hypothesis 1 (H<sup>1</sup>)</b> – There is a difference between child anxiety scores pre- versus post-intervention. Child anxiety scores are reduced post-intervention.</p>
---

Caution should be taken when interpreting statistical significance as there is a risk of either Type I or Type II errors as outlined in Table 4.4, below.

**Table 4.4**

*Type I versus Type II Errors (Cohen et al., 2017)*

Error	Description
Type I	The null hypothesis is not accepted when it is true (false positive), leading the researcher to incorrectly report an effect.
Type II	The null hypothesis is accepted when it is not true (false negative) - there <i>is</i> relationship between the independent and dependent variable, any difference in groups is unlikely to be due to chance. This may error may lead the researcher to incorrectly report no effect.

The likelihood of a Type I error is indicated by the alpha value, representing the level of significance set ( $\alpha$ ). Alpha levels are typically set at  $\alpha = 0.05$  (Goss-

Sampson, 2022) meaning that the chance of the null hypothesis being true is 5% (Ellis, 2010). A p value, generated through statistical tests, indicates how the data compares to the set alpha level; if it is below the alpha level, the null hypothesis can be rejected, if not, the null hypothesis should be accepted (Goss-Sampson, 2022). In practice, if an alpha level is set to 0.05, for the null hypothesis to be rejected, the p value must be  $<0.05$ .

The higher the alpha level (e.g.,  $\alpha = 0.01$ ) the less likely a Type 1 error (Ellis, 2010). Still, the higher the alpha level, the more likely a Type II error, indicated by the beta value ( $\beta$ ) (Ellis, 2010). To reduce the chances of a Type II error, the alpha level would be set lower (e.g.,  $\alpha = 0.1$ ) (Ellis, 2010). An alpha level of 0.05 is recommended (Cohen et al., 2017) .

The alpha cut off should be considered a factor that may influence the *power* of the statistical test. Statistical power, understood as  $1 - \beta$ , should be thought of as the chance that the test will incorrectly reject the null hypothesis (Type II error) (Goss-Sampson, 2022). Sample size may also influence the power of a test. Cohen et al. (2017) suggest that it is more likely to find statistical significance with large samples, leading to an increased possibility of a Type I error. A small sample is more likely to generate Type II errors (Ellis, 2010).

Models from those such as Cohen (1988) are offered to support researchers to calculate sample size needed for a given effect size and statistical power. Shieh et al. (2007) suggest, when performing a Wilcoxon Signed Rank Test, for a power of 0.8, sufficient for reducing the chance of Type II errors (Cohen, 1988), and an alpha of 0.05, a minimum sample size of 4 to 8 may be used.

Parametric tests are considered more powerful than non-parametric tests (Cohen et al., 2017) . Effect size also influences the power of a test, as explored in the following section. In sum, it is suggested that to improve test power, the following should be strived towards (Cohen et al., 2017; Ellis, 2010):

- Large samples
- Large effect sizes
- Lower alpha levels
- Use of parametric tests

#### 4.2.5.2 Effect Size

An effect size suggests the magnitude of group differences. It is suggested that the size of an effect is more important to researchers versus the statistical significance (Cohen et al., 2017) . Therefore, it is suggested that researchers note both statistical significance and effect size when interpreting findings (Cohen et al., 2017) . The effect size when conducting a Wilcoxon Signed Rank test is indicated by the rank-biserial ( $r_B$ ). The interpretations of rank-biserial values are shown in Table 4.5, below.

**Table 4.5**

*Wilcoxon Signed Rank Effect Sizes*

<b>Effect Size</b>	<b>Trivial</b>	<b>Small</b>	<b>Medium</b>	<b>Large</b>
Rank-biserial	<0.1	0.1	0.3	0.5

Small samples may generate moderate or large effect sizes but have no significant differences (Goss-Sampson, 2022). This may indicate a lack of statistical power and that with a larger sample, a significant difference may be found (Goss-Sampson, 2022). Contrastingly, a large sample size may result in statistically significant results whilst having small effect sizes (Goss-Sampson, 2022).

### 4.3 Overarching Research Question: Results of Quantitative Data Analysis

#### 4.3.1 Families

To support transparency and accessibility of the quantitative results, Table 4.6 outlines the families, the parents and their children, which contribute to the data presented.

**Table 4.6***Participant Data Analysed*

Parent	Child	Measure	Follow-up Data Gathered
Parent 1	1a	SCAS-P	No
	1b	SCAS-P	
	1c	SCAS	
Parent 2	2a	SCAS-P	Yes
Parent 3	3a	SCAS-P	Yes
	3b	SCAS-P	
	3c	SCAS	
Parent 4	4a	SCAS-P	No
Parent 5	5a	SCAS	Yes

**4.3.2 Preparing the Raw Data**

Raw scores from the SCAS-P (Spence, 1998) and the SCAS (Spence et al., 2001) were inputted into Microsoft Excel (Microsoft, 2024) and copied into JASP version 0.16.

**4.3.3 Descriptive Statistics**

The research question and null hypothesis are shown below.

**Research Question:** “Is an adapted version of the parenting intervention, PWA (Cartwright-Hatton, 2021), delivered by a TEP, effective in reducing parental perceptions of children’s anxiety?”

**Null Hypothesis:** There is no difference between child anxiety scores pre- versus post- or six-months-post-intervention.

Descriptive statistics are outlined for the total and subtests of the SCAS-P (Spence, 1998) and SCAS (Spence et al., 2001). The findings from the Wilcoxon Signed Rank test are not reported for the SCAS-P data. This was due to a combination of the extremely small sample, the data being derived from family groups, and only one parent completing all the intervention sessions, reducing the

likelihood of developing meaningful statistical inferences and increasing the likelihood of a Type I or II errors.

### 4.3.3.1 Total Child Anxiety

#### 4.3.3.1.1 Total SCAS-P Scores

Descriptive data for the total SCAS-P (Spence, 1998) and SCAS (Spence et al., 2001) scores at pre- and post-intervention were generated using JASP.

Table 4.7 outlines the descriptive statistics for the SCAS-P (Spence, 1998) data. In line with guidelines for reporting non-parametric data, the median (*Mdn*) is reported as it is less sensitive to skewed data compared to the mean (Goss-Sampson, 2022). The Median Absolute Deviation (MAD), as opposed to the Standard Deviation (SD) is given (Goss-Sampson, 2022) as it is less impacted by data which may not be normally distributed (Goss-Sampson, 2022). A raincloud plot shown in Figure 4.2 was generated using JASP to visualise the data, in line with guidelines for reporting non-parametric data (Goss-Sampson, 2022).

**Table 4.7**

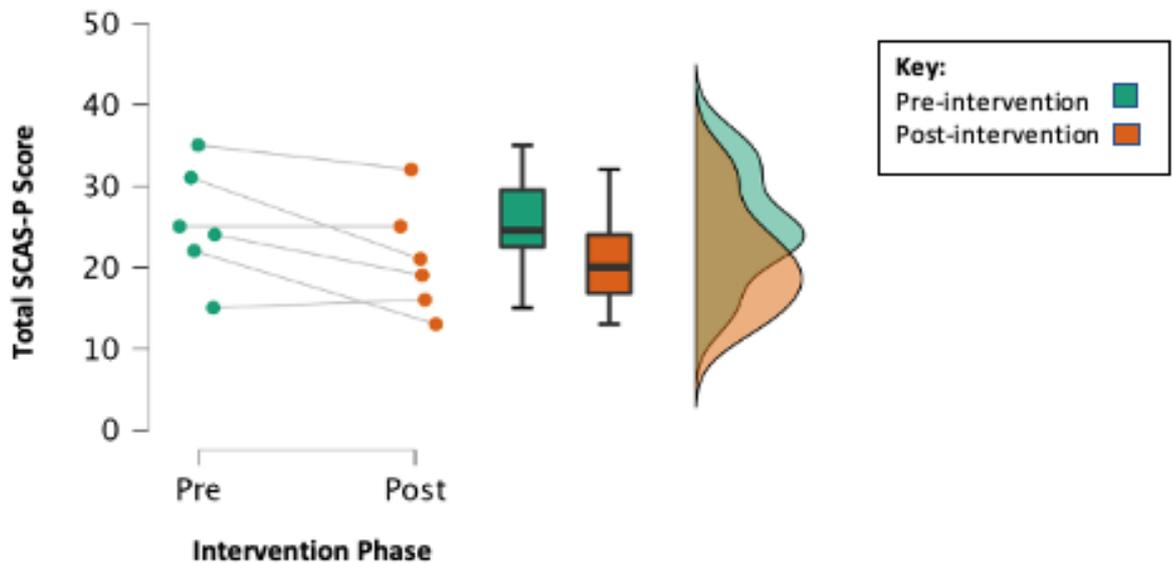
*Descriptive Statistics for Total SCAS-P Scores (Spence, 1998) Pre- and Post-Intervention*

Total SCAS-P Scores					
Intervention	N	Minimum	Maximum	Median	MAD
Phase		Score	Score		
Pre	6	15	35	24.5	4.5
Post	6	13	32	20	4.5

**Figure 4.2**

*Raincloud Plot Demonstrating Pre- and Post-Intervention SCAS-P (Spence, 1998)*

Scores



*Note.* Raincloud plot visualising the SCAS-P (Spence, 1998) pre- and post-intervention data. The raincloud plot shows the individual data points, distribution plots and boxplots. The boxplots demonstrate the upper and lower quartiles, median, minimum, and maximum values.

Table 4.7 demonstrates that median child anxiety scores, as measured by the SCAS-P (Spence, 1998), were lower post-intervention ( $Mdn = 20$ ) versus pre-intervention ( $Mdn = 24.5$ ).

#### **4.3.3.1.2 Total SCAS Scores**

Descriptive data for the total SCAS (Spence et al., 2001) scores at pre- and post-intervention are shown in Table 4.8 and visualised in Figure 4.3. The findings from the Wilcoxon Signed Rank Test are not reported as the sample size was too small to offer meaningful statistical inferences, falling below  $N=6$  (DataNovia, 2018).

**Table 4.8**

*Descriptive Statistics for Total SCAS (Spence et al., 2001) Scores Pre- and Post-Intervention*

Total SCAS Scores					
Intervention Phase	N	Minimum Score	Maximum Score	Median	MAD
Pre	3	1	55	45	10
Post	3	5	67	40	27

**Figure 4.3**

*Raincloud Plot Demonstrating Pre- and Post-Intervention SCAS (Spence et al., 2001) Scores*

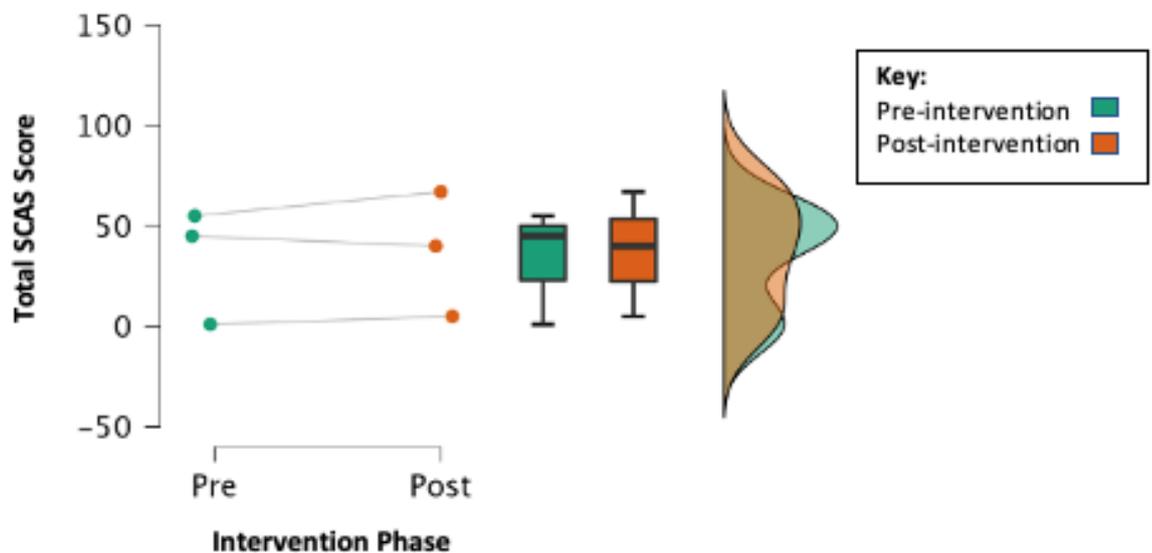


Table 4.7 demonstrates that the median child anxiety scores, as measured by the SCAS (Spence et al., 2001), were lower post-intervention ( $Mdn = 40$ ) versus pre-intervention ( $Mdn = 45$ ).

#### **4.3.3.1.3 Total SCAS-P and SCAS Scores at Follow-up**

Descriptive data for the total SCAS-P (Spence, 1998) and SCAS (Spence et al., 2001) scores are shown in Tables 4.9 and 4.10, respectively. The data reported

contains the data from the parents that filled out the anxiety measures pre-, post-, and six-months-post-intervention, only. The findings from the Friedman's RMANOVA are not reported due to the sample size being too small to offer meaningful statistical inferences (DataNovia, 2018).

**Table 4.9**

*Descriptive Statistics for Total SCAS-P Scores (Spence, 1998) Pre-, Post-, and Six-Months-Post-Intervention*

Total SCAS-P Scores					
Intervention	N	Minimum	Maximum	Median	MAD
Phase		Score	Score		
Pre	3	22	31	25	3
Post	3	13	25	21	4
Six-months post	3	27	31	29	2

Table 4.9 demonstrates that on average, children's levels of anxiety, as measured by the SCAS-P (Spence, 1998) were lower post-intervention (*Mdn* = 21) versus pre-intervention (*Mdn* = 25). However, SCAS-P (Spence, 1998) scores increased at six-months- post-intervention (*Mdn* = 29) compared to immediately post-intervention (*Mdn* = 21) and pre-intervention (*Mdn* = 25).

**Table 4.10**

*Descriptive Statistics for Total SCAS Scores (Spence et al., 2001) Pre-, Post-, and Six-Months-Post-Intervention*

Total SCAS Scores					
Intervention	N	Minimum	Maximum	Median	MAD
Phase		Score	Score		
Pre	2	45	55	50	5
Post	2	40	67	53.5	13.5
Six-months post	2	21	63	42	21

Table 4.10 demonstrates that on average, children's levels of anxiety, as measured by the SCAS (Spence et al., 2001) increased post-intervention (*Mdn* = 53.5) versus pre-intervention (*Mdn* = 50). However, SCAS (Spence et al., 2001) scores decreased at six-months- post-intervention (*Mdn* = 42) compared to immediately post-intervention (*Mdn* = 53.5) and pre-intervention (*Mdn* = 50).

#### **4.3.3.2 Subtests of Child Anxiety**

##### **4.3.3.2.1 SCAS-P Subtest Scores**

Descriptive statistics for the subtest scores for the SCAS-P (Spence, 1998) at pre- and post-intervention are shown in Table 4.11. Raincloud plots are given in Figure 4.4. N=6 for all subtests

**Table 4.11***Descriptive Statistics for Subtest SCAS-P Scores (Spence, 1998) Pre- and Post-Intervention*

Subtest	Intervention Phase	SCAS-P Scores			
		Minimum Score	Maximum Score	Median	MAD
GAD/ Overanxious Disorder	Pre	3	9	5.5	1.5
	Post	2	7	5.5	1
Panic Attack and Agoraphobia	Pre	1	6	3	0.5
	Post	1	3	2	0.5
Physical Injury	Pre	1	8	3	2
	Post	1	5	3	2
Separation Anxiety	Pre	2	14	3	1
	Post	2	11	3.5	1
Social Phobia	Pre	4	8	4.5	0.5
	Post	3	9	4.5	0.5
OCD	Pre	0	7	2.5	1
	Post	0	6	1.5	1

**Figure 4.4**

*Raincloud Plots Demonstrating Pre- and Post-Intervention SCAS-P Subtest Scores*

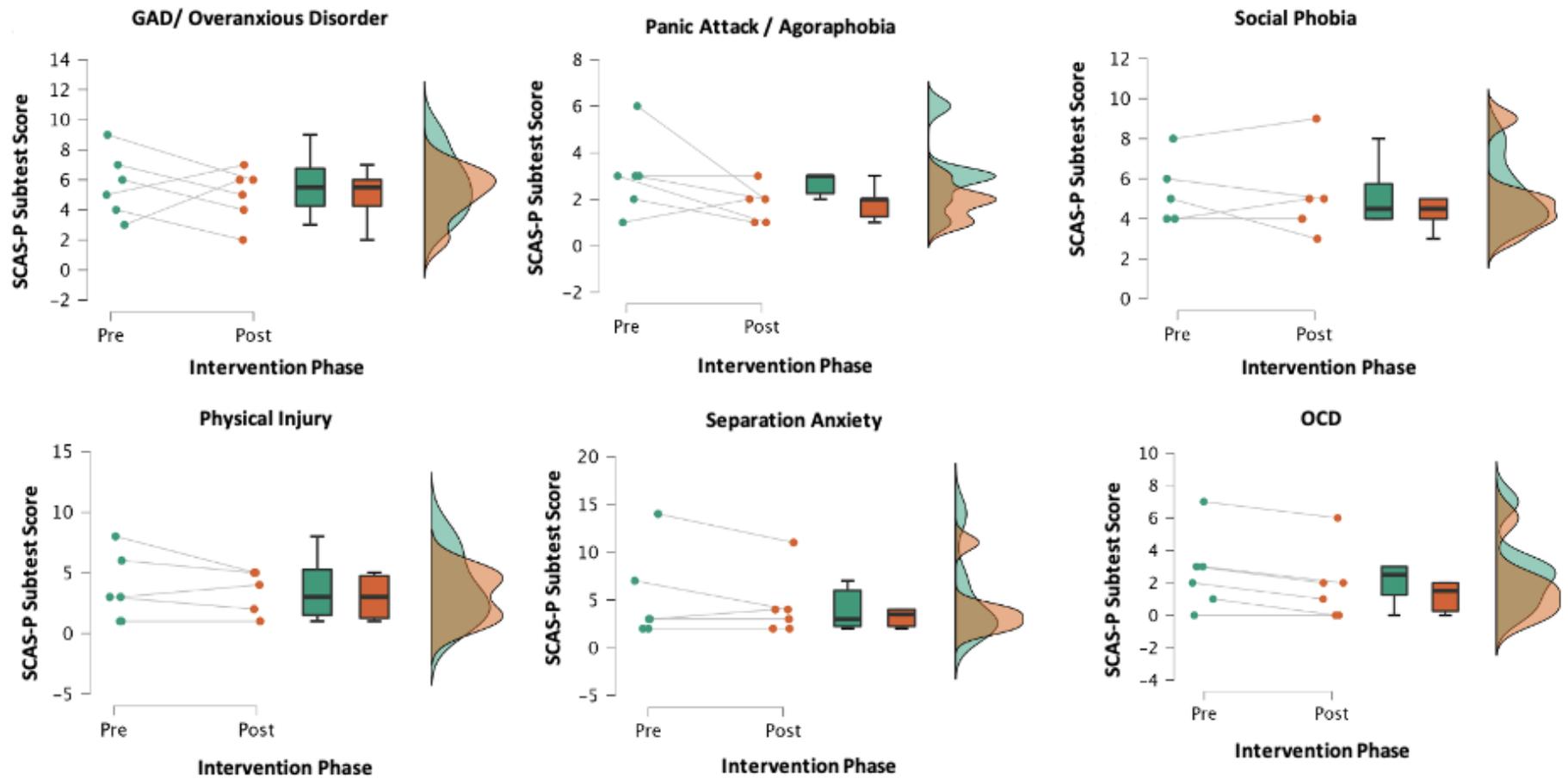


Table 4.11 demonstrates that children's scores on the GAD/ Overanxious subtest remained the same pre- (*Mdn*= 5.5) and post-intervention (*Mdn*= 5.5). Children's scores on the Panic Attack/ Agraphobia subtest reduced at post- (*Mdn*= 2) versus pre-intervention (*Mdn*= 3). Physical Injury subtest scores remained the same pre- (*Mdn*= 3) and post-intervention (*Mdn*= 3). Children's scores on the Separation Anxiety subtest increased from pre- (*Mdn*= 3) to post-intervention (*Mdn*= 3.5). Social Phobia subtest scores remained the same pre- (*Mdn*= 4.5) and post-intervention (*Mdn*= 4.5). Children's scores on the OCD subtest reduced at post- (*Mdn*= 1.5) versus pre-intervention (*Mdn*= 2.5).

#### **4.3.3.2.2 SCAS Subtest Scores**

Descriptive statistics for the subtest scores for the SCAS (Spence et al., 2001) at pre- and post-intervention are shown in Table 4.12. Rainbow cloud plots are given in Figure 4.5. *N*=3 for all subtests.

**Table 4.12***Descriptive Statistics for Subtest SCAS (Spence et al., 2001) Scores Pre- and Post-Intervention*

Subtest	Intervention Phase	SCAS Scores			
		Minimum Score	Maximum Score	Median	MAD
Generalised Anxiety	Pre	1	13	4	3
	Post	0	14	6	6
OCD	Pre	0	0	2	2
	Post	5	10	0	0
Physical Injury	Pre	0	10	8	2
	Post	0	13	11	2
Separation Anxiety	Pre	0	15	12	3
	Post	3	15	12	3
Social Anxiety	Pre	0	12	12	0
	Post	2	15	8	6

**Figure 4.5**

*Raincloud Plots Demonstrating Pre- and Post-Intervention SCAS (Spence et al., 2001) Subtest Scores*

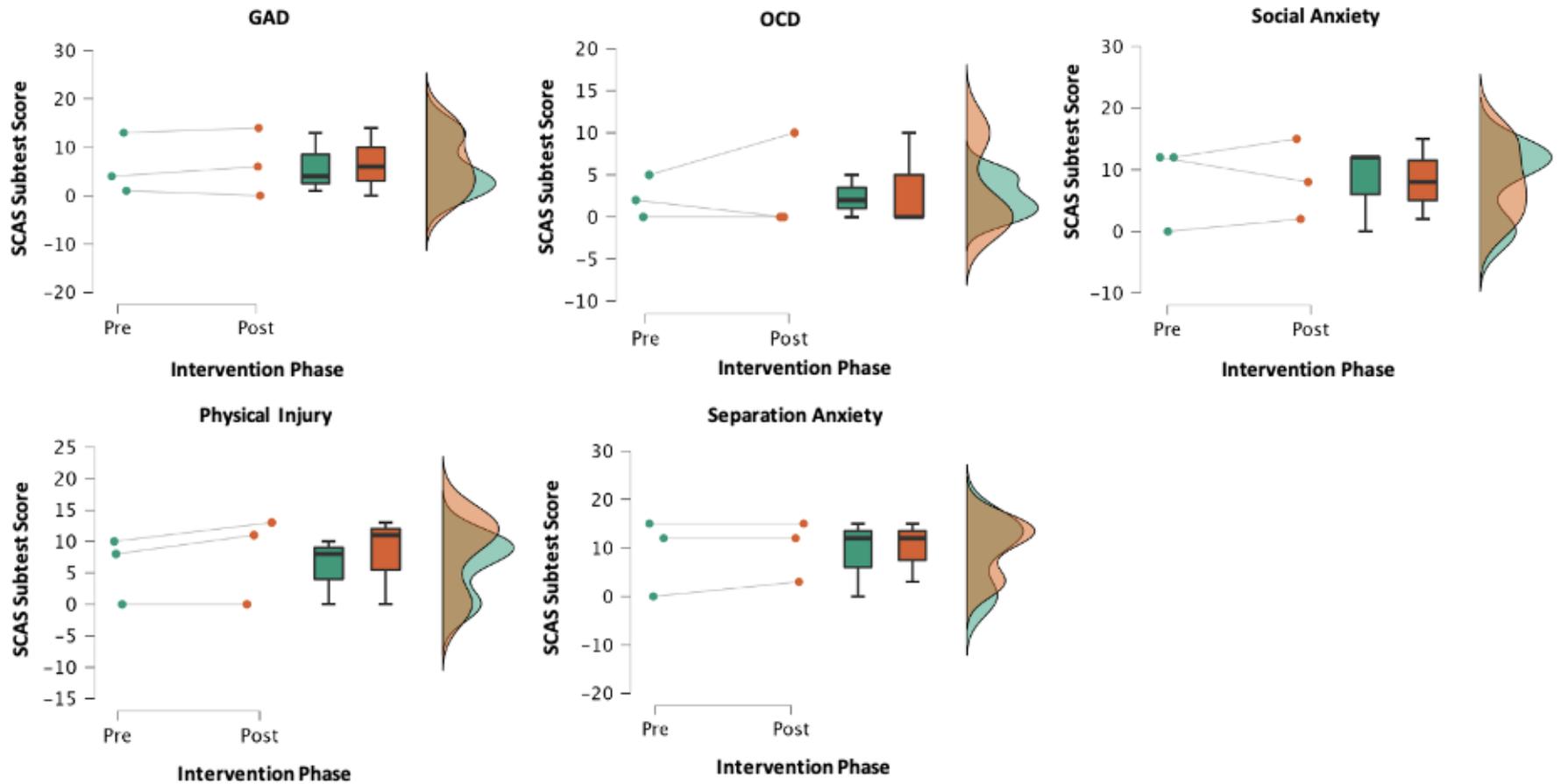


Table 4.12 demonstrates that children's median scores on the Generalised Anxiety subtest increased from pre- (*Mdn*= 4) to post-intervention (*Mdn*= 6). Children's median scores on the OCD subtest reduced at post- (*Mdn*= 0) versus pre-intervention (*Mdn*= 2). Children's median scores on the Physical Injury subtest increased from pre- (*Mdn*= 8) to post-intervention (*Mdn*= 11). Children's median scores on the Separation Anxiety subtest remained the same from pre- (*Mdn*= 12) to post-intervention (*Mdn*= 12). Finally, children's median scores on the Social Anxiety subtest reduced at post- (*Mdn*= 8) versus pre-intervention (*Mdn*= 12).

#### **4.3.3.2.3 SCAS-P and SCAS Subtest Scores at Follow-up**

Descriptive statistics for the subtest scores for the SCAS-P (Spence, 1998) and the SCAS (Spence et al., 2001) at pre-, post-, and six-months-post-intervention are shown in Table 4.13 and 4.13. N=3 for all subtests.

**Table 4.13***Descriptive Statistics for Subtest SCAS-P Scores (Spence, 1998) Pre- , Post and Six-Months-Post-Intervention*

Subtest	Intervention Phase	SCAS-P Scores			
		Minimum Score	Maximum Score	Median	MAD
GAD/ Overanxious Disorder	Pre	4	7	5	1
	Post	2	7	5	2
	Six-months-post	4	6	6	0
Panic Attack and Agoraphobia	Pre	3	6	3	0
	Post	1	2	2	0
	Six-months-post	0	4	2	2
Physical Injury	Pre	3	8	6	2
	Post	2	5	5	0
	Six-months-post	2	9	8	1
Separation Anxiety	Pre	2	7	3	1
	Post	2	4	4	0
	Six-months-post	4	8	4	0
Social Phobia	Pre	4	5	4	0
	Post	3	5	4	1
	Six-months-post	2	9	8	1
OCD	Pre	0	7	1	1
	Post	0	6	0	0
	Six-months-post	0	11	0	0

Table 4.13 shows that median GAD scores remained the same at pre- (*Mdn* = 5) and post-intervention (*Mdn* = 5) but increased at six-months-post intervention (*Mdn* = 6). Panic Attack and Agoraphobia scores reduced from pre- (*Mdn* = 3) to post- (*Mdn* = 2) and six-months-post-intervention (*Mdn* = 2). Physical Injury scores reduced at post- (*Mdn* = 5) versus pre-intervention (*Mdn* = 6); they increased compared to both the pre- and post-intervention scores, six-months-post-intervention (*Mdn* = 8). Separation Anxiety scores increased from pre- (*Mdn* = 3) to post- (*Mdn* = 4) and six-months-post-intervention (*Mdn* = 4). Social phobia scores remained the same pre- (*Mdn* = 4) and post-intervention (*Mdn* = 4) and increased six-months-post-intervention (*Mdn* = 8). Finally, OCD scores decreased at post- (*Mdn* = 0) and six-months-post-intervention (*Mdn* = 0) versus pre-intervention (*Mdn* = 1). *N*=2 for all subtests.

**Table 4.14***Descriptive Statistics for Subtest SCAS (Spence et al., 2001) Scores Pre-, Post- and Six-Months Post-Intervention*

Subtest	SCAS Scores				
	Intervention Phase	Minimum Score	Maximum Score	Median	MAD
Generalised Anxiety	Pre	4	13	8.5	4.5
	Post	6	14	10	4
	Six-months-post	2	12	7	5
OCD	Pre	2	5	3.5	1.5
	Post	0	10	5	5
	Six-months-post	0	7	3.5	3.5
Physical Injury	Pre	8	10	9	1
	Post	11	13	12	1
	Six-months-post	7	11	9	2
Separation Anxiety	Pre	12	15	13.5	1.5
	Post	12	15	13.5	1.5
	Six-months-post	7	13	10	3
Social Anxiety	Pre	0	55	50	5
	Post	0	67	53.5	13.5
	Six-months-post	0	63	42	21

Table 4.14 shows that Generalised Anxiety median scores increased from pre- (*Mdn*=8.5) to post-intervention (*Mdn*=10) and then decreased six-months-post-intervention (*Mdn*=7) compared to both pre- and post-intervention scores. Similarly, OCD Scores increased from pre- (*Mdn*=3.5) to post-intervention (*Mdn*=5) and then decreased six-months-post-intervention (*Mdn*=3.5) compared to both pre- and post-intervention scores. The same pattern can be seen for Physical Injury scores- scores increased from pre- (*Mdn*=9) to post-intervention (*Mdn*=12) and then decreased six-months-post-intervention (*Mdn*=9) compared to both pre- and post-intervention scores. Likewise, Social Anxiety scores increased from pre- (*Mdn*=50) to post-intervention (*Mdn*=53.5) and then decreased six-months-post-intervention (*Mdn*=42) compared to both pre- and post-intervention scores. Separation Anxiety scores remained the same pre- (*Mdn*=13.5) and post-intervention (*Mdn*=13.5), they then reduced six-months-post-intervention (*Mdn*=10).

#### **4.3.4 Overarching Quantitative Results Summary**

Statistical tests of difference were not run due to the small sample size. Descriptive statistics found a reduction in overall SCAS-P (Spence, 1998) scores from pre- to post-intervention. This suggests tentative support for the alternative hypothesis, H<sup>1</sup>: “There is a difference between child anxiety scores pre- versus post-intervention. Child anxiety scores are reduced post-intervention”. Total SCAS (Spence et al., 2001) scores were also found to reduce from pre- to post-intervention. Descriptive data was also given for the follow-up data. SCAS-P (Spence, 1998) scores were shown to reduce from pre- to post-intervention but rise again at six-months-post-intervention, higher than they were at pre-intervention. Overall, SCAS (Spence et al., 2001) scores were found to rise at post-intervention compared to pre-intervention, but decrease six-months-post-intervention, lower than they were at pre-intervention.

#### **4.4 Embedded Qualitative Results**

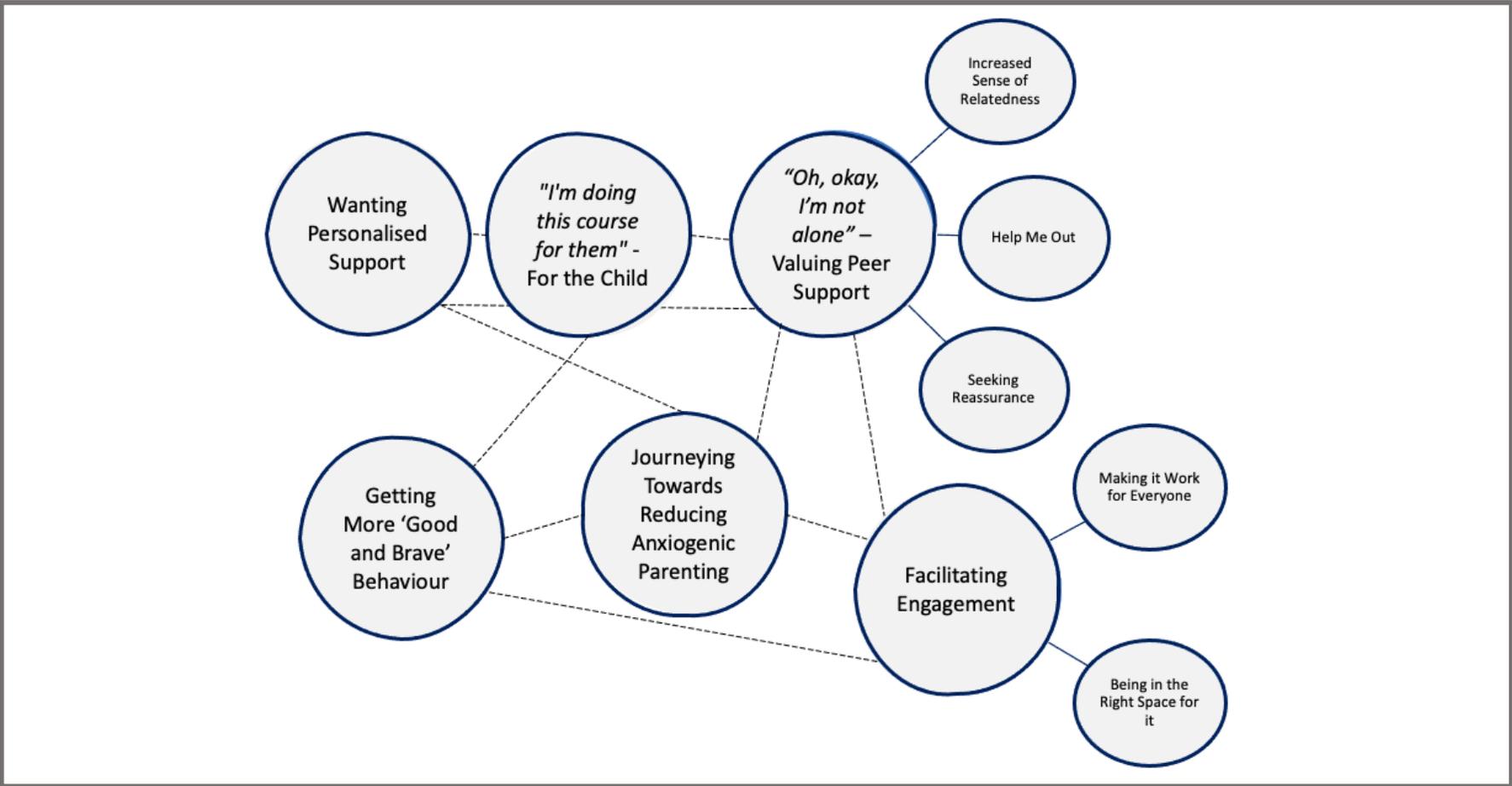
The following section of this chapter will outline the themes generated from the focus group. These themes were generated through RTA, following the phases outlined in chapter 3. The data was analysed with an aim to answer the embedded qualitative research question: “**How do parents perceive the adapted version of the parenting intervention PWA (Cartwright-Hatton, 2021)?**”.

#### **4.4.1 *Thematic Map***

The thematic map shown in Figure 4.6 demonstrates the final six themes generated. Subthemes are demonstrated by full lines. The dotted lines demonstrate possible connections between the themes. The next sections will define and illustrate each theme, and subthemes.

Figure 4.6

Thematic Map



#### **4.4.2 Theme 1: “Oh, okay, I’m not alone” – Valuing Peer Support**

The theme *Valuing Peer Support* explores a recurring pattern of shared meaning within the perspectives expressed by the parents. This shared meaning was expressed in various ways as depicted by the subthemes. The core concept was that they felt a positive impact of the intervention through peer support- be that through concrete, practical support or abstract feelings of relatedness and reassurance. Table 4.15 below offers illustrative quotes for each subtheme. Each subtheme is then defined and explored further. Additional illustrative quotes can be found in Appendix R.

**Table 4.15**

*Subthemes within the Valuing Peer Support Theme*

Subtheme	Illustrative Quotes
Increased Sense of Relatedness	<ul style="list-style-type: none"> <li>• <i>“I just needed that socializing with other parents [...] because the last time I've heard other parents talking about kids was back in children's centre [...] which was ages ago, so I don't think we've got like groups to socialize with parents with school aged children do we? [...] and I think it's such a shame because we still need - I, I personally need that opinion from others and see what other experiences are.”</i></li> <li>• <i>“It's good to hear from mothers. Parents that feel like similar and you get inspiration, and you get a bit of moral support”</i></li> <li>• <i>“I like this format. Being able to meet up with other parents I think umm you if you were doing it online yourself, you wouldn't have other people to bounce off [...] no, you haven't got that interaction and ideas and support from others.”</i></li> </ul>
Help Me Out	<ul style="list-style-type: none"> <li>• <i>“If she'd been naughty, we were taking pompoms out of it because she knew that was like the consequence. But we stopped doing that now after one of the sessions.”</i></li> <li>• <i>“And then yeah, I told this to my husband as well. So, we kind of work as a team.”</i></li> <li>• <i>“I think it's nice to get valuable insight from other parents as well.”</i></li> </ul>
Seeking Reassurance	<ul style="list-style-type: none"> <li>• <i>“It makes me feel I'm not alone. That's the main thing, like...seeing you all having similar issues made me feel like, “oh, OK, I'm not alone, my child is not crazy” [...] It's like it is reassuring one way because like, it's not just mine. So it's the normal behaviour.”</i></li> <li>• <i>“I joined because I felt like my parenting is a little bit in puzzle. I felt like maybe I'm doing something wrong or, you know, children are not behaving. They've got their own views and they're not listening to me and I thought, have I actually, am I doing something wrong?”</i></li> <li>• <i>“He has become quite pessimistic as I said and I wanted to know, is that something normal? Is there anything more I can do?”</i></li> <li>• <i>“I think it's good being with other parents because you kind of like go through your life just dealing with stuff. But it's only when you speak to other people that you realise that maybe that's not normal, umm and so it makes you think “Ohh OK.””</i></li> </ul>

#### **4.4.2.1 Increased Sense of Relatedness**

This subtheme is unified by the concept that parents found that taking part in the parenting intervention enhanced their sense of relatedness, a dimension of the SDT (Ryan & Deci, 2000) and that this is something that they benefitted from. One parent highlighted that the group met their “*need*” to socialise with other parents. A second parent agreed that it was “*good to hear from mothers*”. Likewise, it was interpreted that a third parent valued interacting with other parents and being able to “*bounce off*” of them. Feeling encouragement was interpreted to be important to the parents. A parent summarised that the group intervention offered them an opportunity to “*get a bit of moral support*” from other parents. They felt that being in-person, as opposed to online, facilitated the interpreted sense of interaction and encouragement.

#### **4.4.2.2 Help Me Out**

This subtheme captured the concept that the parents felt supported in completing the intervention by fellow parents, and their partners. The parents expressed that they would share concerns about their child with the other parents and that the other parents may offer them “*valuable insight*” or a different perspective regarding that concern. It was interpreted that the parents also appreciated the ideas or strategies that they offered each other. Finally, parents commented on how they shared their learning from the intervention with their partners and worked “*as a team*” to implement strategies and make positive changes.

#### **4.4.2.3 Seeking Reassurance**

This subtheme explores the concept that parents felt that the intervention offered them opportunities to seek reassurance regarding whether they and/or their child were “*normal*”. It was also interpreted that the parents found the intervention useful for exploring whether they were “*good enough*” parents. For instance, one parent suggested that they joined the intervention to explore whether they were doing “*something wrong*” and shared feeling as though their parenting was in a “*puzzle*”. It felt as though this parent did not trust that they were doing the ‘right’ thing when it came to parenting and worried that this was having a

negative impact on their children’s behaviour. Together, it was interpreted that this parent was experiencing anxiety around their parenting and was seeking support to soothe her worries. Similarly, a parent shares that it was “*reassuring*” to hear that other parents experience difficulties with supporting their children. She highlighted that her comparison of her child to other people’s children caused her to doubt her ability to manage her child’s behaviours and feel as though he was “*crazy*”.

Likewise, a parent expressed concern that her child was “*pessimistic*” and wanted to know if this was “*normal*” or, in my interpretation, something to worry about.

Another parent suggested that, through comparing her child to other parents’ children via group discussions, the intervention reassured her in her thinking that her child was “*not normal*” – something that she was previously “*dealing with*” on her own.

#### **4.4.3 Theme 2: “I’m doing this course for them” – For the Child**

This theme captures the concept that parents felt that the intervention aimed to support their child. Illustrative quotes are given in Table 4.16.

**Table 4.16**

*Illustrative Quotes within the For the Child Theme*

<b>Illustrative Quotes</b>
<ul style="list-style-type: none"> <li>• <i>“I sort of wanted to join the course really to try and help my son. [...] At best I could really just to make sure for him to grow in confidence.”</i></li> <li>• <i>“I thought maybe [child’s name] is so anxious because he can’t- he’s like all force of aggression because he can’t manage his emotions like, oh, this is gonna be good, it’s gonna teach me how to deal with him.”</i></li> <li>• <i>“That’s my reason I came here. Because always keep asking them like, do you have any support [...] because he went through a phase where he had a melt down every single day. Like I just couldn’t [...] I didn’t know how to behave with him.”</i></li> <li>• <i>“I joined because I felt like my parenting is a little bit in puzzle.”</i></li> </ul>

Most parents shared that they joined the intervention with hopes that it would support their child to develop positive emotions such as, “*confidence*” or to manage challenging emotions. Parents suggested that they felt that their child was struggling to regulate their emotions which was leading to perceived challenging

behaviours; they hoped that the intervention would support them in knowing “*how to behave*” in response. It was interpreted that these parents joined the intervention to support their child through adaptations to their parenting.

#### **4.4.4 Theme 3: Journeying Towards Reducing Anxiogenic Parenting**

This theme explored the way in which the intervention may have led to reducing anxiogenic parenting. Illustrative quotes are given in Table 4.17.

**Table 4.17**

*Illustrative Quotes within the Journeying Towards Reducing Anxiogenic Parenting Theme*

<b>Illustrative Quotes</b>
<ul style="list-style-type: none"> <li>• <i>“It’s kind of opened my eyes up into those times where I’ve perhaps felt anxious at home and that can actually reciprocate onto the children, so I’ve been a bit more conscious about that as well.”</i></li> <li>• <i>“My expectations are not as high as they used to be. When I was listening to your story about cleaning the house, I also now say to them “just do a little bit, a little tiny bit every day” [...] and I think that’s [...] why they’re helping now because they know I don’t have to be perfect, I can just do my best and I have noticed that it’s enough.”</i></li> <li>• <i>“To be perfect in everything [...] I know, it’s just the way we’ve been brought up [...], you have to be good at everything.”</i></li> <li>• <i>“I would definitely say the over protection one about like...because my anxiety can get the better of me at times. [...] I’m thinking right, I need to sort of let him open his wings up more and let him...[...] I need to stop mollycoddling him and wrapping him up in bubble wrap”</i></li> <li>• <i>“When he tidied his up his bedroom, it’s completely different to how I tidied his. I can’t go to his bedroom ‘cause I end up having a breakdown. And he came to me and said I’ve done my bedroom. So, I went upstairs and had a look and it’s still like, everything, everywhere, and rather than just exploding, I was like, OK. Well, you’ve tried your best. You’ve done really, really well.”</i></li> </ul>

As demonstrated by the illustrative quotes, the parents discussed having an increased awareness of their own emotions and anxieties following their participation in the intervention. Parents shared that they had become more “*reflective*”. Parents reflected that their anxieties may have originated from cultural

expectations. They shared that they similarly began to reflect upon how their emotions or anxieties may “*reciprocate onto the children*” and that this may be done through parenting behaviours. For instance, a parent felt that her anxiety could “*get the best*” of her and lead her to overprotective behaviours. The parents shared that they had adjusted their parenting behaviours which had resulted in positive changes. For instance, the parent who expressed that she may use overprotective behaviours, shared that her foster child had successfully walked to the shops alone. Similarly, a parent shared that through reducing her expectations, her children began to help her with cleaning the house more. She felt that this was due to them feeling that “*I don't have to be perfect, I can just do my best and I have noticed that it's enough*”. Parents also shared that they used the emotion coaching handouts and strategies to support not only their child, but also themselves in times of distress.

#### **4.4.5 Theme 4: Getting More ‘Good and Brave’ Behaviour**

This theme looks to explore parents’ perspectives that following the intervention, they felt as though they were journeying towards their child demonstrating, in the words of the module, more ‘good and brave’ behaviour. Illustrative quotes are given in Table 4.18.

**Table 4.18**

*Illustrative Quotes within the Getting More 'Good and Brave' Behaviour Theme*

---

Illustrative Quotes
<ul style="list-style-type: none"><li>• <i>“Umm [child’s name] is scared of dog, so again we made a little ladder for him, and we watched movies about dogs. [...] He was umm, he kept his distance from the beginning, but then he even managed to umm throw the ball for the dog. [...] So I think he's getting there.”</i></li><li>• <i>“Yeah, we were like, if she'd been naughty, we were taking pompoms out of it because she knew that was like the consequence. But we stopped doing that now, after one of the sessions. So that was good.”</i></li><li>• <i>“Just to touch on that, he is actually letting me get the shower head and just put it over his like, cheeks and chin. [...] So rather than all over his- he doesn't like it going in his eyes [...] so that goes back to the ladder thing for me”</i></li><li>• <i>“Yeah, I like the course overall and I found few useful tips like star charts, worrying jar. We made for [child’s name]. The very, very important lesson was not to mix rewards and punishments.”</i></li></ul>

---

Parents shared that they had positive views of the content from the module ‘Get More Good and Brave Behaviour’. For example, parents suggested that they found the reward chart input “*very good*”. They also shared that they had begun following the recommendations from the strategies such as “*not to mix rewards and punishments*” and no longer removing stars or “*pom poms*” as a punishment.

Parents shared that they had attempted to create a bravery ladder for their children, following content from the ‘Comfort Zones’ module. All parents who had implemented the bravery ladder strategy reported that the fear that the child had had since reduced. For instance, one parent used the bravery ladder to increase the amount of time their child spent sleeping in her own, versus her parents, room. The theme is named Getting More ‘Good and Brave’ Behaviour, as it was interpreted that the parents felt that they were journeying towards this, and that it was a “*work in progress*”. This is captured by the following quote from one of the parents – “*I've been trying to do it at home, and sometimes we've failed, sometimes we've passed but, but, we'll get there*”.

#### 4.4.6 Theme 5: Wanting Personalised Support

This theme captures parents' shared desires for support to be tailored towards their individual children's needs as well as their own. Illustrative quotes are given in Table 4.19.

**Table 4.19**

*Illustrative Quotes within the Wanting Personalised Support Theme*

---

<b>Illustrative Quotes</b>
<ul style="list-style-type: none"><li>• <i>"I think it will be nicer if it will be more...like example and more things how to deal. Like, say, oh he's smashing up the house... try this this or this."</i></li><li>• <i>"Because I can see you, but I can't see your child. [...] If I can see you both, I've got better picture [...] then we can have a session without them and say I think your boys..."</i></li><li>• <i>"I liked that session to be honest because I was at home. It was my environment. [...] I could show you around my house [...] and also, as you see, they are interested. They want to have a look what's going on and they were very excited."</i></li><li>• <i>"In terms of you bring something to in the initial session that you would like some support with. [...] or like a Hotspots in the beginning [...] and then you can reflect on it and say when they're doing this, this is obviously affecting you because of this hotspot or whatever, do you know what mean?"</i></li><li>• <i>"Why? Why are you getting anxiety and you behaving like this, like that?"</i></li></ul>

---

Parents shared their perspectives that they would have found the intervention more supportive had it been tailored towards their child's unique needs. Parents suggested that the TEP may observe their child to generate formulations as to their child's needs and therefore recommendations to support them. Similarly, a parent felt that it would be useful for their children to attend "at least one or two sessions" of the intervention with the parent, so that the TEP may observe the parent-child interactions and offer tailored formulations and recommendations. In these sessions, the parent suggests that the parent and child may create some of the resources or discuss content such as, 'Seven Confident Thoughts' that are recommended in the intervention.

Likewise, parents suggested that they would have benefitted from the TEP supporting them to understand their unique anxieties or “*hot spots*” and how they may influence how they interpret parenting experiences. It was suggested by one parent that it would have been helpful to have completed the ‘Where are Your Hot Spots’ module “*in the initial sessions*” so that parents had the opportunity to reflect upon how their unique anxieties may influence their parenting, throughout the intervention.

#### **4.4.7 Theme 6: Facilitating Engagement**

This theme captured parental perspectives on how parental engagement with the intervention may be facilitated. This theme was nuanced, and two subthemes emerged, capturing parental perspectives on the practical elements which needed to be in place to support parental engagement, as well as emotional-cognitive elements. Table 4.20 below offers illustrative quotes for each subtheme. Each subtheme is then defined and explored further.

**Table 4.20***Subthemes within the Facilitating Engagement Theme*

Subtheme	Illustrative Quotes
Making it Work for Everyone	<ul style="list-style-type: none"> <li>• <i>“And I was a little bit late, and it was OK because just because you are at home, it's more flexible. Well, here umm you need to be on time [...] and then it didn't work with my work.”</i></li> <li>• <i>“I think mixture is always the best because [...] for me it was very stressful coming here because this one because I, I never know what he's gonna behave like...sometimes he will behave [...] sometimes it's like making noises [...]”</i></li> <li>• <i>“I did probably prefer the group, but it really helped doing it because I couldn't be here if you know what I mean”</i></li> <li>• <i>“It might be a difficult experience because of the language barrier [...] when it's online or on the phone. For me, it's more difficult to understand what people are saying [...] and also if camera is not on you can't see the emotions cause sometimes you can guess from the gestures and from your posture. [...] But when it's all online, it's more formal, and then you need to listen carefully.”</i></li> </ul>
Being in the Right Space for it	<ul style="list-style-type: none"> <li>• <i>“You are afraid to let other people down because they're waiting for you [...] I feel very guilty for it. Well, at home you're more relaxed.”</i></li> <li>• <i>“I don't like being the centre of attention [...] so yeah, I did probably prefer the group, but it really helped doing it because I couldn't be here [...]”</i></li> <li>• <i>“So, for me, like stress the first time but then help push me to get out of the house.”</i></li> <li>• <i>“It's good to have also the link because [...] to like kind of go back and refresh because we're here, we talk about, but we go home and [...] I have some things stuck in my head, but sometimes I kind of lose the track as you get home you like get on your own routine and then you forgot you want to do that”</i></li> <li>• <i>“I think they just find it harder to open up”</i></li> <li>• <i>“I think with men they feel as if they're being told how to parent. [...] whereas us Mums are just like oh, that's really good advice, I'll try that [...] But men are like what? No, I'm not going back there. They're just telling me what to do.”</i></li> </ul>

#### **4.4.7.1 Making it Work for Everyone**

This subtheme was generated by the interpretation that parents felt that several practical elements to attending the intervention may have implications for parental engagement. Parents shared that their partners had wished to attend the course but due to work commitments were unable to do so in the daytime. A parent shared that she would have liked to have completed some of the intervention suggestions within the intervention *“because at home, we don’t always have that time”*. Two parents expressed that the format of the intervention, whether it was in-person or virtual, had implications for childcare and therefore their engagement with the intervention. A parent shared that attending in-person sessions was *“stressful”* as she did not know how her baby would behave in the sessions. Another parent shared that virtual sessions would be *“easier”* as her babies have *“everything at home”*. A parent felt that the virtual 1:1 session was helpful when the alternative was a 1:1 session in-person. Two parents shared that virtual sessions can be challenging to access when English is an additional language for them as they are less able to use non-verbal cues to support understanding. The group concurred that a *“mixture”* of in-person and virtual sessions would be the best way to facilitate parental engagement with the intervention.

#### **4.4.7.2 Being in the Right Space for it**

In comparison to the prior subtheme, this subtheme explores the emotional-cognitive factors that parents felt were important to facilitate parental engagement with the intervention. It was interpreted that the format of the intervention had implications for the parent’s anxiety. One parent discussed feeling *“guilty”* about being late if the session was in-person, as this would cause her to worry that this would mean she is letting someone down. This parent suggested that the opportunity to join the session virtually would reduce this worry. Another parent shared that she experienced *“stress”* in leaving the house for the first session and that she feels more comfortable at home. One parent discussed that she prefers being in a group versus 1:1 intervention as she doesn’t *“like being the centre of attention”*.

The parents discussed their views as to why some of their partners may not engage with the intervention. It was interpreted that one parent felt that her

partner would feel dictated to and “*told how to parent*”. Parents thought that men may not engage with the intervention as “*they just find it harder to open up*”. It was suggested that a “*Dad’s group*” may facilitate fathers in discussing their parenting experiences.

Cognitively, a parent highlighted that she would have liked the links to the intervention videos to support her memory of the intervention content, highlighting that once she goes home, her mind can become occupied with “*routine*” and she can forget what has been learnt.

#### **4.5 Embedded Qualitative Results Summary**

RTA was used to analyse the focus group data, with a goal to answer the research question: “**How do parents perceive the adapted version of the parenting intervention PWA (Cartwright-Hatton, 2021)?**”. Through such analysis, six themes were generated. The themes considered what motivated the parents to join the intervention, aspects of the intervention that the parents felt to be supportive, aspects of the intervention that they felt could be improved, and positive outcomes of the intervention. This section has defined and illustrated each theme.

#### **4.6 Results Summary**

This chapter has outlined the results of this mixed-methods study. To answer the overarching research question, this chapter explored the quantitative results, generated through use of statistical tests of difference. One subtheme of the SCAS-P (Spence, 1998), OCD, reached statistical significance ( $W=15, p=0.0018$ ), showing a reduction in OCD scores from pre- to post-intervention, with a large effect size ( $r_B = 1$ ). Considering effect sizes for SCAS-P (Spence, 1998) scores, results showed tentative support for the alternative hypothesis,  $H^1$ : “There is a difference between child anxiety scores pre- versus post-intervention. Child anxiety scores are reduced post-intervention”. Descriptive results were given for SCAS (Spence et al., 2001) scores, pre- and post-intervention, as well as SCAS (Spence et al., 2001) and SCAS-P (Spence, 1998) scores pre-, post- and six-months-post-intervention. Finally, this chapter defined and illustrated six themes generated from the focus group. This aimed to answer the embedded research question, “**How do parents perceive the adapted version of the parenting intervention PWA (Cartwright-Hatton, 2021)?**”.

## Chapter 5: Discussion

*‘Mixed methods researchers must cover quantitative design elements, qualitative ones, how these elements interact [...] – and, finally, authors of these articles must present findings.’ - Hitchcock and Onwuegbuzie (2022, p.4)*

### 5.1 Aim and Structure

The purpose of this embedded, mixed methods study was to explore the effectiveness of an adapted parenting intervention, *PWA* (Cartwright-Hatton, 2021), delivered by a TEP, in reducing parental perceptions of child anxiety. Subsidiary to this, the research aimed to explore parental perceptions of the intervention. This research aimed to add to the scarce research regarding the effectiveness of parental interventions for parents with anxiety in reducing the IGT of anxiety. Moreover, this research aimed to offer an avenue for EPs to support the growing number of children in the UK experiencing anxiety (NHS England, 2023).

This final chapter will summarise and reflect upon the overarching quantitative findings, as well as the subsidiary qualitative findings, considering their relation to existing research. In line with convergent design integration methods, the quantitative and qualitative results will be compared to offer possible explanations of the data and to “back up the numbers” (Creswell & Creswell, 2023). A side-by-side integration approach will be used to generate a complete understanding of the data (Creswell & Creswell, 2023). The methodological design and procedure will be reviewed in terms of the quantitative, qualitative, and mixed-methods research strands. Implications of this research for policy, future research and the work of EPs will be explored. A conclusion of the findings of will be given.

### 5.2 Overarching Research Question: Quantitative Findings and Interpretations

*“You would have to work quite hard in a research project not to have at least some data in the form of numbers.” - Robson and McCartan (2015, p.409)*

The quantitative research aimed to answer the overarching research question: **“Is an adapted version of the parenting intervention, *PWA* (Cartwright-Hatton, 2021), delivered by a TEP, effective in reducing parental perceptions of children’s anxiety?”**

Five parents took part in this study, aged 25-44 years old. All parents identified their ethnicity as ‘White’. Two parents were British, one parent was

Latvian, and another was Romanian. Together, 9 children's anxiety scores were measured before and after their parents attended the adapted PWA intervention (Cartwright-Hatton, 2021). For 5 children, anxiety scores were also measured six-months-post-intervention.

As previously raised and will be discussed further in this chapter, the SCAS (Spence et al., 2001) pre- and post-intervention, as well as the SCAS (Spence et al., 2001) and SCAS-P (Spence, 1998) follow-up sample sizes were extremely small ( $N < 4$ ). The SCAS-P (Spence, 1998) pre- and immediately post-intervention sample size ( $N = 6$ ) was slightly larger; therefore focus will therefore be given to the quantitative findings derived from the SCAS-P (Spence, 1998) pre- and immediately post-intervention. However, caution should be applied when interpreting such findings due to not only the small sample size but consideration that, as demonstrated in Table 4.6, several parents provided more than one data point due to having more than one child – this is explored further in section 5.5.1.1. Where relevant, reference will be made to the SCAS (Spence et al., 2001) and follow-up data but again, the sample size should be kept in consideration and findings should be interpreted with caution.

## **5.2.1 Overall Anxiety**

### **5.2.1.1 Findings and Interpretations**

Descriptive statistics showed that for school aged children, as measured by the SCAS-P (Spence, 1998), levels of parent-perceived anxiety decreased following their parents' attendance to the parental intervention. Similarly, descriptive statistics found an overall decrease in pre-school aged child anxiety following the parental intervention. Together, results suggest that the intervention may have been effective in reducing parental perceptions of overall child anxiety. These findings offer tentative, emerging support for the hypothesis "there is a difference between child anxiety scores pre- versus post-intervention. Child anxiety scores are reduced post-intervention".

### **5.2.1.2 In Relation to Previous Research**

The finding that parental perceptions of overall child anxiety reduced following parental participation in the intervention supports the emerging research

suggesting the effective use of parental interventions in reducing child internalising behaviours, including anxiety (Cartwright-Hatton et al., 2005, 2018; Davis & Spurr, 1998; Gobrial & Raghavan, 2018; Jewell et al., 2023; McConachie et al., 2014; Palmer et al., 2023; Pillay et al., 2011). This finding supports the RCT research by Cartwright-Hatton et al. (2018) who found that children of parents who participated in the parental intervention showed a greater reduction in anxiety versus those who did not. Of note, the intervention content used in this study was based on that delivered in the Parent Workshop delivered in the research by Cartwright-Hatton et al. (2018). Given the content of the PWA intervention (Cartwright-Hatton, 2021), this finding offers support for interventions including CBA which aim to challenge parent anxious cognitions and anxiogenic parenting behaviours, as well as guiding parents to challenge the anxious cognitions that their child engage with (Cartwright-Hatton, 2021). In section 5.4, the qualitative data will be used to explore the elements of the intervention which may be associated with the possible effectiveness of the intervention in reducing parental perceptions of child anxiety.

### **5.2.1.3 *Considering and Interpreting the Follow-up Data***

According to the descriptive statistics, parental perceptions of overall child anxiety, as measured by the SCAS-P (Spence, 1998), increased six-months-post-intervention in comparison to both pre and post-intervention. This may suggest that the reduction in parental perceptions of child anxiety were not sustained over time. This contrasts with previous research which found that, following the parental intervention, child anxiety stayed below pre-intervention levels, over time (Cartwright-Hatton et al., 2005, 2018).

A possible explanation for this finding could be that the intervention content was not effective in reducing childhood anxiety, long-term. Though this would contrast with findings from Cartwright-Hatton et al. (2018). Alternatively, perhaps the parents needed further sessions to ensure that they were continuing to implement the learning from the intervention, suggesting a limitation of the intervention design. This corresponds with Pincus et al. (2008)'s suggestions that parent's may need coaching sessions in which the individual leading the intervention observes their use of the techniques taught and offers guidance to ensure they are being followed as intended.

Another explanation may be that the parents who returned to the follow-up session may be those experiencing most distress which may reflect a rise in child anxiety scores (Sperling et al., 2021). This highlights the challenge of interpreting data from a small sample – it may not be representative of all parents who took part in the intervention. As suggested by Sperling et al. (2021), this distress may be explained by the anxiety parents may feel should their child be continuing to experience anxiety (Sperling et al., 2021). Indeed, scores on the physical injury SCAS-P subtest show that an increase in scores six-months-post-intervention was found for the two children who showed high scores in that subtest at pre-intervention. This may indicate that these parents may have felt increased distress given their child’s high levels of anxiety in this area, and this distress may have increased if their child continued to experience this anxiety post-intervention hence the parent reporting higher scores on this subtest. Indeed, the same parents reported an overall decrease in preschool-child anxiety six-months-post-intervention, via the SCAS indicating targeted concern regarding their school-aged children. This fits with the bioecological model of child development, highlighting the interaction between child and parent characteristics for child outcomes (Bronfenbrenner & Morris, 2007).

### **5.2.2 Subtests of Anxiety- Findings, Interpretations and Previous Research**

This section will consider the effectiveness of the parenting intervention in reducing parental perceptions of different forms of child anxiety as indicated by the SCAS-P (Spence, 1998) subtest scores. The findings will also be interpreted in relation to existing research.

#### **5.2.2.1 Reductions in Subtest Anxiety Scores**

Descriptive statistics showed that parental perceptions of children’s levels of OCD, as measured by the SCAS-P (Spence, 1998) OCD subtest reduced following the parental intervention. This suggests the adapted PWA (Cartwright-Hatton, 2021) parental intervention for parents with anxiety may be effective in reducing child OCD. Supporting this further, parental perceptions of the preschool-children’s levels of OCD also reduced post-intervention, as measured by the SCAS (Spence et al., 2001). The follow-up data suggests that the reduction in child OCD scores in both

school-aged and preschool aged children were maintained over time, offering tentative support for the maintenance of such positive effects of the intervention.

Parental perceptions of children's levels of panic attack/agoraphobia, as measured by the SCAS-P (Spence, 1998) panic attack/agoraphobia subtest, also reduced following the parental intervention. These results offer tentative support for the use of the adapted PWA parental intervention (Cartwright-Hatton, 2021) for reducing child panic attack/agoraphobia. Again, this reduction was maintained six-months-post-intervention.

To the researcher's knowledge, no other research has yet explored the influence of a parental intervention for parents with anxiety on subtest scores of child anxiety such as, OCD and panic. Therefore, these exploratory results offer novel evidence to the field. In section 5.4, the qualitative findings will be used to offer possible explanations for the indicated decrease in such subtests of child anxiety.

#### **5.2.2.2 No Change in Subtest Anxiety Scores**

Results from the SCAS-P (Spence, 1998) showed no change in GAD or social phobia subtest scores pre- versus post-intervention. The lack of change in anxiety scores across these subtests may be interpreted positively – there was a not a median rise in scores (Palmer et al., 2023). No difference in median anxiety scores were found in relation to the physical injury subtest. Considering individual scores, two children's physical injury scores remained the same following intervention, three reduced and one child's score increased by one. This may suggest that use of the median, in this case, may be misleading. When mean differences are calculated, a drop in physical injury scores is found post- ( $M=3$ ) versus pre-intervention ( $M=3.67$ ). Due to the extremely small sample size, the median was reported due to it less sensitive to skewed data compared to the mean (Goss-Sampson, 2022). Though, the physical injury scores did show normal distribution of scores. Perhaps, similarly to the panic subtest, with a larger sample, a decrease in physical injury scores following the intervention could have been found (Goss-Sampson, 2022).

#### **5.2.2.3 Increase in Separation Anxiety Scores**

Children's separation anxiety subtest scores increased following the parental intervention. This may suggest that the intervention served to increase parental

perceptions of their children's levels of separation anxiety. This is an unexpected finding considering previous research which found that parental interventions for parents with anxiety reduces child anxiety (Cartwright-Hatton et al., 2018), along with research showing the use of a parental interventions for reducing pre-existing SAD in children (Pincus et al., 2008).

There may be several possible explanations for this unexpected finding. First, this finding may represent a challenge in interpreting data from an extremely small sample (Dwivedi et al., 2017; Sauro, 2013). When considering the median, an increase of 0.5 scores is found post- versus pre-intervention. Considering individual scores, three participants showed no change in SAD scores and two showed a reduction in SAD scores. This suggests that for most participants, the intervention reduced or did not worsen their perceptions of their child's level of SAD. For one child, their SAD subtest score increased by one. Therefore, the increase in median SAD scores may be misleading (Sauro, 2013). This supports the caution that has been taken within this discussion in deriving any inferences from both the SCAS (Spence et al., 2001) and follow-up data which are generated from even smaller samples.

A second explanation, at least for the one child whose parent indicated a rise in their child's SAD scores, may be due to a lack of tailoring of the intervention to children who may experience separation anxiety (Pincus et al., 2008). In line with the findings from Pincus et al. (2008), perhaps the intervention required tailoring to the children's specific anxieties for progress to be seen. This is discussed further in section 5.4 with reference to the qualitative findings. Another possible interpretation, using Pincus et al. (2008)'s observations, could be that parents may have used the techniques but needed further guidance on doing so as taught (Pincus et al., 2008). Finally, through trialling the techniques, such as the Bravery Ladder, in relation to the SAD, parents' distress may have increased which may reflect a rise in scores (Sperling et al., 2021)

Still, it is emphasised that, according to individual scores, most parents did not see a worsening of child separation anxiety. Moreover, levels of child separation anxiety as measured by the SCAS (Spence et al., 2001) stayed the same following the intervention and decreased six-months-post-intervention.

### 5.2.3 *Summary of Quantitative Findings and Interpretations*

The quantitative findings from the SCAS-P (Spence, 1998) and SCAS (Spence et al., 2001) offer emerging support for the hypothesis that there is a difference between child anxiety scores pre- versus post-intervention. Descriptive results from the SCAS-P (Spence, 1998) showed a decrease in parental perceptions of overall child anxiety following the parental intervention. This finding is in line with previous research (Cartwright-Hatton et al., 2018). Offering new evidence to the literature base, results showed a decrease in child OCD and panic SCAS-P (Spence, 1998) subtest scores. The qualitative findings will be used to further explore these findings, offering novel ideas to the field. Results showed no change in scores across the GAD, social phobia and physical injury SCAS-P (Spence, 1998) subtests. Further scrutiny of the results suggests that, with a larger sample, physical injury scores may have shown a decrease. However, this is speculative. SAD SCAS-P (Spence, 1998) subtest scores were found to rise following the intervention. This reported increase may be a symptom of using an extremely small sample. Nevertheless, possible explanations for this rise, in relation to existing research, were explored.

### 5.3 **Embedded Qualitative Themes and Interpretations**

*“A good story doesn’t just fizzle out” - Braun and Clarke (2022, p.146)*

The following section of the discussion will return to the themes generated and defined in chapter 4. It will draw conclusions, highlighting why the voices of the parents who took part in this intervention, and analysis of such, matter (Braun & Clarke, 2022). The following section will provide an integrative discussion of the findings from the RTA with a goal to offer a deeper understanding and possible explanations of parental perspectives, giving reference to existing literature (Braun & Clarke, 2022).

The qualitative strand of this study aimed to answer the subsidiary research question: **“How do parents perceive the adapted version of the parenting intervention PWA (Cartwright-Hatton, 2021)?”**. In line with evaluation research, the aim of this research question was to explore whether it met the needs to the families involved; what made it effective, or not, and how the intervention may be improved (Robson & McCartan, 2015). This qualitative data aimed to support EP practice, “backing up the numbers” (Creswell & Creswell, 2023) regarding evidence-

based practice, whilst identifying avenues to make this intervention most accessible to parents, should it be perceived as supportive.

The first section will offer an integrative discussion of the interpretation that the intervention had a positive impact on the parents' children - this corresponds with the overarching quantitative research question exploring the effectiveness of the intervention in reducing parental perceptions of child anxiety.

### **5.3.1 Positive Impact: The Child**

It is interpreted that the parents who took part in the parental intervention believed that it had a positive impact on their child's wellbeing. This is captured by the theme *Getting More 'Good and Brave' Behaviour*. Parents shared their positive perspectives regarding the 'Get More Good and Brave Behaviour' module content. This module covered praise, star charts and rewards. It encouraged parents to praise effort, and not perfection, for instance. It taught parents not to remove rewards as punishments, and that they may be used to support children with tackling 'stuck' behaviours such as, certain fears. Parents shared that they followed the guidance from the module and that it had been "useful" and "good". Parents noticed that children began helping them more, for instance, indicating an enhanced sense of self-competency (Bögels & Tarrier, 2004). These findings are in line with existing research and theory (Gobrial & Raghavan, 2018; Jewell et al., 2023; Palmer et al., 2023; Pillay et al., 2011).

The interpretation that content supporting parents with anxiety with praising their children may have enhanced their child's wellbeing is supported by theory. Supporting parents in using affection and support with their children (relational approaches) was interpreted, in the SLR, to be an important aspect of parenting interventions for reducing child internalising behaviours. Increased parental praise is associated with enhanced parental warmth (Flessner et al., 2016; Murray et al., 2009). Increased parental warmth has been associated with children developing positive cognitions about the world, their self-worth and competence, which challenge anxious cognitions (Flessner et al., 2016; Murray et al., 2009; Schneider et al., 2009). Praising *efforts* versus *perfection* has been suggested to challenge perfectionism (Yarbro et al., 2013). Yarbro et al. (2013) suggested children may develop perfectionism as attempts for caregiver validation. As discussed in the

theme *Journeying Towards Reducing Anxiogenic Parenting*, parents indicated adapting their parenting to praise efforts versus perfection. For example, one parent shared “*I went upstairs and had a look and it's still like, everything, everywhere, and rather than just exploding, I was like, OK. Well, you've tried your best. You've done really, really well.*”. The role of perfectionism in relation the child anxiety scores reported in this study is explored further in section 5.4.

Parents also shared the positive impact of the ‘Comfort Zones’ module on their children. This module offered psychoeducation detailing how avoidance can maintain anxiety. It guided parents to gradually expose their child to their fears using Bravery Ladders. Parents reported that they had created Bravery Ladders to support their children in making progress towards overcoming fears such as, water, dogs, and separation. All parents reported steps of progress in their children overcoming their fears through use of such graduated exposure techniques, in line with previous research (Pincus et al., 2008; Silk et al., 2013)

This corresponds with the cognitive theory of anxiety which suggests that negative cognitive distortions such as, an underestimated ability to cope, may lead to avoidance of behaviours which reinforce feelings of anxiety (Clark & Beck, 2011; Creswell et al., 2006). In line with CBA, when the individual does not avoid the fearful event, they can challenge these cognitive distortions, evidencing an ability to cope and reducing feelings of anxiety (Cartwright-Hatton, 2021). It also supports the information transfer theory of IGT of anxiety (Alloy, 2001; Murray et al., 2009), showing that when parents encouraged gradual approach-orientated behaviours, as opposed to supporting their children to avoid the fear (accommodation), child confidence grew and anxiety reduced (Sperling et al., 2021).

*Getting More ‘Good and Brave’ Behaviour* is considered alongside the theme “*I’m doing this course for them*” – *For the Child*. Parents shared that their reason for joining the parenting intervention was to support their child to regulate their emotions and to develop “*confidence*”. Parents shared hopes that the course would support them in knowing how to respond to their children’s perceived challenging behaviours. Considering the theme *Getting More ‘Good and Brave’ Behaviour*, it may be interpreted that this intervention supported the parents in reaching such aims. The parents described the techniques such as, the rewards, that they have

implemented to support their child in developing more 'good and brave' behaviours, overcoming anxieties, and thus enhancing their emotional wellbeing.

### **5.3.2 Positive Impact: The Parent**

The theme *Journeying Towards Reducing Anxiogenic Parenting* explored reductions in anxiogenic parenting following parents' participation in the intervention. Parents shared that they developed an enhanced understanding of the origins of their anxieties. Cultural influences such as, a strive towards perfectionism in relation to Latvian and Romanian cultures were considered. This is an interesting reflection and one that fits with the bioecological model of development, highlighting the influence of the macrosystem (society) on the development of anxiety. It also reiterates the unique experiences of individuals from minority ethnic and cultural backgrounds who attend parenting interventions and the importance of considering the influence of this on intervention content and outcomes (Mendez et al., 2013).

Parents shared that they reflected on how their own anxieties may "*reciprocate onto the children*" and that this may be done through parenting behaviours. This indicates that, in line with CBA, parents began to identify maladaptive patterns of thinking and behaving which may be leading to anxiety in themselves and their children. It is suggested that this realisation may support parents in adapting their parenting behaviours to reduce the likelihood of such reciprocation. Indeed, parents reflected upon how their anxieties may lead to overprotection (Flessner et al., 2016; Murray et al., 2009). Through learning about the connection between parental anxiety and overprotection, one parent shared that she made progress towards reducing overprotection. Parents followed the guidance from the 'Protection and Overprotection' module, testing out their fears using "*baby steps*", much like gradual exposure. Parents reported the positive impact of this on their children, including increased independence. This corresponds with cognitive theories that suggest that reduced overprotection may enhance children's confidence in tackling developmentally suitable challenges, enhancing their feelings of self-competence (Chorpita & Barlow, 1998).

As mentioned in the prior section, parents also reported using increased warmth in their interactions with their children including praise, support and

affection (Kirkham et al., 2018). Parents shared that they effectively used Emotion Coaching, as taught in the 'Be your Child's Emotion Coach' module, to support their children and themselves in times of heightened emotion. This supports the use of relational approaches in parenting interventions for reducing child internalising behaviours such as, anxiety, in line with the findings from the SLR (Cartwright-Hatton et al., 2018; Gobrial & Raghavan, 2018; Jewell et al., 2023; McConachie et al., 2014; Palmer et al., 2023).

The theme *"Oh, okay, I'm not alone" – Valuing Peer Support* may highlight an aspect of the intervention, beyond its content, which may have supported parents in reducing anxiogenic parenting. The core concept of this theme was that the parents who took part in the intervention felt a positive impact of the intervention through peer support. Parents suggested that the intervention gave them access to peer insights and strategies. It is interesting that although the intervention content aimed to offer such insight, parents particularly appreciated such when it came from fellow parents/ peers. This may be explained through exploration of the subtheme *Increased Sense of Relatedness*. Parents described benefitting from the opportunity to *"socialise"* with other parents and receive *"moral support"* from their peers. It was suggested that physical proximity, aided by the in-person sessions, facilitated this peer interaction and encouragement. It was felt that the parents were describing an increased sense of relatedness, the dimension of the SDT (Ryan & Deci, 2000) explained as a feeling of connection, community and sense of belonging (Calp, 2020; Ryan & Deci, 2000). This corresponds with findings from Palmer et al. (2023).

Peer support and a sense of relatedness has been associated with reductions in anxiety (Preyde & Ardal, 2003; Sharma et al., 2022). It is suggested that this reduction in anxiety could be explained by peer support challenging the thoughts outlined in the Negative Cognitive Triad (Beck, 1976). Perhaps through sharing of *"ideas"* and *"moral support"* from *"similar"* peers, parents could challenge negative views about the future (e.g., "I won't cope"), themselves (e.g., "I am useless") and the world (e.g., "people are unkind").

It may be inferred that through an enhanced sense of relatedness, parents' wellbeing/anxiety improved which may have caused a decrease in their anxiogenic

parenting. For instance, parents cited use of the techniques shared with them by the other parents which supported parents to enhance warmth within their parenting. Still, this research did not include a measure of parent anxiety or anxiogenic behaviours, so this interpretation is speculative.

Seeking peer support may have also met parental needs for reassurance as captured by the *Seeking Reassurance* subtheme. As discussed in chapter 2, ERS can serve to maintain anxiety (Rector et al., 2011). This may highlight a disadvantageous side of peer support to be mindful of when delivering interventions for parents with anxiety. Parents shared that seeing other parents “*struggling*” with similar experiences was “*reassuring*” and helped them feel that they and their children were “*normal*” (or “*not*”), that they had not done something “*wrong*” and that they were “*not alone*”. To the researcher’s knowledge, research has not yet explored how interventions may prevent ERS via peer support in interventions for parents with anxiety (Rector et al., 2019). This is discussed further in section 5.4.

### **5.3.3 Improving the Intervention**

The qualitative data offered insights into what facilitated, and posed barriers to, engagement along with how the intervention could be improved. Within the *Facilitating Engagement* theme, parents shared both practical and emotional-cognitive elements to support parental engagement with the intervention. Within the subtheme *Making it Work for Everyone*, partners shared that work commitments and childcare may pose barriers to parents engaging with the intervention, in line with Cartwright-Hatton et al. (2018)’s findings. During recruitment, several parents expressed interest in the intervention but were unable to attend due to their working hours or childcare needs. Similarly, all parents, except one, cited childcare as their reason for dropping out of the intervention.

Parents shared that, considering the format of the intervention, a mix of both online and in-person sessions would be preferable. It was suggested that online sessions would remove childcare barriers whilst opportunities for in-person sessions would facilitate peer support. This preference for a blended delivery approach is in line with previous research (Hall & Bierman, 2015; Kenworthy et al., 2022). Still, considering equitable practice, one parent noted that as English was their second language, online sessions may be difficult to access.

Parents shared feelings of anxiety associated with attending in-person sessions, these anxieties related to being on time and managing childcare. This corresponds with Cartwright-Hatton et al. (2018)'s suggestion that parents' experiences of anxiety may pose a barrier to intervention engagement.

Parents suggested that memory aids such as, home access to the intervention videos, would support their memory of the techniques and thus use of them. This fits with Pincus et al. (2008)'s findings that parents may need additional intervention sessions to support the implementation of learnt strategies.

Another idea for how the intervention could be improved, from the parents' perspectives, was to tailor the content of the intervention to the needs of the parents and children taking part. This is captured by the *Wanting Personalised Support* theme. Parents suggested that the (T)EP may observe parent-child interactions and offer tailored recommendations. Parents also suggested that they may attempt the techniques taught in the module, with their child, during a session. Parents shared that they would like further insight into their anxiety and its influence on their parenting. They would like this at the start of the intervention so that they can reflect on this learning throughout.

These suggestions depict content similar to that seen in the module created specifically for parents with children with SAD in Pincus et al. (2008)'s research. This module included coaching on the live use of the techniques, psychoeducation regarding anxiety, as well as tailoring to the child's specific anxiety (separation). Pincus et al. (2008) demonstrated that this tailored approach reduced child separation anxiety beyond the non-tailored version of the parenting intervention, alone. This may suggest that the tailored interventions suggested by the parents in this study may be useful in further reducing parental perceptions of child anxiety.

No fathers took part in the intervention. As shown in chapter 2, the majority of participants within research into parental interventions are women (Ahmadzadeh et al., 2019; Pahl et al., 2012). Parents speculated as to the reasons for why some of their partner's may not engage with the intervention. Some suggested work commitments were a barrier to their attendance. Some suggested that men may feel as though they are being dictated to and that they "*just find it harder to open up*". An intervention for fathers only was suggested by one parent. At home,

parents shared that some of their partners (fathers) were eager to learn from the intervention and worked on the techniques together as a “*team*”. This suggests that fathers may be interested in learning from the intervention but that facilitating factors and barriers may need to be identified and addressed to support their engagement.

#### **5.3.4 Summary of Qualitative Findings and Interpretations**

The embedded qualitative strand to this research offers insight into how parents perceived the adapted version of the parenting intervention *PWA* (Cartwright-Hatton, 2021), as per the aims of evaluation research. Parents shared the positive impact of the intervention on their children, noting an increase in their ‘good and brave’ behaviours. Parents shared a decrease in anxiogenic parenting behaviours such as, overprotection and reduced warmth, and perfectionism. Peer support was suggested to be a benefit of the intervention. It was suggested that this may be due to peer support providing an increased sense of relatedness for parents, improving their wellbeing which may, in turn, reduce anxiogenic parenting. It was cautioned that, within peer support, intervention leaders should be mindful of ERS. Parents offered several practical, emotional, and cognitive factors for consideration when promoting engagement with the intervention.

#### **5.4 Mixed Methods Integration**

*‘There is something elusive about integration’ - Hitchcock and Onwuegbuzie (2022, p.2)*

The following section will offer meta-inferences from the quantitative and qualitative data. This discussion has taken a side-by-side approach to data integration. A popular way of integrating mixed-methods data is using a joint display (Creswell & Creswell, 2023). Although joint displays may be used with convergent mixed methods designs, this can be complex (Creswell, 2014; Guetterman et al., 2015). As the qualitative data in this study was gathered using a focus group versus individual interviews (e.g., Bradt et al., 2015), it was felt that mapping individual quotes onto quantitative findings may be misleading. Moreover, parental perspectives of the intervention expanded beyond aspects which may have explained the quantitative findings meaning a joint display could be reductive.

### 5.4.1 *Meta-inferences*

Meta-inferences may be conceptualised as insights that the researcher draws through comparing the qualitative and quantitative databases (Creswell & Creswell, 2023). These inferences are given in addition to those outlined for the findings from the separate databases.

#### 5.4.1.1 *Overall Reduction in Child Anxiety*

The descriptive, quantitative findings showed a reduction in parental perceptions of both school-aged and preschool-aged child anxiety. In section 5.2, it was outlined that this finding fits with existing research and theory. This section will explore how the qualitative findings may explain or expand upon the quantitative findings, extending and/or supporting existing research.

Considering the positive association between anxiogenic parenting and child anxiety, the quantitative finding of a reduction in parental perceptions of child anxiety corresponds with the qualitative interpretation that the intervention supported parents with *Journeying Towards Reducing Anxiogenic Parenting*. For instance, parents reported a reduction in overprotection and increased warmth. It was tentatively suggested that, alongside the intervention content, peer support may have supported parents in challenging anxious cognitions which may foster anxiogenic parenting (Alloy, 2001).

Parent perspectives offer support for the suggestion that a reduction in anxiogenic parenting may explain the reduction in child anxiety scores. It was discussed that the 'Comfort Zones' module supported parents in reducing accommodation, an anxiogenic parenting behaviour, and supporting children to challenge and thus reduce anxious cognitions about specific fears. Parents also shared that the 'Get More Good and Brave Behaviour' supported parents in reducing anxiogenic parenting through increasing warmth towards their children via praising efforts versus perfection, for instance. Parents associated the implementation of the techniques learnt from this module with enhanced child wellbeing and sense of competence, challenging child anxious cognitions.

Together, qualitative findings suggested that the parental intervention was associated with a reduction in anxiogenic parenting, which was associated with a reduction in child anxious cognitions and thus anxiety scores, supporting previous

research (Cartwright-Hatton et al., 2018; Flessner et al., 2016; Murray et al., 2009; Palmer et al., 2023; Schneider et al., 2009).

#### **5.4.1.2 Reduction in Subtests of Child Anxiety**

##### **5.4.1.2.1 OCD**

This research presents a novel finding that child OCD scores reduced following parental participation in the adapted version of the parenting intervention, *PWA* (Cartwright-Hatton, 2021). The qualitative findings may be used to support the understanding of this association. Several possible interpretations are offered, below.

Parents discussed perfectionism, an anxious cognition often associated with obsessive thinking and OCD (Yarbro et al., 2013). They shared their experiences of having been “*brought up*” believing that they have to be “*perfect in everything*”. Through the intervention, parents shared that they began recognising their perfectionism within their parenting, particularly regarding tidiness of their homes. Parents shared that the intervention supported them to not only recognise their perfectionism but work to reduce it. This is captured well by the following quote: “*My expectations are not as high as they used to be. When I was listening to your story about cleaning the house, I also now say to them “just do a little bit, a little tiny bit every day” [...] and I think that's [...] why they're helping now because they know I don't have to be perfect, I can just do my best and I have noticed that it's enough.*”. This quote captures that the reduction in the parent’s perfectionism lead to increased self-competency in their child, associated with a reduction in negative anxious cognitions (Bögels & Tarrier, 2004)

This qualitative finding may be used to support the quantitative findings of a reduction in school-aged child OCD scores. Considering the social learning theory (Bandura, 1986) that parents may teach anxious behaviours via modelling (Flessner et al., 2016; Murray et al., 2009), it makes sense that a reduction in parental perfectionism may lead to a reduction in child perfectionism which may contribute to the manifestation of OCD, explaining why a reduction in parental perfectionism may have led to reduced child OCD scores (Yarbro et al., 2013).

Additionally, parents reported using increased warmth within their parenting. Yarbro et al. (2013)’s found that reduced parental warmth may be linked

to child perfectionism, typically seen in OCD, suggesting to the child that perfect performances are required to feel accepted by their caregiver. In this study, parents shared that, following the intervention, they began to praise their child's effort as opposed to perfection. It may therefore be suggested that increased parental warmth, including praising of efforts versus perfection, as per the intervention guidance, may have led to a reduction in parental perceptions of child OCD levels.

Thompson-Hollands et al. (2014) also cites the link between parental accommodation and OCD. As parents reported a reduction in accommodation, this may also explain a reduction in child OCD scores.

#### **5.4.1.2.2 *Panic Attack/Agoraphobia***

The quantitative results also showed a reduction in child panic attack/agoraphobia scores following the parental intervention. Again, the qualitative findings may be used to shed light on this association. Parents shared that through the intervention, they reduced overprotection, and this led to an increase in child independence.

Schneider et al., (2009) suggested that parents with panic disorder exhibit increased overcontrol and overprotection compared to parents without mental health needs, and that this was associated with increased child anxiety with children feeling unable to cope with novel situations. Although Schneider et al., (2009) did not measure the subtest of panic, using cognitive theories of anxiety (Alloy, 2001; Murray et al., 2009), it may be suggested that feelings of panic may be transferred to the child via overprotective parenting, suggesting to the child that in the face of challenges, they will not cope, causing panic. As parents reported reducing overprotection following the intervention, this may explain a reduction in child panic. Still, as parental anxiety was not measured, it is not clear whether parents in this sample experienced panic. Further research is needed to explore anxiogenic parenting and the development of panic disorder in children.

Another explanation for the reduction in panic attack/agoraphobia scores may be due to the use of the Bravery Ladder. Items on the panic attack/agoraphobia subtest explore specific fears such as, "being in crowded places" (Spence, 1998). According to the parents, the Bravery Ladder effectively supported

children in reducing their fears, in line with previous research (Hirshfeld-Becker et al., 2007; Pincus et al., 2008; Silk et al., 2013).

#### **5.4.1.3 *Generating and Maintaining Reductions in Child Anxiety***

*“This is, arguably, one of educational psychology’s unspoken problems” - Chidley and Stringer (2020, p.444)*

Comparison of the qualitative and quantitative data is used to support interpretations of subtests of anxiety that did not show a reduction in scores following the intervention, alongside the finding that overall school-aged anxiety scores increased at follow up.

It may be interpreted that instances where parental perceptions of child anxiety did not reduce may be due to a lack of tailoring of the intervention to meet the needs of the parents and children. Parents shared that they would like the TEP to have observed their interactions with the child and tailor the intervention to support their specific needs/anxieties. This suggestion fits with Pincus et al. (2008)’s finding that inclusion of intervention content designed for parents of children with SAD decreased child SAD beyond that of the non-tailored version of the intervention. This may suggest that parental perceptions of child anxiety in this study may have decreased further had the intervention addressed the specific challenges that the child or parent was experiencing. Indeed, as mentioned, the parent’s concerns regarding the child’s anxiety has implications for their perceptions of the child’s abilities to cope with distress which may increase anxiogenic parenting and therefore the likelihood of child anxiety (Creswell & O’Connor, 2006). Thus, addressing the parents’ concerns may hold promise for further reducing IGT of anxiety. This interpretation fits with the previously made suggestion that separation anxiety scores may have been reduced had content been tailored towards techniques to do so.

Another possible interpretation for instances whereby parental perceptions of child anxiety were not reduced may be due to the lack of implementation support. Parents shared that they would like further support in remembering the techniques taught in the session. As captured by the names of the themes, parents shared that they were *journeying* towards a reduction in anxiogenic parenting and *getting* ‘Good and Brave’ child behaviours, indicating a need for further support.

Although, as part of the intervention, parents are asked to trial the techniques taught and feedback their experiences in the following session, the intervention does not include live coaching or implementation sessions. Such coaching and implementation support was suggested by Pincus et al. (2008) to be important for ensuring that parents are implementing techniques as intended, and therefore most likely to reduce child anxiety. The idea that ongoing support following teaching of intervention content is required to increase the likelihood of the effective use of taught strategies is not new and continues to be explored within implementation science. In line with participant views and Pincus et al. (2008)'s findings, research indicates that EPs should offer continued support following intervention delivery through practices such as, consultation, supervision and coaching to embed learning and achieve best outcomes (Chidley & Stringer, 2020; Fixsen et al., 2009; Hagermoser Sanetti & Collier-Meek, 2019).

#### **5.4.2 Summary of Mixed Methods Integration**

Meta-inferences were given to offer a more complete understanding of both the quantitative and qualitative findings from this research. Through comparing the datasets, it was suggested that the parental perceptions of an overall reduction in child anxiety following the intervention could be associated with a reduction in anxiogenic parenting behaviours – overprotection, reduced warmth, and accommodation. A reduction in these behaviours was also associated with reductions in child OCD and panic. Additionally, it was inferred that a reduction in parental perfectionism may account for the novel finding that child OCD scores reduced following the intervention. It was interpreted that child anxiety may be further reduced through the parental intervention with the inclusion of tailoring, coaching and implementation support.

#### **5.5 Methodological Review: Strengths and Limitations**

*“Think of this as a gift to other researchers – what might they need to know before they embark on a similar study”- Braun and Clarke (2022, p.149)*

This study used a mixed-methods research design to explore the effectiveness of a parenting intervention for parents with anxiety in reducing parental perceptions of child anxiety, along with parental perspectives of the intervention. A convergent, embedded mixed-methods approach was chosen due to

its suitability to evaluation research, providing qualitative findings to expand upon quantitative results (Robson & McCartan, 2015). The following section will offer a methodological review for the quantitative and qualitative strands of the study. A mixed-methods review will also be considered.

### **5.5.1 Quantitative Review**

The quality of quantitative research is associated with internal and external validity (Mertens, 2005). Tashakkori and Teddlie (2009) suggest that reliability of measures should also be reviewed. The measures taken within the study to support the internal and external validity, as shown in Table 3.4, should be acknowledged as methodological strengths. Alongside the strengths of this study, several limitations should also be considered.

#### **5.5.1.1 Internal Validity**

A strength of the research was the consistency of the instrumentation. The same measures of anxiety were used at pre-, post-, and six-months-post intervention, enhancing internal validity (instrumentation). As post-intervention measures were taken between 1 to 6 months post-intervention, the ages of the children may have changed during this time - this was considered when deciding the measure of anxiety to be completed. As previously mentioned, the SCAS-P (Spence, 1998) is designed for school-children aged 7-13 years old (Spence, 1998) and the SCAS is designed for “preschool”-children aged 3-6 years old (Spence et al., 2001). One child in this study was six years old at pre-intervention. It was decided that their parent was to complete the SCAS-P (Spence, 1998) versus the SCAS (Spence et al., 2001). This was to ensure that a consistent measure of anxiety could be taken post-intervention when they child may have turned 7 years old. It was also considered that the child was no longer in preschool or Early Years, suggesting the school-aged measure of anxiety may have been more appropriate. The SCAS-P (Spence, 1998) has been used as a measure of anxiety for children aged 6 years in previous research (Forcadell et al., 2021; Orgilés et al., 2019; Zainal et al., 2014). Still, as the child was younger than the suggested age for completion of the SCAS-P (Spence, 1998) as per the manual, internal and subsequent external validity may be reduced.

Considering threats to internal validity through history, participant's shared events that occurred throughout the study which may have influenced findings, including family bereavement. It is considered that such events may have influenced the children's level of anxiety (Barlow, 2002; Cooley-Strickland et al., 2009; Dowdney, 2000), reducing internal validity.

A key limitation of the quantitative research is the use of an extremely small sample size due to difficulties in recruiting and maintaining participants. Whilst 16 parents expressed interest in the study, half of such attended the first session. Three participants withdrew from the research (experimental mortality). This resulted in sample size of five parents and nine children. Parents completed the SCAS-P (Spence, 1998) for six children pre- and immediately post-intervention. Parents completed the SCAS (Spence et al., 2001) for three children. Accordingly, inferential statistics were not conducted to explore the SCAS-P (Spence, 1998) or SCAS (Spence et al., 2001) data. This meant that neither the statistical significance of the relationship between the intervention and child anxiety scores, nor the magnitude of difference in scores pre-versus-post intervention could be determined, reducing implications of the research. Similar implications were seen for the follow-up data.

Treatment fidelity may also have been reduced as, whilst parents received all module handouts, only one parent attended all five intervention sessions, meaning not all parents received the entire intervention content. This may have limited the effectiveness of the intervention in reducing parental perceptions of child anxiety; had inferential statistics been conducted, this may have resulted in a Type II error. The reduction in treatment fidelity may mean that the descriptive statistics reported may not reflect the potential effectiveness of the intervention as it was not received by all parents, as intended as per the intervention design.

Another limitation of this research is that due to parent's submitting anxiety measures for each of their children, more than one data point (child anxiety score) may belong to the same one parent (i.e., a data family). This may mean that parental factors such as one parent's perceptions of child anxiety or intervention engagement, may influence more than one data point, influencing the overall results reported.

A final limitation of this research is the lack of a control group. This meant that causal inferences could not be made from the results. Still, this limitation also represents an ethical strength of the study.

#### **5.5.1.2 External Validity**

This study did not use random population sampling thus the sample used within the study may not be representative of all the parents that EPs work with. The external validity of the research may also be negatively impacted by self-selection bias. The parents that took part in the study may represent parents with certain characteristics such as, an ability to find childcare or parents who are particularly anxious about their child's wellbeing. Likewise, all participants identified as White. Together the findings may not be generalisable to families with different characteristics or of different ethnicities with whom EPs work.

#### **5.5.1.3 Reliability of Measures**

The SCAS-P (Spence, 1998) and SCAS (Spence et al., 2001) were used due to showing good internal reliability and validity (Edwards et al., 2010; Orgilés et al., 2019; Spence, 1998). The use of such measures is therefore considered a strength of this study. However, the self-report nature of the measures may mean that the findings were vulnerable to factors such as, researcher bias whereby parents may have rated their child's levels of anxiety to meet the intended outcomes of the research (Rosenthal, 1966).

#### **5.5.2 Qualitative Review**

The quality of qualitative research is not judged by the same parameters as those for quantitative research. Instead, the criteria for the quality of qualitative research includes: credibility, transferability, dependability, confirmability and reflexivity (Lincoln & Guba, 1985; Nowell et al., 2017).

Considering credibility, a limitation of the qualitative research may be that there was not a second researcher to make notes in the focus group whilst the first researcher moderated. This may mean that the researcher missed non-verbal interactions or opportunities to encourage parents to expand upon their views, reducing the richness of the interpretation (Robson & McCartan, 2015). This may

have reduced the “fit” between parents’ views and the researcher’s interpretations of such (Tobin & Begley, 2004).

Credibility may also have been impacted by group dynamics. Krueger and Casey (2000) suggest that participants who know each other may have established dynamics which may have meant that the researcher did not hear all the parents’ contributions and thus their interpretations may be biased towards the views of parents who were confident in expressing their views, for instance. Still, within the focus group, the researcher checked their interpretation of the parents’ views and asked if parents had additional views that they wished to add, which the researcher may have missed.

Following guidelines for best practice (Braun & Clarke, 2022; Creswell & Creswell, 2023), transferability and dependability was aided by a clear and logical outline of the research and analytical process followed for the research. For instance, the moderator style, alongside topics presented within the focus group were outlined. The analytical process was outlined using the six steps of RTA. A reflexive journal was kept, facilitating confirmability and reflexivity. The researcher considers that her own experiences of anxiety may have influenced the interpretations of the data. Though it is also considered that this may add a richness to the interpretation.

### **5.5.3 *Mixed Methods Review***

Mixed-methods research has been criticised from a philosophical standpoint. It has been suggested that use of both quantitative and qualitative data presents a philosophical incompatibility (Cohen et al., 2017; Gelo et al., 2008). It is also presented that gathering of both dataset is time consuming and complex (McCrudden & Marchand, 2020). In chapter 3, it was suggested that the rich understanding of the research phenomena that mixed-methods research provides outweighs such costs (McCrudden & Marchand, 2020), and that following of a pragmatic paradigm is fitting with real world research and indeed EP practice (Robson & McCartan, 2015). It is suggested that this research supports such ideas. The use of a pragmatic paradigm allowed for flexibility in researching the parental intervention in a way that was most likely to generate positive outcomes (Mertens, 2005). Inclusion of an experimental strategy increased the strength of this

evaluation study (Robson & McCartan, 2015). Alongside this, through gathering parental perspectives, in line with the aims of evaluation research, this convergent, embedded mixed methods study was able to expand upon the quantitative findings. This research offered possible explanations for the change in parent-reported anxiety scores, along with views on how the intervention could be improved so that it further reduces parental perceptions of child anxiety. It is suggested that through use of a mixed-methods design, inference transferability was enhanced; the findings presented have real world applications, corresponding with the role of EPs as scientist-practitioners (British Psychological Society, 2002; Fallon et al., 2010; Gelo et al., 2008).

#### **5.5.4 Review of the Research Focus**

The overarching focus of this research was to explore the effectiveness of the parenting intervention in reducing parental perceptions of child anxiety. The focus on measuring child anxiety offered clear data for interpretation as to whether this intervention could be implemented, by EPs, to support the reduction of parental perceptions of child anxiety. Through the qualitative data, the effectiveness of the intervention in reducing anxiogenic parenting, a proposed mechanism for the IGT of parental anxiety, was explored. However, this research may have also explored the effectiveness of the parenting intervention in reducing anxiogenic parenting using a quantitative measure like that used in Palmer et al. (2023)'s research. It was suggested that inclusion of a quantitative measure of anxiogenic parenting pre- and post-intervention may have supported qualitative inferences that parental anxiogenic parenting decreased, leading to a reduction in parent-reported child anxiety.

#### **5.6 Implications of Findings**

*“Imagine this like a coda to your adventure; you’re safely back, and now have the space to reflect on what you did, the impacts that your choices and actions along the way might have had”- Braun and Clarke (2022, p.149)*

This final section will move from reflecting back to the data and instead look forward, exploring the implications that this research will have for policy, EP practice and future research (Braun & Clarke, 2022). Of note, generalisability of qualitative findings can be considered problematic (Braun & Clarke, 2022). Braun

and Clarke (2022) suggest that qualitative findings generated through RTA should be “softly generalised” with possible implications for contexts beyond the study.

### **5.6.1 Implications for Policy**

Chapter 1 detailed a rise in child mental health needs in the UK from 2017 (NHS England, 2023). Supporting children’s wellbeing was presented, in the State of the Nation report, to be central to the Department for Education’s plans for post-pandemic recovery (gov.uk, 2023). It was reported that The Department for Education aims to support the mental health of young people through offering school funding to increase access to early, specialist mental health support within education settings (Department for Education, 2023a). It was also highlighted that the government suggest the use of parental interventions to support families to reduce risk factors associated with child mental health needs (Public Health England, 2021).

The findings from this research indicate that implementation of a parenting intervention for parents with anxiety may be effective in reducing parental perceptions of child anxiety and therefore supporting child wellbeing. These findings indicate the use of offering systemic support to families to reduce child anxiety. Delivery of parenting interventions for parents with anxiety offers an avenue to reduce the need for children to (or to wait to) access direct interventions through services such as, CAMHS, which are struggling to meet demand and therefore the mental health needs of children (Briant, 2023; Jewell et al., 2023). Together, offering support to parents with anxiety through parenting interventions which offer guidance on how they may reduce their child’s anxiety, should be considered within educational policies to support the reduction of child anxiety.

Department for Education funding for the delivery of the parenting intervention, and subsequent implementation/ coaching sessions, would reduce the possible barriers that traded delivery models may pose to EPs in delivering this support to schools (Lee & Woods, 2017). Access to this intervention should be available to all families in schools. It is hoped that should the parent intervention be free to schools and thus available to all parents, this would reduce suggested cultural biases which may influence whether children from minority backgrounds are referred for mental health support (Albano et al., 2003). The funded delivery of

this intervention would also mean that children from areas of Low Socioeconomic Status are more likely to receive mental health support.

### **5.6.2 Implications for Educational Psychologists**

As scientist-practitioners (Fallon et al., 2010), the findings of this study offer evidence-based practice implications for EPs. This research suggests that EPs may offer the delivery of the adapted parenting intervention, *PWA* (Cartwright-Hatton, 2021) to settings they work with, to reduce child anxiety. This research also suggests the possible use of the intervention for reducing anxious thought and behaviours similar to those seen in OCD and panic.

Considering the meta-inferences outlined, it is suggested that the intervention should continue to include opportunities for peer support. This may be facilitated through blended delivery of interventions. The content of the intervention should continue to include that delivered in the ‘Comfort Zones’, ‘Protection and Overprotection’, ‘Be your Child’s Emotion Coach’ and ‘Get More Good and Brave Behaviour’ modules. It was suggested that such module content was perceived as useful by parents and appeared to reduce anxiogenic parenting behaviours associated with child anxiety.

EPs may adjust the intervention to further meet the needs of the parents and children participating in it. Intervention content should be tailored to meet the needs of the parents, and their children. To do this, in the initial session, the EP may discuss parent goals for the intervention. These goals and the parents’ perceived progression towards them may be reviewed throughout the intervention to ensure that parent and child needs are met. A Solution-Focussed Brief Therapy approach may be fitting for this (de Shazer et al., 2021). Opportunities for coaching and implementation sessions to increase the chances of the taught strategies being used to generate and maintain a reduction in parental perceptions of child anxiety, should be used.

EPs should be cautious of ERS. As part of the intervention, EPs may empower parents, challenging their underestimation of coping abilities. Again, a SFBT approach ((de Shazer et al., 2021) may be used to do this.

This research has shown that parents are interested in engaging with EP support regarding parenting for parents with anxiety. It is suggested that more

parents may be reached should adaptations be made to reduce barriers to attendance. For example, evening timeslots may be offered to working parents.

### **5.6.3 Implications for Future Research**

Future research may replicate this mixed-methods study using a larger sample size so that inferential statistics may be conducted, and statistical power enhanced, leading to improved validity and breadth of findings. Further research is also required to explore the associations between elements of the parenting intervention and reductions in subtests of anxiety. This research provided novel findings that the adapted version of the parenting intervention, *PWA* (Cartwright-Hatton, 2021) led to reductions in child OCD, however the mechanism for this remains tentative. In line with social justice aims of EPs (Health and Care Professions Council, 2018), future research may investigate whether parenting interventions are effective in reducing internalising behaviours in children from a range of majority *and* minority ethnic backgrounds, and if not, what adjustments must be made to ensure equal opportunities for families of all ethnic backgrounds. This research added to this field, suggesting that in-person elements to intervention delivery are important for supporting parents who speak EAL to access the content and interpersonal benefits of the intervention. Future research may also explore how to engage fathers in the intervention, investigating the facilitation of a “*Dad’s group*”.

## **5.7 Conclusion and Reflections**

*“Conclusions are the ultimate so what of the story”- Braun and Clarke (2022, p.146)*

This research aimed to answer the overarching research question “Is an adapted version of the parenting intervention *PWA* (Cartwright-Hatton, 2021), delivered by a TEP, effective in reducing parental perceptions of children’s anxiety?”. Subsidiary to this, it aimed to answer “How do parents perceive the adapted version of the parenting intervention *PWA* (Cartwright-Hatton, 2021)?”. This research has provided an original contribution to the literature, offering insights into the effectiveness of this intervention along with parental views on how and why the intervention was effective and how it may be improved.

The quantitative research found a decrease in overall child anxiety scores pre-versus-post intervention, indicating tentative yet emerging support for its

effectiveness in reducing parental perceptions of child anxiety. This finding fit with the limited but existing research (Cartwright-Hatton et al., 2018). A novel finding was that school-aged child OCD and panic attack/agoraphobia scores also reduced.

The qualitative findings suggested that the parents perceived the parenting intervention to be beneficial to their child's wellbeing; children developed their confidence in the face of fears and showed enhanced self-competence. Parents shared an increased understanding of the IGT of anxiety, along with a decrease in anxiogenic parenting behaviours such as, accommodation, overprotection, and reduced warmth. It was suggested that through peer support, parents experienced an increased sense of relatedness. This may have been associated with a reduction in anxious cognitions and, in turn, anxiogenic parenting. Parents offered ideas to improve the intervention including, blended delivery, inclusion of tailored content, coaching, and support with implementation of strategies.

Meta-inferences offered a more in-depth understanding of the findings gathered through this research. It was suggested that reductions in child OCD scores may relate to a decrease in parental perfectionism. It was suggested that the reduction in child panic scores could be explained by a decrease in anxiogenic parenting behaviours such as, accommodation. A lack of reduction in child anxiety scores at follow up, and in further subtests of anxiety may be explained by the small sample size but also by the lack of implementation support given to parents to guide them with using the taught techniques.

The quality of the quantitative, qualitative and mixed-methods research was explored. The key limitations of the study included the small sample size, reducing statistical power and validity, reduced treatment fidelity and the families of data used. Though several strengths such as, consistency of measures was cited. Strengths of the qualitative data included credibility and transferability. The use of a mixed-methods research design fit with the aims of evaluation research and enhanced the richness and inference transferability of the findings.

As highlighted by the final quote of this chapter, it is important that this research serves as a step towards reducing the child anxiety that continues to rise in the UK (gov.uk, 2023). Several implications for policy, research and EP practice have been outlined. It is the hope of this research that with further research, government

and EP support, more of the 15% of parents in the UK, experiencing anxiety (Joint Commissioning Panel for Mental Health, 2012) will have the opportunity to experience an enhanced sense of relatedness; a reduction in anxiogenic parenting, and importantly, a reduction in their child's anxiety. The ultimate hope is that this research and intervention can be used to reduce the IGT of anxiety.

## References

- Achenbach, T. M. (1978). The child behavior profile: I. boys aged 6--11. *Journal of Consulting and Clinical Psychology, 46*(3), 478–488.  
<https://doi.org/10.1037//0022-006X.46.3.478>
- Achenbach, T. M. (1992a). *Manual for child behavior checklist 4-18 and 1992 profile*. Department of Psychiatry.
- Achenbach, T. M. (1992b). *Manual for the child behavior checklist 2-3 and 1992 profile*. Department of Psychiatry University of Vermont.
- Adelman, C. B., & Lebowitz, E. R. (2012). Poor insight in pediatric obsessive compulsive disorder: Developmental considerations, treatment implications, and potential strategies for improving insight. *Journal of Obsessive-Compulsive and Related Disorders, 1*(2), 119–124.  
<https://doi.org/10.1016/J.JOCD.2012.02.003>
- Ahmadzadeh, Y. I., Eley, T. C., Leve, L. D., Shaw, D. S., Natsuaki, M. N., Reiss, D., Neiderhiser, J. M., & McAdams, T. A. (2019). Anxiety in the family: a genetically informed analysis of transactional associations between mother, father and child anxiety symptoms. *Journal of Child Psychology and Psychiatry, 60*(12), 1269–1277. <https://doi.org/10.1111/JCPP.13068>
- Albano, A. M., Chorpita, B. F., & Barlow, D. H. (2003). Child Anxiety Disorders. In E. J. Mash & R. A. Barkley (Eds.), *Child Psychopathology* (2nd ed.).
- Alloy, L. B. (2001). The developmental origins of cognitive vulnerability to depression: Negative interpersonal context leads to personal vulnerability inflammation and mood symptoms. *Cognitive Therapy and Research, 25*(4).  
<https://doi.org/10.1023/A:1005527218169>
- Allport, G. W. (1954). *The nature of prejudice*. Addison-Wesley.
- American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders: DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.
- Attwood, T. (2004). *Exploring Feelings (Anxiety)*. Future Horizons.
- Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Prentice-Hall Inc.
- Barlow, D. H. (2002). *Anxiety and its disorders: The nature and treatment of anxiety*

- and panic*. The Guildford Press.
- Beck. (1985). *Anxiety Disorders and Phobias*. Basic Books.
- Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. Meridian.
- Beck, A. T., Emery, G., & Greenberg, R. L. (1985). *Anxiety disorders and phobias: a cognitive perspective*. Basic Books.
- Beck, A. T., & Haigh, E. A. P. (2014). Advances in cognitive theory and therapy: The generic cognitive model. *Annual Review of Clinical Psychology, 10*, 1–24.  
<https://doi.org/10.1146/ANNUREV-CLINPSY-032813-153734>
- Beesdo-Baum, K., & Knappe, S. (2012). Developmental epidemiology of anxiety disorders. *Child and Adolescent Psychiatric Clinics of North America, 21*(3), 457–478. <https://doi.org/10.1016/J.CHC.2012.05.001>
- Bell, C. C. (1994). DSM-IV: Diagnostic and Statistical Manual of Mental Disorders. *JAMA, 272*(10), 828–829.  
<https://doi.org/10.1001/JAMA.1994.03520100096046>
- Billington, T. (2012). *Separating, losing and excluding children: narratives of difference*. Taylor and Francis.
- Bögels, S. M., & Tarrier, N. (2004). Unexplored issues and future directions in social phobia research. *Clinical Psychology Review, 24*(7), 731–736.  
<https://doi.org/10.1016/J.CPR.2004.07.003>
- Borsboom, D. (2017). A network theory of mental disorders. *World Psychiatry, 16*(1), 5–13. <https://doi.org/10.1002/WPS.20375>
- Bowlby, J. (1969). *Attachment and loss volume I: Attachment*. The Hogarth Press and the Institute of Psycho-Analysis.
- Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. SAGE Publications Inc.
- Bradt, J., Potvin, N., Kesslick, A., Shim, M., Radl, D., Schriver, E., Gracely, E. J., & Komarnicky-Kocher, L. T. (2015). The impact of music therapy versus music medicine on psychological outcomes and pain in cancer patients: a mixed methods study. *Supportive Care in Cancer, 23*(5), 1261–1271.  
<https://doi.org/10.1007/S00520-014-2478-7/TABLES/4>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101.

<https://doi.org/10.1191/1478088706QP0630A>

Braun, V., & Clarke, V. (2021). Can I use TA? Should I use TA? Should I not use TA?

Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Counselling and Psychotherapy Research*, 21(1), 37–47.

<https://doi.org/10.1002/CAPR.12360>

Braun, V., & Clarke, V. (2022). *Thematic analysis: a practical guide* (V. Clarke (ed.))

[Book]. SAGE.

Brendel, K. E., & Maynard, B. R. (2013). Child–parent interventions for childhood anxiety disorders: A systematic review and meta-analysis. *Research on Social Work Practice*, 24(3), 287–295. <https://doi.org/10.1177/1049731513503713>

Briant, N. (2023). *Some children in Northamptonshire waiting more than a year for mental health help, health boss says.*

<https://www.northantstelegraph.co.uk/health/some-children-in-northamptonshire-waiting-more-than-a-year-for-mental-health-help-health-boss-says-4020181>

Briggs-Gowan, M. J., & Carter, A. S. (2002). The Brief Infant-Toddler Social and Emotional Assessment Manual Version 2.0. *Journal of Pediatric Psychology*, 29(2), 143–155. <https://doi.org/10.1093/JPEPSY/JSH017>

Brinkmeyer, M. Y., & Eyberg, S. M. (2003). Parent-child interaction therapy for oppositional children. In A. E. Kazdin & J. R. Weis (Eds.), *Evidence-based psychotherapies for children and adolescents*. The Guilford Press.

British Psychological Society. (2002). Professional practice guidelines: Division of Educational and Child Psychology. *Professional Practice Guidelines*, 229642, 1–28.

British Psychological Society. (2018). Code of ethics and conduct. *The British Psychological Society*, July, 100–102. [www.bps.org.uk](http://www.bps.org.uk).

Bronfenbrenner, U., & Morris, P. A. (2007). The bioecological model of human development. *Handbook of Child Psychology*.

<https://doi.org/10.1002/9780470147658.CHPSY0114>

Brumariu, L. E., & Kerns, K. A. (2015). Mother–child emotion communication and childhood anxiety symptoms. *Cognition and Emotion*, 29(3), 416–431.

<https://doi.org/10.1080/02699931.2014.917070>

- Burke, K., Dittman, C. K., Forbes, E. J., & Eggins, E. (2021). PROTOCOL: A systematic review and meta-analysis of randomised controlled trials evaluating the impact of parenting programmes for parents of adolescents (10–18 years) on adolescent mental health outcomes, positive development and the parent–adolescent relationship. *Campbell Systematic Reviews*, *17*(1).  
<https://doi.org/10.1002/CL2.1146>
- Burnham, S. (2013). Realists or pragmatists? “Reliable evidence” and the role of the educational psychologist. *Educational Psychology in Practice*, *29*(1), 19–35.  
<https://doi.org/10.1080/02667363.2012.734277>
- Calp, S. (2020). I Belong to This World! A teacher practice for developing relatedness in the school environment. *European Journal of Education Studies*, *7*(1), 22–40. <https://doi.org/10.5281/zenodo.3694140>
- Carter, L. F. (1959). Proceedings of the sixty-seventh annual business meeting of the American Psychological Association, Inc.: Report of the recording secretary. *American Psychologist*, *14*(12), 741–763. <https://doi.org/10.1037/H0043919>
- Cartwright-Hatton, S. (2021). *Parenting With Anxiety: Helping Anxious Parents Raise Confident Children (PWA)*. Identifier NCT04755933.  
<https://clinicaltrials.gov/ct2/show/NCT04755933>
- Cartwright-Hatton, S., Ewing, D., Dash, S., Hughes, Z., Thompson, E. J., Hazell, C. M., & Field, A. P. (2018). Preventing family transmission of anxiety: Feasibility RCT of a brief intervention for parents. *British Journal of Clinical Psychology*, *57*(3), 351–366. <https://doi.org/https://dx.doi.org/10.1111/bjc.12177>
- Cartwright-Hatton, S., McNally, D., White, C., & Sam, V. (2005). Parenting Skills Training: An effective intervention for internalizing symptoms in younger children? *Journal of Child and Adolescent Psychiatric Nursing*, *18*(2), 45–52.  
<https://doi.org/https://dx.doi.org/10.1111/j.1744-6171.2005.00014.x>
- Casline, E., Patel, Z. S., Timpano, K. R., & Jensen-Doss, A. (2021). Exploring the link between transdiagnostic cognitive risk factors, anxiogenic parenting behaviors, and child anxiety. *Child Psychiatry and Human Development*, *52*(6), 1032–1043.  
<https://doi.org/10.1007/S10578-020-01078-2>
- Challacombe, F. L., Salkovskis, P. M., Woolgar, M., Wilkinson, E. L., Read, J., & Acheson, R. (2017). A pilot randomized controlled trial of time-intensive

- cognitive–behaviour therapy for postpartum obsessive–compulsive disorder: Effects on maternal symptoms, mother–infant interactions and attachment. *Psychological Medicine*, 47(8), 1478–1488.  
<https://doi.org/10.1017/S0033291716003573>
- Chapman, L., Hutson, R., Dunn, A., Brown, M., Savill, E., & Cartwright-Hatton, S. (2022). The impact of treating parental anxiety on children’s mental health: An empty systematic review. *Journal of Anxiety Disorders*, 88.  
<https://doi.org/10.1016/J.JANXDIS.2022.102557>
- Chidley, S., & Stringer, P. (2020). Addressing barriers to implementation: an implementation framework to help educational psychologists plan work with schools. *Educational Psychology in Practice*, 36(4), 443–457.  
<https://doi.org/10.1080/02667363.2020.1838448>
- Chorpita, B. F., & Barlow, D. H. (1998). The development of anxiety: The role of control in the early environment. *Psychological Bulletin*, 124(1), 3–21.  
<https://doi.org/10.1037/0033-2909.124.1.3>
- Clark, D. A., & Beck, A. T. (2011). *Cognitive therapy of anxiety disorders: science and practice*. Guilford Press.
- Clarke, V., & Braun, V. (2017). Thematic analysis [Article]. *The Journal of Positive Psychology*, 12(3), 297–298. <https://doi.org/10.1080/17439760.2016.1262613>
- Class Critters. (2020). *Squirrel Scale*.  
<https://www.facebook.com/classcritters/photos/a.105774220787157/347298179968092/?type=3>
- Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Routledge. <https://doi.org/10.4324/9780203771587>
- Cohen, L., Manion, L., & Morrison, K. (2017). *Research methods in education* (8th ed.). Taylor & Francis.
- Cooley-Strickland, M., Quille, T. J., Griffin, R. S., Stuart, E. A., Bradshaw, C. P., & Furr-Holden, D. (2009). Community violence and youth: Affect, behavior, substance use, and academics. *Clinical Child and Family Psychology Review*, 12(2), 127–156. <https://doi.org/10.1007/S10567-009-0051-6/TABLES/2>
- Creswell, C., & Cartwright-Hatton, S. (2007). Family treatment of child anxiety: Outcomes, limitations and future directions. *Clinical Child and Family*

- Psychology Review*, 10(3), 232–252. <https://doi.org/10.1007/S10567-007-0019-3/TABLES/1>
- Creswell, C., & O'Connor, T. G. (2006). Anxious cognitions in children: An exploration of associations and mediators. *British Journal of Developmental Psychology*, 24(4), 761–766. <https://doi.org/10.1348/026151005X70418>
- Creswell, C., O'Connor, T. G., & Brewin, C. R. (2006). A longitudinal investigation of maternal and child “anxious cognitions.” *Cognitive Therapy and Research*, 30(2), 135–147. <https://doi.org/10.1007/S10608-006-9021-1>
- Creswell, C., O'Connor, T. G., & Brewin, C. R. (2008). The impact of parents' expectations on parenting behaviour: An experimental investigation. *Behavioural and Cognitive Psychotherapy*, 36(4), 483–490. <https://doi.org/10.1017/S1352465808004414>
- Creswell, & Creswell, J. D. (2023). *Research design: qualitative, quantitative, and mixed methods approaches* (6th ed.). SAGE Publications, Inc.
- Creswell, J. W. (2014). *A concise introduction to mixed methods research*. SAGE Publications Inc.
- Dadds, M. R., & Barrett, P. M. (2001). Practitioner review: Psychological management of anxiety disorders in childhood. *Journal of Child Psychology and Psychiatry*, 42(8), 999–1011. <https://doi.org/10.1111/1469-7610.00798>
- Daly, M., Sutin, A. R., & Robinson, E. (2022). Longitudinal changes in mental health and the COVID-19 pandemic: Evidence from the UK household longitudinal study. *Psychological Medicine*, 52(13), 2549–2558. <https://doi.org/10.1017/S0033291720004432>
- DataNovia. (2018). *Wilcoxon test in R: The ultimate guide*. <https://www.datanovia.com/en/lessons/wilcoxon-test-in-r/>
- Davey, E., Creswell, C., Percy, R., & Reardon, T. (2022). ‘It opened my eyes’: Parents' experiences of their child receiving an anxiety disorder diagnosis. *Clinical Child Psychology and Psychiatry*, 27(3), 658–669. <https://doi.org/10.1177/13591045221088708>
- Davis, H., & Spurr, P. (1998). Parent counselling: An evaluation of a community child mental health service. *Journal of Child Psychology and Psychiatry*, 39(3), 365–376. <https://doi.org/https://dx.doi.org/10.1017/S002196309700214X>

- Dawson, J., Singh-Dhesi, D., Difficulties, B., Dawson, J., & Singh-Dhesi, D. (2010). Educational psychology working to improve psychological well-being: an example. *Emotional and Behavioural Difficulties*, *15*(4), 295–310.  
<https://doi.org/10.1080/13632752.2010.523213>
- de Shazer, S., Dolan, Y., Korman, H., Trepper, T., McCollum, E., & Berg, I. K. (2021). *More than miracles: The state of the art of solution-focused brief therapy*. Taylor and Francis.
- Department for Education. (2023a). *How we're helping look after the mental health of children and young people - The education hub*.  
<https://educationhub.blog.gov.uk/2023/10/10/how-were-helping-look-after-the-mental-health-of-children-and-young-people/>
- Department for Education. (2023b). *Keeping children safe in education 2023 statutory guidance for schools and colleges*.  
[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/1181955/Keeping\\_children\\_safe\\_in\\_education\\_2023.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1181955/Keeping_children_safe_in_education_2023.pdf)
- Department for Education, & Department of Health. (2015). *Special educational needs and disability code of practice: 0 to 25 years statutory guidance for organisations which work with and support children and young people who have special educational needs or disabilities* (Issue January, p. 35).
- Dovidio, J. F., Love, A., Schellhaas, F. M. H., & Hewstone, M. (2017). Reducing intergroup bias through intergroup contact: Twenty years of progress and future directions. *Group Processes and Intergroup Relations*, *20*(5), 606–620.  
[https://doi.org/10.1177/1368430217712052/ASSET/IMAGES/LARGE/10.1177\\_1368430217712052-FIG1.JPEG](https://doi.org/10.1177/1368430217712052/ASSET/IMAGES/LARGE/10.1177_1368430217712052-FIG1.JPEG)
- Dowdney, L. (2000). Annotation: Childhood bereavement following parental death. *Journal of Child Psychology and Psychiatry*, *41*(7), 819–830.  
<https://doi.org/10.1111/1469-7610.00670>
- Drew, R. (2015). *Investigation into the impact of parent groups supporting a CBT based intervention for children demonstrating anxious thinking*. University of Nottingham.
- Dunsmuir, S., & Cobbald, A. (2016). A framework for promoting child mental health

- in schools. In B. Kelly, L. M. Woolfson, & J. Boyle (Eds.), *Frameworks for Practice in Educational Psychology* (2nd ed.). Jessica Kingsley Publishers.
- Dwivedi, A. K., Mallawaarachchi, I., & Alvarado, L. A. (2017). Analysis of small sample size studies using nonparametric bootstrap test with pooled resampling method. *Statistics in Medicine*, *36*(14), 2187–2205.  
<https://doi.org/10.1002/SIM.7263>
- Ebbert, A. M., Infurna, F. J., & Luthar, S. S. (2019). Mapping developmental changes in perceived parent-adolescent relationship quality throughout middle school and high school. *Development and Psychopathology*, *31*(4), 1541–1556.  
<https://doi.org/https://dx.doi.org/10.1017/S0954579418001219>
- Edwards, S. L., Rapee, R. M., Kennedy, S. J., & Spence, S. H. (2010). The assessment of anxiety symptoms in preschool-aged children: The revised preschool anxiety scale. *Journal of Clinical Child & Adolescent Psychology*, *39*(3), 400–409.  
<https://doi.org/10.1080/15374411003691701>
- Einfeld, S. L., & Tonge, B. J. (1995). The Developmental Behavior Checklist: The development and validation of an instrument to assess behavioral and emotional disturbance in children and adolescents with mental retardation. *Journal of Autism and Developmental Disorders*, *25*(2), 81–104.  
<https://doi.org/10.1007/BF02178498>
- Ellis, P. D. (2010). The essential guide to effect sizes: Statistical power, meta-analysis, and the interpretation of research results. *The Essential Guide to Effect Sizes*. <https://doi.org/10.1017/CBO9780511761676>
- Emerson, L. M., Ogielka, C., & Rowse, G. (2019). A systematic review of the role of parents in the development of anxious cognitions in children. *Journal of Anxiety Disorders*, *62*, 15–25. <https://doi.org/10.1016/J.JANXDIS.2018.11.002>
- Erath, S. A., Flanagan, K. S., & Bierman, K. L. (2007). Social anxiety and peer relations in early adolescence: Behavioral and cognitive factors. *Journal of Abnormal Child Psychology*, *35*(3), 405–416. <https://doi.org/10.1007/S10802-007-9099-2/FIGURES/2>
- Evangelou, M., & Sylva, K. (2007). Evidence on effective early childhood interventions from the united Kingdom: An evaluation of the Peers Early Education Partnership (PEEP). *Early Childhood Research & Practice*, *9*(1).

- Fallon, K., Woods, K., & Rooney, S. (2010). *Educational psychology in practice: A discussion of the developing role of educational psychologists within children's services*. <https://doi.org/10.1080/02667360903522744>
- Finlay, L., & Gough, B. (2003). *Reflexivity: A practical guide for researchers in health and social sciences*. Blackwell Science.
- Fixsen, D. L., Blase, K. A., Naoom, S. F., & Wallace, F. (2009). Core implementation components. *Research on Social Work Practice, 19*(5), 531–540. <https://doi.org/10.1177/1049731509335549>
- Flessner, C. A., Murphy, Y. E., Brennan, E., & D'Auria, A. (2016). The Parenting Anxious Kids Ratings Scale-Parent Report (PAKRS-PR): Initial scale development and psychometric properties. *Child Psychiatry Human Development, 48*. <https://doi.org/10.1007/s10578-016-0688-6>
- Forcadell, E., Garcia-Delgar, B., Medrano, L., Garcia, C., Orgilés, M., Lázaro, L., & Lera-Miguel, S. (2021). Spanish validation of the parent version of the spence children's anxiety scale (Scas-p) in a clinical sample. *Behavioral Psychology/ Psicología Conductual, 29*(2), 365–381. <https://doi.org/10.51668/BP.8321209N>
- Foulkes, L., & Andrews, J. L. (2023). Are mental health awareness efforts contributing to the rise in reported mental health problems? A call to test the prevalence inflation hypothesis. *New Ideas in Psychology, 69*, 101010. <https://doi.org/10.1016/J.NEWIDEAPSYCH.2023.101010>
- Fox, M. (2011). Practice-based evidence - overcoming insecure attachments. *Educational Psychology in Practice, 27*(4), 325–335. <https://doi.org/10.1080/02667363.2011.615299>
- Gall, M. D., Gall, J. P., & Borg, W. R. (2003). *Educational research: an introduction* (7th ed.). Allyn and Bacon.
- Gallagher, M. W., Bentley, K. H., & Barlow, D. H. (2014). Perceived Control and Vulnerability to Anxiety Disorders: A Meta-analytic Review. *Cognitive Therapy and Research, 38*. <https://doi.org/10.1007/s10608-014-9624-x>
- Gardner, F., Leijten, P., Mann, J., Landau, S., Harris, V., Beecham, J., Bonin, E.-M., Hutchings, J., & Scott, S. (2017). Could scale-up of parenting programmes improve child disruptive behaviour and reduce social inequalities? Using individual participant data meta-analysis to establish for whom programmes

- are effective and cost-effective. *Public Health Research*, 5(10), 1–144.  
<https://doi.org/10.3310/PHR05100>
- Gelo, O., Braakmann, D., & Benetka, G. (2008). Quantitative and qualitative research: Beyond the debate. In *Integrative Psychological and Behavioral Science* (Vol. 42, Issue 3, pp. 266–290). <https://doi.org/10.1007/s12124-008-9078-3>
- Gersten, R., Fuchs, L. S., Compton, D., Coyne, M., Greenwood, C., & Innocenti, M. S. (2005). Quality indicators for group experimental and quasi-experimental research in special education. *Exceptional Children*, 71(2), 149–164.  
<https://doi.org/10.1177/001440290507100202>
- Ginsburg, G. S., Becker, E. M., Keeton, C. P., Sakolsky, D., Piacentini, J., Albano, A. M., Compton, S. N., Iyengar, S., Sullivan, K., Caporino, N., Peris, T., Birmaher, B., Rynn, M., March, J., & Kendall, P. C. (2014). Naturalistic follow-up of youths treated for pediatric anxiety disorders. *JAMA Psychiatry*, 71(3), 310–318.  
<https://doi.org/10.1001/JAMAPSYCHIATRY.2013.4186>
- Gobrial, E., & Raghavan, R. (2018). Calm Child Programme: Parental programme for anxiety in children and young people with autism spectrum disorder and intellectual disabilities. *Journal of Intellectual Disabilities*, 22(4), 315–327.  
<https://doi.org/10.1177/1744629517704536>
- Goss-Sampson, M. A. (2022). *Statistical analysis in JASP 0.16.1: A guide for students*. Elsevier BV. <https://doi.org/10.2139/SSRN.4105959>
- Gottman, J. M., Katz, L. F., & Hooven, C. (1997). Meta-emotion: How families communicate emotionally. In *Meta-Emotion: How Families Communicate Emotionally*. Lawrence Erlbaum Associates.  
<https://doi.org/10.4324/9780203763568>
- Gough, D. (2007). Weight of Evidence: a framework for the appraisal of the quality and relevance of evidence. *Research Papers in Education*, 22(2), 213–228.  
<https://doi.org/10.1080/02671520701296189>
- gov.uk. (2018). *Data protection: The data protection act*. <https://www.gov.uk/data-protection>
- gov.uk. (2023). *State of the nation 2022: children and young people's wellbeing*. <https://www.gov.uk/government/publications/state-of-the-nation-2022->

children-and-young-peoples-wellbeing

- Greene, J. C. (2008). Is mixed methods social inquiry a distinctive methodology? *Journal of Mixed Methods Research, 2*(1), 7–22.  
<https://doi.org/10.1177/1558689807309969>
- Guetterman, T. C., Fetters, M. D., & Creswell, J. W. (2015). Integrating quantitative and qualitative results in health science mixed methods research through joint displays. *Annals of Family Medicine, 13*(6), 554–561.  
<https://doi.org/10.1370/AFM.1865>
- Gus, L., Rose, J., & Gilbert, L. (2015). Emotion Coaching: A universal strategy for supporting and promoting sustainable emotional and behavioural well-being. *Educational and Child Psychology, 32*(1), 31–41.  
<https://doi.org/10.2/JQUERY.MIN.JS>
- Hagermoser Sanetti, L. M., & Collier-Meek, M. A. (2019). Increasing implementation science literacy to address the research-to-practice gap in school psychology. *Journal of School Psychology, 76*, 33–47.  
<https://doi.org/10.1016/J.JSP.2019.07.008>
- Hall, C. M., & Bierman, K. L. (2015). Technology-assisted interventions for parents of young children: Emerging practices, current research, and future directions. *Early Child Research Quarterly, 33*, 21–32.  
<https://doi.org/10.1016/j.ecresq.2015.05.003>
- Hannon, P. (1995). *Literacy, home, and school: research and practice in teaching literacy with parents*. Falmer Press.
- Harrington, R., Peters, S., Green, J., Byford, S., Woods, J., & McGowan, S. (2000). Randomised comparison of the effectiveness and costs of community and hospital based mental health services for children with behavioural disorders. *BMJ: British Medical Journal, 321*(7268), 1047–1050.  
<https://doi.org/https://dx.doi.org/10.1136/bmj.321.7268.1047>
- Health and Care Professions Council. (2018). *Standards of conduct, performance and ethics*. <https://www.hcpc-uk.org/standards/standards-of-conduct-performance-and-ethics/>
- Hedges, D. W., Brown, B. L., & Shwalb, D. A. (2009). A direct comparison of effect sizes from the clinical global impression-improvement scale to effect sizes from

- other rating scales in controlled trials of adult social anxiety disorder. *Human Psychopharmacology: Clinical and Experimental*, 24(1), 35–40.  
<https://doi.org/10.1002/HUP.989>
- Hingley, S., Edwards-Hughes, E., Lane, W., Man, C., Thornton, A., Coleman, N., & Public, K. (2022). *Parent, pupil and learner panel - May wave*.  
[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/1122898/PPLP\\_report\\_rw3\\_may.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1122898/PPLP_report_rw3_may.pdf)
- Hirshfeld-Becker, D. R., Biederman, J., Henin, A., Faraone, S. V., Davis, S., Harrington, K., & Rosenbaum, J. F. (2007). Behavioral inhibition in preschool children at risk is a specific predictor of middle childhood social anxiety: A five-year follow-up. *Journal of Developmental and Behavioral Pediatrics*, 28(3), 225–233. <https://doi.org/10.1097/01.DBP.0000268559.34463.DO>
- Hitchcock, J. H., & Onwuegbuzie, A. J. (2022). *The Routledge handbook for advancing integration in mixed methods research*. Routledge.
- Hoffmann, T. C., Glasziou, P. P., Boutron, I., Milne, R., Perera, R., Moher, D., Altman, D. G., Barbour, V., Macdonald, H., Johnston, M., Kadoorie, S. E. L., Dixon-Woods, M., McCulloch, P., Wyatt, J. C., Phelan, A. W. C., & Michie, S. (2014). Better reporting of interventions: template for intervention description and replication (TIDieR) checklist and guide. *BMJ*, 348.  
<https://doi.org/10.1136/BMJ.G1687>
- Hogan, A. E., Scott, K. G., & Bauer, C. R. (1992). The Adaptive Social Behavior Inventory (Asbi): A new assessment of social competence in high-risk three-year-olds. *Journal of Psychoeducational Assessment*, 10(3), 230–239.  
<https://doi.org/10.1177/073428299201000303>
- Houston, S. (2001). Beyond social constructionism: Critical realism and social work. *British Journal of Social Work*, 31, 845–861.  
<https://doi.org/https://doi.org/10.1093/bjsw/31.6.845>
- Hurrell, K. E., Houwing, F. L., & Hudson, J. L. (2017). Parental Meta-Emotion Philosophy and Emotion Coaching in Families of Children and Adolescents with an Anxiety Disorder. *Journal of Abnormal Child Psychology*, 45(3), 569–582.  
<https://doi.org/10.1007/S10802-016-0180-6/TABLES/4>
- Hutchings, J., Gardner, F., Bywater, T., Daley, D., Whitaker, C., Jones, K., Eames, C.,

- & Judy, E. (2007). Parenting intervention in Sure Start services for children at risk of developing conduct disorder: Pragmatic randomised controlled trial. *British Medical Journal*, *334*(7595), 678.  
<https://doi.org/https://dx.doi.org/10.1136/bmj.39126.620799.55>
- JASP. (2018). *JASP - free and user-friendly statistical software*. <https://jasp-stats.org/previous-versions/>
- Jewell, C., Wittkowski, A., Collinge, S., & Pratt, D. (2023). A brief cognitive behavioural intervention for parents of anxious children: Feasibility and acceptability study. *Child and Youth Care Forum*, *52*(3), 661–681.  
<https://doi.org/10.1007/s10566-022-09704-x>
- Johnson, S. L., Carver, C. S., & Joormann, J. (2013). Impulsive responses to emotion as a transdiagnostic vulnerability to internalizing and externalizing symptoms. *Journal of Affective Disorders*, *150*(3), 872–878.  
<https://doi.org/10.1016/J.JAD.2013.05.004>
- Joint Commissioning Panel for Mental Health. (2012). *Guidance for commissioners of perinatal mental health services*. [www.jcpmh.info](http://www.jcpmh.info)
- Kagan, E. R., Frank, H. E., & Kendall, P. C. (2017). Accommodation in youth with OCD and anxiety. *Clinical Psychology: Science and Practice*, *24*(1), 78–98.  
<https://doi.org/10.1111/CPSP.12186>
- Kearns, T. (2017). *Applying self-determination theory (SDT) in an emancipatory study with anxious adolescents to investigate any changes in anxiety and wellbeing*. University of East London.
- Kenworthy, L., Childress, D., Armour, A. C., Verbalis, A., Zhang, A., Troxel, M., Handsman, R., Kocher, K., Myrick, Y., Werner, M., Alexander, K. C., Cannon, L., & Anthony, L. G. (2022). Leveraging technology to make parent training more accessible: Randomized trial of in-person versus online executive function training for parents of autistic children. *Autism*, *1*(13).  
<https://doi.org/10.1177/13623613221111212>
- Kerns, K. A., & Brumariu, L. E. (2014). Is insecure parent–child attachment a risk factor for the development of anxiety in childhood or adolescence? *Child Development Perspectives*, *8*(1), 12–17. <https://doi.org/10.1111/CDEP.12054>
- King, N. (2012). Doing template analysis. In G. Symon & C. Cassell (Eds.), *Qualitative*

- Organizational Research: Core Methods and Current Challenges*. SAGE Publications, Inc. <https://doi.org/10.4135/9781526435620>
- Kirkham, N., Coldren, J., Oudgenoeg-Paz, O., Lam, C. B., Kien, K., Chung, H., & Li, X. (2018). *Parental warmth and hostility and child executive function problems: A longitudinal study of chinese families*. <https://doi.org/10.3389/fpsyg.2018.01063>
- Kitzinger, J. (1995). Qualitative Research: Introducing focus groups. *BMJ*, *311*(7000), 299–302. <https://doi.org/10.1136/BMJ.311.7000.299>
- Krueger, R. A., & Casey, M. A. (2000). *Focus groups: a practical guide for applied research* (3rd ed.). Sage Publications.
- Lawrence, P. J., Harvey, K., Williams, C., & Creswell, C. (2022). Barriers and facilitators to targeted anxiety prevention programmes in families at risk: a qualitative interview study. *European Child & Adolescent Psychiatry*, *31*(4), 565–575. <https://doi.org/10.1007/S00787-020-01703-4>
- Lawrence, P. J., Murayama, K., & Creswell, C. (2019). Systematic review and meta-analysis: Anxiety and depressive disorders in offspring of parents with anxiety disorders. *Journal of the American Academy of Child and Adolescent Psychiatry*, *58*(1), 46–60. <https://doi.org/10.1016/j.jaac.2018.07.898>
- Lee, K., & Woods, K. (2017). Exploration of the developing role of the educational psychologist within the context of “traded” psychological services. *Educational Psychology in Practice*, *33*(2), 111–125. <https://doi.org/10.1080/02667363.2016.1258545>
- Lessof, C., Ross, A., Brind, R., Bell, E., & Newton, S. (2016). *Longitudinal Study of Young People in England cohort 2: Health and wellbeing at wave 2*. [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/599871/LSYPE2\\_w2-research\\_report.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/599871/LSYPE2_w2-research_report.pdf)
- Lewis, E. G., & Cardwell, J. M. (2020). The big five personality traits, perfectionism and their association with mental health among UK students on professional degree programmes. *BMC Psychology*, *8*(54). <https://doi.org/10.1186/s40359-020-00423-3>
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. SAGE Publications Inc.
- Lindsay, G. (2007). Educational psychology and the effectiveness of inclusive

- education/mainstreaming. *British Journal of Educational Psychology*, 77(1), 1–24. <https://doi.org/10.1348/000709906X156881>
- Mammarella, I. C., Donolato, E., Caviola, S., & Giofrè, D. (2021). Anxiety profiles and protective factors: A latent profile analysis in children. *Personality and Individual Differences*, 124, 201–208. <https://doi.org/10.1016/j.paid.2017.12.017>
- Maxwell, J. A., & Chmiel, M. (2014). Generalization in and from qualitative analysis. In U. Flick (Ed.), *The SAGE Handbook of Qualitative Data Analysis* (pp. 540–553). SAGE Publications, Inc. <https://doi.org/10.4135/9781446282243.N37>
- McConachie, H., McLaughlin, E., Grahame, V., Taylor, H., Honey, E., Tavernor, L., Rodgers, J., Freeston, M., Hemm, C., Steen, N., & Le Couteur, A. (2014). Group therapy for anxiety in children with autism spectrum disorder. *Autism: The International Journal of Research and Practice*, 18(6), 723–732.
- McCrudden, M. T., & Marchand, G. (2020). Multilevel mixed methods research and educational psychology. *Educational Psychologist*, 55(4), 197–207. <https://doi.org/10.1080/00461520.2020.1793156>
- McHugh, R. K., & Otto, M. W. (2012). Refining the measurement of distress intolerance. *Behavior Therapy*, 43(3), 641–651. <https://doi.org/10.1016/J.BETH.2011.12.001>
- McLeod, P. L., & Kettner-Polley, R. B. (2004). Contributions of psychodynamic theories to understanding small groups. *Small Group Research*, 35(3), 333–361. <https://doi.org/10.1177/1046496404264973>
- Mendez, L. R., Ogg, J., Loker, T., & Fefer, S. (2013). Including parents in the continuum of school-based mental health services: A review of intervention program research. *Journal of Applied School Psychology*, 29(1), 1–36. <https://doi.org/10.1080/15377903.2012.725580>
- Mercer, J., & Main St, E. (2011). Attachment theory and its vicissitudes: Toward an updated theory. *Article Theory & Psychology*, 21(1), 25–45. <https://doi.org/10.1177/0959354309356136>
- Mertens, D. (2005). *Research and evaluation in education and psychology: integrating diversity with quantitative, qualitative, and mixed methods* (2nd ed.). Sage Publications.

- Mertens, D. (2019). Research and Evaluation in Education and Psychology. In *SAGE Publications* (5th ed.).
- Mian, N. D., Wainwright, L., Briggs-Gowan, M. J., & Carter, A. S. (2011). An ecological risk model for early childhood anxiety: The importance of early child symptoms and temperament. *Journal of Abnormal Child Psychology*, *39*(4), 501–512. <https://doi.org/10.1007/S10802-010-9476-0/TABLES/2>
- Microsoft. (2024). *Free Online Spreadsheet Software: Excel | Microsoft 365*. [https://www.microsoft.com/en-gb/microsoft-365/excel?ef\\_id=\\_k\\_Cj0KCQjwzZmwBhD8ARIsAH4v1gV7qI0leYHulaQ4YkoNjo5X1dp84cBV6YEQBv8t3T5YyHcW0dmWtbgaAvrIEALw\\_wcB\\_k\\_&OCID=AIDcmmp20rgnjr\\_SEM\\_\\_k\\_Cj0KCQjwzZmwBhD8ARIsAH4v1gV7qI0leYHulaQ4YkoNjo5X1dp84cBV6YEQBv8t3T5YyHc](https://www.microsoft.com/en-gb/microsoft-365/excel?ef_id=_k_Cj0KCQjwzZmwBhD8ARIsAH4v1gV7qI0leYHulaQ4YkoNjo5X1dp84cBV6YEQBv8t3T5YyHcW0dmWtbgaAvrIEALw_wcB_k_&OCID=AIDcmmp20rgnjr_SEM__k_Cj0KCQjwzZmwBhD8ARIsAH4v1gV7qI0leYHulaQ4YkoNjo5X1dp84cBV6YEQBv8t3T5YyHc)
- Mills, C. (2016). Epidemic or psychiatrisation? children’s mental health in a global context. In A. J. Williams, T. Billington, D. Goodley, & T. Corcoran (Eds.), *Critical Educational Psychology* (p. 259). Wiley-Blackwell.
- Mindham, J., & Espie, C. A. (2003). Glasgow Anxiety Scale for people with an Intellectual Disability (GAS-ID): development and psychometric properties of a new measure for use with people with mild intellectual disability. *Journal of Intellectual Disability Research*, *47*(1), 22–30. <https://doi.org/10.1046/J.1365-2788.2003.00457.X>
- Minitab. (2023). *Data considerations for one-way ANOVA*. <https://support.minitab.com/en-us/minitab/21/help-and-how-to/statistical-modeling/anova/how-to/one-way-anova/before-you-start/data-considerations/>
- Moher, D., Shamseer, L., Clarke, M., Ghersi, D., Liberati, A., Petticrew, M., Shekelle, P., Stewart, L. A., & PRISMA P-Group. (2015). Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015 elaboration and explanation. *BMJ*, 148–160. <https://doi.org/10.1186/2046-4053-4-1>
- Moore, J. (2005). Recognising and questioning the epistemological basis of educational psychology practice. *Educational Psychology in Practice*, *21*(2), 103–116. <https://doi.org/10.1080/02667360500128721>
- Morales-Muñoz, I., Mallikarjun, P. K., Chandan, J. S., Thayakaran, R., Upthegrove, R.,

- & Marwaha, S. (2023). Impact of anxiety and depression across childhood and adolescence on adverse outcomes in young adulthood: a UK birth cohort study. *The British Journal of Psychiatry*, 222(5), 212–220.  
<https://doi.org/10.1192/BJP.2023.23>
- Moran, H. (2010). Clinical observations of the differences between children on the autism spectrum and those with attachment problems: The coventry grid. *Good Autism Practice (GAP)*.
- Morawska, A., Sanders, M. R., Haslam, D., Filus, A., & Fletcher, R. (2020). Child adjustment and parent efficacy scale: Development and initial validation of a parent report measure. *Australian Psychologist*, 49(4), 241–252.  
<https://doi.org/10.1111/AP.12057>
- Morgan, D. L. (1997a). Planning focus groups. In *SAGE Publications*. SAGE Publications.
- Morgan, D. L. (1997b). The focus group guidebook. In *SAGE Publications*. SAGE Publications. <https://doi.org/10.4135/9781483328164>
- Morgan, D. L. (1997c). Focus groups as qualitative research. In *Focus Groups as Qualitative Research*. SAGE Publications, Inc.  
<https://doi.org/10.4135/9781412984287>
- Murray, L., Creswell, C., & Cooper, P. J. (2009). The development of anxiety disorders in childhood: an integrative review. *Psychological Medicine*, 39(9), 1413–1423. <https://doi.org/10.1017/S0033291709005157>
- NAHT, & Place2Be. (2022). *Schools staff witness increase in pupil anxiety, low self-esteem and depression*. <https://www.naht.org.uk/News/Latest-comments/Press-room/ArtMID/558/ArticleID/1501/Schools-staff-witness-increase-in-pupil-anxiety-low-self-esteem-and-depression>
- National Health Service. (2018a). *Mental health of children and young people in england, 2017*. <https://gss.civilservice.gov.uk/wp->
- National Health Service. (2018b). *Overview - Generalised anxiety disorder in adults*. <https://www.nhs.uk/mental-health/conditions/generalised-anxiety-disorder/overview/>
- Nauta, M. H., Scholing, A., Rapee, R. M., Abbott, M., Spence, S. H., & Waters, A. (2004). A parent-report measure of children's anxiety: Psychometric properties

- and comparison with child-report in a clinic and normal sample. *Behaviour Research and Therapy*, 42(7), 813–839. [https://doi.org/10.1016/S0005-7967\(03\)00200-6](https://doi.org/10.1016/S0005-7967(03)00200-6)
- NHS. (2013). *Obsessive compulsive disorder*. <https://www.gosh.nhs.uk/conditions-and-treatments/conditions-we-treat/obsessive-compulsive-disorder/>
- NHS Digital. (2018). *Mental health of children and young people in England: Summary of key findings*. <https://gss.civilservice.gov.uk/wp->
- NHS Digital. (2023). *Mental health of children and young people in England, 2023 - wave 4 follow up to the 2017 survey*. <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2023-wave-4-follow-up>
- NHS England. (2023). *One in five children and young people had a probable mental disorder in 2023*. <https://www.england.nhs.uk/2023/11/one-in-five-children-and-young-people-had-a-probable-mental-disorder-in-2023/>
- NHS Inform. (2023). *Anxiety disorders in children*. <https://www.nhsinform.scot/illnesses-and-conditions/mental-health/anxiety-disorders-in-children>
- Niederberger, M., Keller, M., Niederberger, M., & Keller, M. (2018). Mixed methods studies in health promotion: A case-study based on the life situations of young people of refugee backgrounds in Germany. *Public Health - Emerging and Re-Emerging Issues*. <https://doi.org/10.5772/INTECHOPEN.76711>
- Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, 16(1). <https://doi.org/10.1177/1609406917733847>
- Oates, J., Carpenter, D., Fisher, M., Goodson, S., Hannah, B., Kwiatkowski, R., Prutton, K., Reeves, D., & Wainwright, T. (2021). BPS code of human research ethics. *BPS Code of Human Research Ethics*. <https://doi.org/10.53841/BPSREP.2021.INF180>
- Ollendick, T. H., & Benoit, K. E. (2012). A parent-child interactional model of social anxiety disorder in youth. *Clinical Child and Family Psychology Review*, 15(1), 81–91. <https://doi.org/10.1007/S10567-011-0108-1/FIGURES/1>
- Orgilés, M., Rodríguez-Menchón, M., Fernández-Martínez, I., Morales, A., & Espada,

- J. P. (2019). Validation of the parent report version of the Spence Children's Anxiety Scale (SCAS-P) for Spanish children. *Clinical Child Psychology and Psychiatry*, 24(4), 776–790. <https://doi.org/10.1177/1359104519835579>
- Page, M., McKenzie, J., Bossuyt, P., Boutron, I., Hoffmann, J. T. C., Mulrow, C., & et al. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ*. <https://doi.org/10.1136/bmj.n71>
- Pahl, K. M., Barrett, P. M., & Gullo, M. J. (2012). Examining potential risk factors for anxiety in early childhood. *Journal of Anxiety Disorders*, 26(2), 311–320. <https://doi.org/10.1016/J.JANXDIS.2011.12.013>
- Palmer, E., Woolgar, M., Carter, B., Cartwright-Hatton, S., & Challacombe, F. L. (2023). Preventing anxiety in the children of anxious parents - feasibility of a brief, online, group intervention for parents of one- to three-year-olds. *Child and Adolescent Mental Health*, 28(1), 33–41. <https://doi.org/10.1111/camh.12596>
- Parrish, C. L., & Radomsky, A. S. (2010). Why do people seek reassurance and check repeatedly? An investigation of factors involved in compulsive behavior in OCD and depression. *Journal of Anxiety Disorders*, 24(2), 211–222. <https://doi.org/10.1016/J.JANXDIS.2009.10.010>
- Petrenko, C. L. M. (2013). A review of intervention programs to prevent and treat behavioral problems in young children with developmental disabilities. *Journal of Developmental and Physical Disabilities*, 25(6), 651–679. <https://doi.org/10.1007/S10882-013-9336-2/TABLES/2>
- Petticrew, M., & Roberts, H. (2008). Systematic reviews in the social sciences. In *Systematic Reviews in the Social Sciences: A Practical Guide*. Wiley.
- Phillips, D. C., & Burbles, N. C. (2000). *Postpositivism and educational research* -. Rowman & Littlefield.
- Pillay, M., Alderson-Day, B., Wright, B., Williams, C., & Urwin, B. (2011). Autism Spectrum Conditions-Enhancing Nurture and Development (ASCEND): An evaluation of intervention support groups for parents. *Clinical Child Psychology and Psychiatry*, 16(1), 5–20. <https://doi.org/https://dx.doi.org/10.1177/1359104509340945>
- Pincus, D. B., Santucci, L. C., Ehrenreich, J. T., & Eyberg, S. M. (2008). The

- implementation of modified parent-child interaction therapy for youth with separation anxiety disorder. *Cognitive and Behavioral Practice*, 15(2), 118–125. <https://doi.org/10.1016/J.CBPRA.2007.08.002>
- Pinquart, M. (2017). Associations of parenting dimensions and styles with internalizing symptoms in children and adolescents: A meta-analysis. *Marriage & Family Review*, 53(7), 613–640. <https://doi.org/10.1080/01494929.2016.1247761>
- Pollard, J., Reardon, T., Williams, C., Creswell, C., Ford, T., Gray, A., Roberts, N., Stallard, P., Ukoumunne, O. C., & Violato, M. (2023). The multifaceted consequences and economic costs of child anxiety problems: A systematic review and meta-analysis. *JCPP Advances*, 3(3), e12149. <https://doi.org/10.1002/JCV2.12149>
- Preyde, M., & Ardal, F. (2003). Effectiveness of a parent “buddy” program for mothers of very preterm infants in a neonatal intensive care unit. *CMAJ: Canadian Medical Association Journal*, 168(8), 969. [/pmc/articles/PMC152679/](https://doi.org/10.1503/cmaj)
- Public Health England. (2021). *Promoting children and young people’s mental health and wellbeing A whole school or college approach Public Health England working with the Department for Education*. Crown.
- Reardon, T., Spence, S. H., Hesse, J., Shakir, A., Creswell, C., Alkozei, A., Cook, S., Corcoran, A., Crosby, J., Cruddace, S., Gitau, R., Hughes, Z., Karalus, J., O’Grady, R., Percy, R., Shildrick, S., Thirlwall, K., Willetts, L., & Cooper, P. (2018). Identifying Children With Anxiety Disorders Using Brief Versions of the Spence Children’s Anxiety Scale for Children, Parents, and Teachers. *Psychological Assessment*, 30(10), 1342–1355. <https://doi.org/10.1037/pas0000570>.supp
- Rector, N. A., Kamkar, K., Cassin, S. E., Ayearst, L. E., & Laposa, J. M. (2011). Assessing excessive reassurance seeking in the anxiety disorders. *Journal of Anxiety Disorders*, 25(7), 911–917. <https://doi.org/10.1016/J.JANXDIS.2011.05.003>
- Rector, N. A., Katz, D. E., Quilty, L. C., Laposa, J. M., Collimore, K., & Kay, T. (2019). Reassurance seeking in the anxiety disorders and OCD: Construct validation, clinical correlates and CBT treatment response. *Journal of Anxiety Disorders*, 67. <https://doi.org/10.1016/J.JANXDIS.2019.102109>

- Robson, C., & McCartan, K. (2015). *Real world research* (4th ed.). Wiley.
- Rose, J., McGuire-Snieckus, R., Gilbert, L., & McInnes, K. (2019). Attachment Aware Schools: the impact of a targeted and collaborative intervention. *Pastoral Care in Education, 37*(2), 162–184.  
<https://doi.org/10.1080/02643944.2019.1625429>
- Rosenthal, R. (1966). *Experimenter effects in behavioral research*. Appleton-Century-Crofts.
- Rutherford, H. J. V., Wallace, N. S., Laurent, H. K., & Mayes, L. C. (2015). Emotion regulation in parenthood. *Developmental Review, 36*, 1–14.  
<https://doi.org/10.1016/J.DR.2014.12.008>
- Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist, 55*(1), 68–78. <https://doi.org/10.1037/0003-066X.55.1.68>
- Sanson, A., Hemphill, S. A., & Smart, D. (2004). Connections between temperament and social development: A Review. *Social Development, 13*(1), 142–170.  
<https://doi.org/10.1046/J.1467-9507.2004.00261.X>
- Sauro, J. (2013). *Best practices for using statistics on small sample sizes*. MeasuringU. <https://measuringu.com/small-n/>
- Schleider, J. L., Abel, M. R., & Weisz, J. R. (2015). Implicit theories and youth mental health problems: A random-effects meta-analysis. *Clinical Psychology Review, 35*, 1–9. <https://doi.org/10.1016/J.CPR.2014.11.001>
- Schneider, S., Houweling, J. E. G., Gommlich-Schneider, S., Klein, C., Nündel, B., & Wolke, D. (2009). Effect of maternal panic disorder on mother-child interaction and relation to child anxiety and child self-efficacy. *Archives of Women's Mental Health, 12*(4), 251–259. <https://doi.org/10.1007/S00737-009-0072-7>
- Schneider, S., Unnewehr, S., Florin, I., & Margraf, J. (2002). Priming panic interpretations in children of patients with panic disorder. *Journal of Anxiety Disorders, 16*(6), 605–624. [https://doi.org/10.1016/S0887-6185\(02\)00126-3](https://doi.org/10.1016/S0887-6185(02)00126-3)
- Scottish Executive Education Department. (2002). *Review of provision of educational psychology services in scotland*. <http://www.aspep.org.uk/wp-content/uploads/2014/05/Currie-Report-2002.pdf>
- Sellers, R., Warne, N., Pickles, A., Maughan, B., Thapar, A., & Collishaw, S. (2019).

- Cross-cohort change in adolescent outcomes for children with mental health problems. *The Journal of Child Psychology and Psychiatry and Allied Disciplines*.  
<https://doi.org/10.1111/jcpp.13029>
- Shafran, R., Thordarson, D. S., & Rachman, S. (1996). Thought-action fusion in obsessive compulsive disorder. *Journal of Anxiety Disorders*, *10*(5).  
[https://doi.org/https://doi.org/10.1016/0887-6185\(96\)00018-7](https://doi.org/https://doi.org/10.1016/0887-6185(96)00018-7)
- Sharma, S., Govindan, R., & Kommu, J. V. S. (2022). Effectiveness of parent-to-parent support group in reduction of anxiety and stress among parents of children with autism and Attention Deficit Hyperactivity Disorder. *Indian Journal of Psychological Medicine*, *44*(6), 575–579.  
<https://doi.org/10.1177/02537176211072984>
- Shaw, D. S., Keenan, K., Vondra, J. I., Delliquadri, E., & Giovannelli, J. (1997). Antecedents of preschool children’s internalizing problems: A longitudinal study of low-income families. *Journal of the American Academy of Child and Adolescent Psychiatry*, *36*(12), 1760–1767. <https://doi.org/10.1097/00004583-199712000-00025>
- Shieh, G., Jan, S. L., & Randles, R. H. (2007). Power and sample size determinations for the Wilcoxon signed-rank test. *Journal of Statistical Computation and Simulation*, *77*(8), 717–724. <https://doi.org/10.1080/10629360600635245>
- Silk, J. S., Sheeber, L., Tan, P. Z., Ladouceur, C. D., Forbes, E. E., McMakin, D. L., Dahl, R. E., Siegle, G. J., Kendall, P. C., Mannarino, A., & Ryan, N. D. (2013). “You can do it!”: The role of parental encouragement of bravery in child anxiety treatment. *Journal of Anxiety Disorders*, *27*(5), 439.  
<https://doi.org/10.1016/J.JANXDIS.2013.06.002>
- Silverman, W. K., & Albano, A. M. (1996). *The anxiety disorders interview schedule for children and parents— DSM-IV version*. Graywind.  
[https://www.scirp.org/\(S\(351jmbntvnsjt1aadkposzje\)\)/reference/ReferencesPapers.aspx?ReferenceID=720677](https://www.scirp.org/(S(351jmbntvnsjt1aadkposzje))/reference/ReferencesPapers.aspx?ReferenceID=720677)
- Smalheiser, N. R. (2017). Nonparametric tests. In *Data Literacy: How to Make Your Experiments Robust and Reproducible* (pp. 157–167). Academic Press.  
<https://doi.org/10.1016/B978-0-12-811306-6.00012-9>
- Spence, S. H. (1998). A measure of anxiety symptoms among children. *Behaviour*

- Research and Therapy*, 36(5), 545–566. [https://doi.org/10.1016/S0005-7967\(98\)00034-5](https://doi.org/10.1016/S0005-7967(98)00034-5)
- Spence, S. H., Rapee, R., McDonald, C., & Ingram, M. (2001). The structure of anxiety symptoms among preschoolers. *Behaviour Research and Therapy*, 39(11), 1293–1316. [https://doi.org/10.1016/S0005-7967\(00\)00098-X](https://doi.org/10.1016/S0005-7967(00)00098-X)
- Sperling, J., Boger, K., & Potter, M. (2021). Associations between parental distress and pediatric anxiety and obsessive-compulsive disorder treatment outcomes. *Clinical Child Psychology and Psychiatry*, 26(4), 1102–1110. <https://doi.org/10.1177/13591045211028159>
- Stallard, P. (2009). *Anxiety: cognitive behaviour therapy with children and young people*. Routledge.
- Stockings, E. A., Degenhardt, L., Dobbins, T., Lee, Y. Y., Erskine, H. E., Whiteford, H. A., & Patton, G. (2016). Preventing depression and anxiety in young people: a review of the joint efficacy of universal, selective and indicated prevention. *Cambridge University Press*. <https://doi.org/10.1017/S0033291715001725>
- Tashakkori, A., & Teddlie, C. (1998). *Mixed methodology: combining qualitative and quantitative approaches*. Sage.
- Tashakkori, A., & Teddlie, C. (2009). Integrating qualitative and quantitative approaches to research. *The SAGE Handbook of Applied Social Research Methods*, 283–317. <https://doi.org/10.4135/9781483348858.N9>
- Teddlie, C., & Tashakkori, A. (2010). *SAGE handbook of mixed methods in social & behavioral research* (2nd ed.). SAGE Publications, Inc. <https://doi.org/10.4135/9781506335193>
- Tesch, R. (1990). Qualitative research: Analysis types and software tools. *Qualitative Research: Analysis Types and Software Tools*, 1–331. <https://doi.org/10.4324/9781315067339/QUALITATIVE-RESEARCH-ANALYSIS-TYPES-SOFTWARE-RENATA-TESCH>
- The Children’s Society. (2023). *The good childhood report*. <https://www.childrenssociety.org.uk/sites/default/files/2023-09/TheGoodChildhoodReport2023.pdf>
- The Health Foundation. (2022). *Children and young people’s mental health*. <https://www.health.org.uk/news-and-comment/charts-and->

infographics/children-and-young-people-s-mental-health

The Royal College of Psychiatrists. (2016). *Parental mental illness*.

Then, K. L., Rankin, J. A., & Ali, E. (2014). Focus group research: what is it and how can it be used? - PubMed. *Winter*, 24(1).

Thompson-Hollands, J., Kerns, C. E., Pincus, D. B., & Comer, J. S. (2014). Parental accommodation of child anxiety and related symptoms: range, impact, and correlates. *Journal of Anxiety Disorders*, 28(8), 765–773.

<https://doi.org/10.1016/J.JANXDIS.2014.09.007>

Tobin, G. A., & Begley, C. M. (2004). Methodological rigour within a qualitative framework. *Journal of Advanced Nursing*, 48(4), 388–396.

<https://doi.org/10.1111/J.1365-2648.2004.03207.X>

Treisman, K. (2020). *Take what you need tokens*.

<http://www.safehandsthinkingminds.co.uk/wp-content/uploads/2020/06/take-what-you-need-pdf.pdf>

University of Nottingham. (2021). *Code of research conduct and research ethics*.

<https://www.nottingham.ac.uk/sociology/documents/ethics-documents/code-of-research-conduct-and-research-ethics.pdf>

Van Ameringen, M., Mancini, C., & Farvolden, P. (2003). The impact of anxiety disorders on educational achievement. *Journal of Anxiety Disorders*, 17(5), 561–571. [https://doi.org/10.1016/S0887-6185\(02\)00228-1](https://doi.org/10.1016/S0887-6185(02)00228-1)

Wan, S. (2020). *Sheep scale 1-9 meme*.

[https://samanthawan.com.au/2020/08/22/sheep-scale-meme/?fbclid=IwAR17152gkbMMrh5wJ2QIfZ5iZhckqzGRRssh\\_RJbazDffXH40OphHCtcQ](https://samanthawan.com.au/2020/08/22/sheep-scale-meme/?fbclid=IwAR17152gkbMMrh5wJ2QIfZ5iZhckqzGRRssh_RJbazDffXH40OphHCtcQ)

Webster-Stratton, C. (1990). Long-term follow-up of families with young conduct problem children: From preschool to grade school. *Journal of Clinical Child & Adolescent Psychology*, 19(2), 144–149.

[https://doi.org/10.1207/S15374424JCCP1902\\_6](https://doi.org/10.1207/S15374424JCCP1902_6)

Willner, C. J., Gatzke-Kopp, L. M., & Bray, B. C. (2016). The dynamics of internalizing and externalizing comorbidity across the early school years. *Development and Psychopathology*, 28(4 Pt 1), 1033.

<https://doi.org/10.1017/S0954579416000687>

- Wood, J. J., Piacentini, J. C., Southam-Gerow, M., Chu, B. C., & Sigman, M. (2006). Family cognitive behavioral therapy for child anxiety disorders. *Journal of the American Academy of Child & Adolescent Psychiatry*, 45(3), 314–321. <https://doi.org/10.1097/01.CHI.0000196425.88341.B0>
- Woods, K. (2014). The preparation of practitioner educational psychologists in England. *International Journal of School & Educational Psychology*, 2(3), 198–204. <https://doi.org/10.1080/21683603.2014.934642>
- World Health Organization. (2004a). *Prevention of mental disorders : Effective interventions and policy options*. World Health Organisation. <https://apps.who.int/iris/handle/10665/43027>
- World Health Organization. (2004b). *Promoting mental health: concepts, emerging evidence, practice*. World Health Organization.
- Wu, Y. J., & Lee, J. (2022). The most salient global predictors of adolescents' subjective Well-Being: parental support, peer support, and anxiety. *Child Indicators Research*, 15(5), 1601–1629. <https://doi.org/10.1007/S12187-022-09937-1/TABLES/2>
- Yarbro, J., Mahaffey, B., Abramowitz, J., & Kashdan, T. B. (2013). Recollections of parent–child relationships, attachment insecurity, and obsessive–compulsive beliefs. *Personality and Individual Differences*, 54(3), 355–360. <https://doi.org/10.1016/J.PAID.2012.10.003>
- Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, 15(2), 215–228. <https://doi.org/10.1080/08870440008400302>
- YoungMinds. (2018). *A new era for young people's mental health*. <https://www.youngminds.org.uk/media/5dilibjw/a-new-era-for-young-peoples-mental-health.pdf>
- YoungMinds. (2020). *Coronavirus: Impact on young people with mental health needs*. <https://www.youngminds.org.uk/media/355gyqcd/coronavirus-report-summer-2020-final.pdf>
- Zainal, H., Magiati, I., Tan, J. W. L., Sung, M., Fung, D. S. S., & Howlin, P. (2014). A preliminary investigation of the Spence children's anxiety parent scale as a screening tool for anxiety in young people with autism spectrum disorders. *Journal of Autism and Developmental Disorders*, 44(8), 1982–1994.

<https://doi.org/10.1007/S10803-014-2075-0/TABLES/4>

Zurich. (2022). *'Generation Anxiety': Two years of crisis leads to major spike in child stress*. <https://www.zurich.co.uk/news-and-insight/two-years-of-crisis-leads-to-major-spike-in-child-stress>

## Appendices

### Appendix A

#### Search Strategy Terms and Results per Database

**Table A1**

*Demonstration of the number of articles found from the PsychINFO database using varying search terms*

Database 10.11.23	Search Terms	Number of articles
PsychINFO	<p>APA PsycInfo &lt;1806 to October Week 5 2023&gt;</p> <p>1 (anxiety or anx* or internalising or internalizing or depressi* or depression or "social withdrawl" or somatic).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests &amp; measures, mesh word] 613956</p> <p>2 ("parent* intervention" or "parent program*" or "parent training" or "parent-child").mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests &amp; measures, mesh word] 69344</p> <p>3 (child or adolsecen* or teen* or "young person" or infant).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests &amp; measures, mesh word] 591580</p> <p>4 1 and 2 and 3 11372</p> <p>5 limit 4 to (peer reviewed journal and english language and (childhood &lt;birth to 12 years&gt; or adolescence &lt;13 to 17 years&gt;</p>	63

	<p>or adulthood &lt;18+ years&gt; and (100 childhood &lt;birth to age 12 yrs&gt; or 120 neonatal &lt;birth to age 1 mo&gt; or 140 infancy &lt;2 to 23 mo&gt; or 160 preschool age &lt;age 2 to 5 yrs&gt; or 180 school age &lt;age 6 to 12 yrs&gt; or 200 adolescence &lt;age 13 to 17 yrs&gt; or "300 adulthood &lt;age 18 yrs and older&gt;" or 320 young adulthood &lt;age 18 to 29 yrs&gt;) and "0110 peer-reviewed journal" and english) 7921</p> <p>6 (united kingdom or england).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests &amp; measures, mesh word] 51242</p> <p>7 5 and 663</p>	
Total (prior to removing duplicates in Mendeley)		63
<b>Total (after removing duplicates in Mendeley)</b>		63

**Table A2**

*Demonstration of the number of articles found from the Web of Science database using varying search terms*

<b>Database 10.11.23</b>	<b>Search Terms</b>	<b>Number of articles</b>
Web of Science	<p>internalising or internalizing or somatic or "social withdrawal" or anxiety or anx* or depression or depressi* (Title) AND child or infant or "young person" or adolescen* or teen* (Title) AND parent intervention or parent program* or parent training or parent-child (Title) AND internalising or internalizing or somatic or "social withdrawal" or anxiety or anx* or depression or depressi* (Abstract) AND parent intervention or parent program* or parent training or parent-child (Abstract) AND child or infant or "young person" or adolescen* or teen* (Abstract) and Article (Document Types) and English (Languages) and ENGLAND or NORTH IRELAND or WALES or SCOTLAND (Countries/Regions) and Article (Document Types)</p> <p style="text-align: right;">Date Run: Fri Nov 10 2023 12:13:14 GMT+0000 (Greenwich Mean Time)      Results: 15</p>	15
Total (prior to removing duplicates in Mendeley)		15
<b>Total (after removing duplicates in Mendeley)</b>		15

**Table A3**

*Demonstration of the number of articles found from the EBSCO database using varying search terms*

<b>Database 10.11.23</b>	<b>Search Terms</b>	<b>Number of articles</b>
ERIC / EBSCO	AB ( parents or caregivers or mother or father or parent ) AND AB ( children or adolescents or child or teenager or infant ) AND AB ( intervention or training or program ) AND AB ( internalising OR internalizing OR anxiety OR depression OR somatic OR "social withdrawal" ) <b>Limiters</b> - Publication Scholarly (Peer Reviewed) Journals <b>Expanders</b> - Apply equivalent subjects <b>Narrow by SubjectGeographic:</b> - united kingdom (northern ireland) <b>Narrow by SubjectGeographic:</b> - united kingdom (england) : - english <b>Search modes</b> - Boolean/Phrase <b>Narrow by SubjectGeographic:</b> - united kingdom <b>Narrow by Language</b>	27
Total (prior to removing duplicates in Mendeley)		27
<b>Total (after removing duplicates in Mendeley)</b>		27

**Appendix B**  
**Eligibility Criteria - Full Text Screen**

**Table A4**

*The application of the inclusion and exclusion criteria for assessing eligibility of full texts*

<b>Key:</b>
Meets criteria
May meet criteria
Does not meet criteria
Missing data

Reference	Eligibility Criteria									Overall eligibility?
	1. Population	2. Intervention	3. Context	4. Outcomes	5. Comparison	6. Language	7. Date of Publication	8. Type of Publication	9. Review Topic	
Cartwright-Hatton et al. (2005)	a	a			pre & post intervention measures			a		8/9 - if accept comparison
	b	b						b		
Fulgoni et al. (2019)	a	a	Australia					a		
	b	b						b		
Clulow et al. (2010)	a	a						a		
	b	b						b		

Dunn et al. (2022)	a	a					protocol	a	effect of parent-child aspect of parent training program on internalising symptoms	protocol
	b	b						b		
Buchanan-Pascal et al. (2019)	a	a	Australia		cluster, one without an aspect of the intervention but both with the intervention			a		
	b	b						b		
Pillay et al. (2011)	a	a			pre & post intervention measures, quasi-experimental			a		8/9 - if accept comparison
	b	b						b		
Tsivos et al. (2015)	a	a		parent outcomes or parent-child dyad outcomes				a		
	b	b						b		
Davis and Spurr (1998)	a	a			pre & post intervention measures			a		
	b	b						b		
Cartwright-Hatton et al. (2018)	a	a						a		
	b	b						b		

										may not have an effectiveness score
Gobrial & Reghavan (2018)	a	a						a		mixed methods and LDs and autism
	b	b						b		
Hutchings et al. (2007)	a	a		SDQ (incl emotional symptoms)				a		
	b	b secondary outcome						b		
Lau et al. (2013)	a	a		internalising behaviours but not due to parent intervention				a		parent administered child intervention
	b	b						b		
Svanberg et al. (2010)	a	a		maternal factors and infant attachment style	alternative interventions			a		maternal factors and infant attachment style (unless take compulsivity as internalising symptom)
	b	b						b		
Hogg et al. (2014)	a	a		More about the parents experiences of the group (qual)				a		
	b	b						b		

Jewell et al. (2023)	a	a						a		
	b	b						b		
Evangelou et al. (2007)	a	a			pre & post intervention measures, quasi-experimental			a		8/9 - if accept comparison
	b	b					b			
McConachie et al. (2014)	a	a		child intervention ran parallel				a		
	b	b					b			
Palmer et al. (2023)	a	a						a		
	b	b						b		
Pass et al. (2018)	a	a						a		
	b	b						b		
Reardon et al. (2022)	a	a						a		research proposal
	b	b						b		
Skryabina et al. (2016)	a	a						a		
	b	b						b		

Wink et al. (2017)	a	a						a		
	b	b						b		
Yuan & Freeman (2011)	a	a		parent feelings towards baby (mother-infant bonding)				a		
	b	b						b		
Harrington et al. (2000)	a	a		conduct problems	pre and post - randomised but the comparison was another intervention setting			a	secondary	
	b	b						b		

**Appendix C**  
**Application of Weight of Evidence Framework to Included Studies for**  
**Review**

**Table A5**

*Demonstration of how ratings were calculated for each Weight of Evidence (Gough, 2007) criteria*

<b>Criteria</b>	<b>Ratings</b>
A	High (13-18), Medium (7-12), Low (0-6)
B	High (3), Medium (2), Low (0-1)
C	High (5-6), Medium (3-4), Low (0-2)
D	High (19-27), Medium (10-18), Low (0-9)

**Table A6**

*Quality appraisal of the included studies using the Weight of Evidence Framework*

Weight of Evidence Criteria	Criteria for Current Review		Cartwright-Hatton et al. (2005)	Cartwright-Hatton et al. (2018)	Davis and Spurr (1998)	Evangelou & Sylva (2007)	Gobrial et al. (2018) - Phase 2 Study	Jewell et al. (2023)	McConachie et al. (2014)	Palmer et al. (2023)	Pillay et al., (2011)
A. Research design quality	<b>Intervention</b>	1. Intervention methodology details given	1	1	0	1	1	1	1	1	1
		2. Intervention transparency (e.g. number of sessions and length of intervention)	1	1	0	0	1	1	1	1	1
		3. Treatment given to the control group (if used) is outlined	n/a	1	1	1	n/a	n/a	1	n/a	n/a
		4. Intervention fidelity outlined (e.g., measurement of adherence to intervention given)	0	0	0	0	0	1	1	0	0

	<b>Design</b>	1. Randomised group allocation	n/a	1	0	n/a	n/a	n/a	1	n/a	n/a
		2. More than one outcome measure is used	0	1	1	1	0	1	1	1	1
		3. Definition of Dependent Variables given	1	1	1	1	1	1	1	1	1
		4. Reliability and/or validity of measures discussed	1	1	0	0	0	1	1	1	1
	<b>Participants</b>	1. Number of participants specified	1	1	1	1	1	1	1	1	1
		2. Socio-demographics (e.g., ethnicity and income) of parents is given	0	1	0	0	0	1	0	1	0
		3. Sampling methods specified	1	1	1	1	1	1	1	1	1
		4. Age-range and gender of all participants (parents and children) reported	0	1	1	0	1	1	0	0	0
		5. Inclusion and exclusion criteria given	1	1	0	0	0	1	1	1	0
		6. Sufficient information is given to confirm if the participants showed the difficulties presented	1	1	1	1	1	1	1	1	1
	<b>Findings</b>	1. Results shown clearly	1	1	1	1	1	1	1	1	1
		2. Effect size given	1	0	0	1	0	1	0	1	0
		3. Additional qualitative aspect included	0	0	0	0	1	1	1	1	1
4. Conclusion justified by data		1	1	1	1	1	1	1	1	1	

	<b>Overall</b>		11	15	9	10	10	16	15	14	11
B. Method appropriateness for answering research question	1. RCT or feasibility RCT		0	1	0	0	0	0	1	0	0
	2. Control and intervention groups were comparable		n/a	1	1	1	n/a	n/a	1	n/a	n/a
	3. Follow up measure		1	1	0	0	0	0	1	1	0
	<b>Overall</b>		1	3	1	1	0	0	3	1	0
C. Relevance of research focus for answering review question	1. Sample consists of parents or caregivers of children aged 0-25 years		1	1	1	1	1	1	1	1	1
	2. Children aged 0-25 years		1	1	1	1	1	1	1	1	1
	3. Research explores the effectiveness of parenting intervention(s) in reducing child internalising behaviours		1	1	1	1	1	1	1	1	1
	4. The intervention is based on a psychological approach, paradigm or theory		1	1	1	1	1	1	1	1	1
	5. Conducted in the UK		1	1	1	1	1	1	1	1	1
	6. Conducted in years up to 2023		1	1	1	1	1	1	1	1	1
	<b>Overall</b>		6	6	6	6	6	6	6	6	6
D. Overall rating		18	24	16	17	16	22	24	21	17	

## Appendix D

### Key Study Characteristics of Included Studies

**Table A7**

*Outline of the key study characteristics of the included studies*

Reference	Aim	Participants	Design	Internalising Behaviours - Outcome Measures	Follow up	Findings	WoE rating
Cartwright-Hatton et al. (2005)	To explore whether manipulating parenting behaviours results in alterations in their children's internalising behaviours and whether such potential changes are	a. Parents (n= 43) b. Children (n= 43), aged 2 – 4.5 years	Pre-experimental	The Child Behaviour Checklist (CBC) (Achenbach, 1992b, 1992a)	6 months	Parent reports of internalising behaviours significantly reduced across the intervention (p <.001) with a small effect size of 0.4 (Cohen, 1988). No	Medium

	maintained over time.					<p>significant change in such behaviours 6 months post-intervention. 17 children scored over the clinical cut-off for internalising behaviours as per the CBC (Achenbach, 1992b, 1992a) prior to intervention. This number fell to 2 children, post-intervention</p>	
--	-----------------------	--	--	--	--	--	--

Cartwright-Hatton et al. (2018)	To investigate the feasibility of a group-based, one-session preventative parenting intervention for parents with anxiety	<p>a. Parents (n= 100)</p> <p>b. Children (n= 100), aged 3-9 years</p>	<p>Feasibility RCT*</p> <p><i>*Control group received no intervention from researchers but continued current treatment they were receiving for their own anxiety</i></p>	<p>Child ADIS-PV (Silverman &amp; Albano, 1996)</p> <p>Children &lt;5 years old:</p> <p>1. Spence Children's Anxiety Scale-Parent Report (SCAS-P) (Spence, 1998) or Spence Pre-school Anxiety Scale-Parent Report (SCAS-P) (Spence et al., 2001)</p> <p>2. Fear Survey Schedule for Children – II Parent Version (FSSC-II-PV) (Bouldin &amp; Pratt, 1998)</p>	3 and 12 months	<p>Children whose parents attended the parenting intervention showed greater reduction in anxiety symptoms versus the control group.</p> <p>16.5% more children in the control group received an anxiety diagnosis 12-months</p>	High
---------------------------------	---	--	--	---	-----------------	--	------

				Children > 5 years old: 1. SCAS (Spence, 1998) 2. FSCC – Revised (Ollendick, 1983)		following intervention.	
Davis and Spurr (1998)	To evaluate the effects of a family intervention and to gather parental views on the intervention.	a. Parents (n= 93) b. Children (n= 93), aged 1- 4 years	Quasi-experimental*  <i>*Control group received treatment as usual or were on the waiting list for the intervention</i>	The Child Behaviour Checklist (CBC) (Achenbach, 1992b, 1992a)	N/A	A significant reduction in CBC scores from pre to post-intervention were found (p <0.5) in the intervention group only.	Medium
Evangelou & Sylva (2007)	To explore the effects of a	a. Parents (n= 73)	Quasi-experimental*	Adaptive Social Behaviour	N/A	No significant	Medium

	parenting intervention on children's language, social-emotional and cognitive development.	b. Children (n= 73), aged 3-5 years	<i>*Control group received no intervention</i>	Inventory (ASBI) (Hogan et al., 1992)		differences were found on measures of child social-emotional development between children in the intervention and control group.	
Gobrial et al. (2018)	To design a parenting intervention for anxiety and assess its feasibility with parents with children with autism and anxiety disorders.	a. Parents (n=7) b. Children (n=7), aged 5-14 years	Pre-experimental	Glasgow Anxiety Scale for children with IDs (GAS-ID) (Mindham & Espie, 2003)	N/A	A significant reduction in child anxiety scores from pre- to post-intervention was found (p <0.5).	Medium

Jewell et al. (2023)	<p>To investigate the feasibility of engaging, recruiting and retaining parents of children experiencing anxiety in a brief group cognitive behavioural intervention.</p> <p>To explore parent perspectives regarding the acceptability of the intervention and measures of outcomes.</p> <p>To explore possible clinical benefits related</p>	<p>a. Parents (n= 19) b. Children (n=19), aged 4-9 years</p>	Pre-experimental	<p>Spence Children's Anxiety Scale-Parent Report (SCAS-Parent) (Spence, 1998) or Spence Pre-school Anxiety Scale-Parent Report (SCAS-P) (Spence et al., 2001) and/or Spence Children's Anxiety Scale (SCAS-child, Spence 1998)</p> <p>The Child Adjustment and Parent Efficacy Scale (CAPES)</p>	N/A	<p>Parent and child rated outcomes found a reduction in child anxiety scores from session one to three. Effect sizes were moderate - large regarding parent-rated outcomes (PAS <math>d=-0.68</math>; SCAS-parent <math>d=-1.19</math>). Child self-reported anxiety scores (<math>d=-0.22</math>) and</p>	High
----------------------	--	--	------------------	--	-----	--	------

	to the intervention regarding child anxiety symptoms.			(Morawska et al., 2020)		children's behavioural problems ( $d=-0.32$ ) showed a small effect size. Children's emotional problems showed a moderate-large effect size ( $d=-0.73$ ). The magnitude of change in total intensity was small-moderate ( $d= -0.45$ ). Parental confidence	
--	---	--	--	-------------------------	--	--	--

						and efficacy increased, showing a small-moderate effect size ( $d= 0.41$ )	
McConachie et al. (2014)	To explore the feasibility and acceptability of adapted group therapy for children with anxiety and autism.	a. Parents (n=32) b. Children (n=32), aged 9-13 years	Pilot RCT*  <i>*Control group received delayed therapy</i>	Spence Children's Anxiety Scale-Parent Report (SCAS-Parent) (Spence, 1998) and Spence Children's Anxiety Scale (SCAS-child, Spence 1998)  ADIS child version (Silverman & Albano, 1996)	6 and 9 months	Parents in the intervention group were significantly more likely to report a reduction in child anxiety scores versus those in the control ( $p=.045$ ). A reduction in anxiety disorder severity was	High

				CGI-I (Hedges et al., 2009)		shown for 76% of children in the intervention group versus 33% in the control.	
Palmer et al. (2023)	<p>To investigate the feasibility and acceptability of a brief online intervention for parents with anxiety, with one- to three-year-old children.</p> <p>To explore the effect of the intervention on parental mental health,</p>	<p>a. Parents (n=30)</p> <p>b. Children (n=30), aged 15-47 months</p>	Pre-experimental	Infant and Toddler Social Emotional Assessment (BITSEA) (Briggs-Gowan & Carter, 2002)	8 weeks after baseline	<p>No significant changes were found in BITSEA problem subscale scores pre and post intervention (p=.176) nor the competence subscale (p=.155). No</p>	High

	confidence and perceptions and child behavioural and emotional symptoms .					negative outcomes on child social and emotional measures were found.	
Pillay et al. (2011)	To evaluate a parent intervention for parents of children with autism.	a. Parents (n= 79) b. Children (n= 58), aged 4-18 years	Pre-experimental	Developmental Behaviour Checklist (DBC) (Einfeld & Tonge, 1995)	N/A	Parent-reported child anxiety scores reduced from pre- to post-intervention.	Medium

Appendix E  
Recruitment Poster

# ARE YOU A PARENT/ CARER WHO EXPERIENCES ANXIETY?

Would you like to learn new ways to develop your child's **confidence** & help them cope with their emotions ?

Would you like to help families across the UK?

**JOIN OUR FREE PARENTING SESSIONS**

**What are we researching?** Do parenting sessions for parents with anxiety reduce their child's anxiety?

**What will the research involve?** Sessions, ran by a Trainee Educational Psychologist, which will support you with:

- Helping your children cope with their emotions, manage stress and to develop "7 confident thoughts"
- Managing your "hot spots"

**Who can take part?** Parents or carers who identify as anxious, and have a child aged 2 - 11 years old

Follow this link:  
<https://forms.office.com/e/QD1Es1mZyj>  
or  
Scan or hold the QR code for more information:

**DEADLINE TO REGISTER INTEREST: DATE**

University of Nottingham  
UK | CHINA | MALAYSIA  
[isabel.williams@nottingham.ac.uk](mailto:isabel.williams@nottingham.ac.uk)

## Appendix F

### Demographics Questionnaire

#### Demographics Questionnaire

Please complete the questionnaire below to tell me a bit more about you. If you have any questions, please ask or email Izzie. Thank you.

1. **What gender do you identify as?**

Woman

Man

Non-binary

Prefer not to say

2. **What is your age?**

Under 18

18-24

25-34

35-44

45-54

Over 54

3. **Please specify your ethnicity**

Asian or Asian British

Black, Black British, Caribbean or African

Mixed or multiple ethnic groups

White

Other (please state)

Prefer not to say

4. **Which languages can you speak fluently?**

5. **What is the highest degree or level of education you have completed?**

Some Secondary School

Secondary School

Foundation degree, diploma or apprenticeship (Levels 1-5)

Bachelors degree

Masters degree

Doctorate

6. **What is your marital status?**

Married

Single

Cohabiting

In a relationship

Prefer not to say

7. **How many children do you have?**

One

Two

Three

Four

More than Four (please state)

8. **Where is your home located?**

9. **What is your current employment status?**

Employed Full-time

Employed Part-time

Seeking opportunities or Unemployed

Retired

Prefer not to say

## Appendix G

### Session Plans

#### Session 1 PWA Intervention

Activity	Script	Resources Needed/ To do
<b>Introduction</b>	<ul style="list-style-type: none"> <li>• Intro (who I am)</li> <li>• Thank you for coming along</li> <li>• So these sessions will be all about working together to support each other in raising confident children who have the tools to manage their emotions – that’s our goal!</li> <li>• So we will be following online parenting sessions that wer created by a clinical psychologist, Sam Cartwright-Hatton, to support parents with anxiety. And as we go through it we will have opportunities to discuss our thoughts and things like that.</li> <li>• In the first video I will show you today, Sam will introduce the sessions a bit more but if you have any questions as we go along, please do let me know</li> <li>• To give you an idea, each week we will watch a couple of videos together and have a chat about those, if you would like to do this. After each session together, you are invited to go away and have a go at some of things we talk about in the sessions. So at the start of each session there is an opportunity for us to discuss how you found the things that you tried out from the last session ... again, it is completely up to you how much you feel comfortable sharing in these sessions. They are for you!</li> <li>• And in our final session together, I would really love to just come together and hear how you found the sessions.</li> <li>• Does that sound okay so far?</li> </ul>	
<b>Ethics</b>	<p>So a few things I wanted to mention...</p> <ul style="list-style-type: none"> <li>• We will always have a break each session but if at any point you want to take a moment out or grab a cup of tea or a biscuit, please do go ahead and do that.</li> <li>• Throughout the next few weeks, we will be chatting about feelings of anxiety, our parenting but also our experiences of being parented. I do recognise that these topics can be challenging to discuss. Again, please do take breaks as you need them. Also, I have put on the table a list of places that can offer you additional support if you</li> </ul>	<ul style="list-style-type: none"> <li>• Print consent form</li> <li>• List of extra support</li> </ul>

	<p>would like to explore those. I will also be around at the end of the session if you would like to talk.</p> <ul style="list-style-type: none"> <li>As I said before, please do get involved in a way that feels comfortable to you. You are able to leave the sessions at any time.</li> <li>I want to say that I will not disclose personal information (e.g., names) from our sessions</li> </ul>	
<b>Housekeeping</b>	<ul style="list-style-type: none"> <li>Okay! Final bit from me!! You're doing well so far..</li> <li>A few housekeeping bits <ul style="list-style-type: none"> <li>There are refreshments available here...</li> <li>There are toilets here...</li> <li>In the case of a fire...</li> <li>(any H&amp;S)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Print any school procedures</li> </ul>
<b>Icebreaker activities</b>	<ul style="list-style-type: none"> <li>Okay! Enough from me</li> <li>So, it would be lovely to get to know each other a bit more if you guys feel comfortable doing this</li> <li>I am not sure if anyone knows each other already?</li> <li>So I thought we could go round and say: <ul style="list-style-type: none"> <li>Our name</li> <li>Who is at home with us</li> <li>And also, I have some photos of a sheep so maybe you can give us an idea of what sheep you are feeling like today and why!</li> </ul> </li> <li>But, you are more than welcome to opt out of this, just say pass and we can move on</li> <li>I will start us off, so...!</li> <li><b>Complete register!!</b></li> </ul>	<ul style="list-style-type: none"> <li>Print sheep pictures</li> <li>Print register</li> </ul>
<b>Ground rules</b>	<ul style="list-style-type: none"> <li>Thank you, it was lovely to get to know everyone a bit more....</li> <li>So the next thing I wanted to do is make some ground rules together so that we feel safe getting involved in our sessions</li> <li>So there are a couple of bits I want to include, so: <ul style="list-style-type: none"> <li>Do not discuss families or children, by name, that are not participating in the intervention</li> <li>What is discussed is confidential and cannot be discussed outside of the sessions</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Large paper/ flipchart</li> <li>Pens</li> </ul>

	<ul style="list-style-type: none"> <li>• Is there anything else people would like me to put up here...?</li> <li>• And we will keep these up in every session to remind us</li> </ul>	
<b>Completion of SCAS-P or SCAS</b>	<ul style="list-style-type: none"> <li>• So just before we have a break, I would like to ask you to please complete these forms for each of your children (ask ages and give accordingly – SCAS for 6-18y, preschool for &lt;6y)</li> <li>• These forms measure your child's current feelings of anxiety</li> <li>• We will then come back and re-do these in our final session together</li> <li>• And then if you could please complete the demographics sheet too</li> <li>• Once you're finished we will have a X minute break</li> <li>• And once you're back we will have a look at our first video together which is just an intro really</li> <li>• All okay?</li> </ul>	<ul style="list-style-type: none"> <li>• Print SCAS-P</li> <li>• Print SCAS</li> <li>• Print demographics</li> <li>• Bring pens</li> </ul>
<b>Module 1: Starter</b>	<ul style="list-style-type: none"> <li>• <i>Intro video</i></li> <li>• <i>Info page</i> <ul style="list-style-type: none"> <li>○ So this bit just goes through the things I have spoken to you about already really, so there are actually 9 modules, not 8 and we will do about 2 a session</li> <li>○ As I said, there will be a chance for you to go away and try out some of the actions we speak about but we will go through that together</li> </ul> </li> <li>• <i>Meet the Parents</i> <ul style="list-style-type: none"> <li>○ Okay so this section introduces you to 5 fictional parents who will travel through the course with you</li> </ul> </li> <li>• <i>How do you view the world?</i> <ul style="list-style-type: none"> <li>○ Okay so this is a bit of a quiz... I completed it before so I will read the statements out and just have a think or jot down if you agree or not (read out)</li> </ul> </li> <li>• <i>7 Confident thoughts video</i></li> <li>• <i>Quiz</i> <ul style="list-style-type: none"> <li>○ Read out and then answer</li> </ul> </li> <li>• <i>Video related to quiz</i></li> <li>• <i>Anxiety story video</i></li> </ul>	<ul style="list-style-type: none"> <li>• Starter module notes</li> </ul>

	<ul style="list-style-type: none"> <li>○ If anyone does want the link to this video, let me know and I will send it to you</li> <li>• <i>Child personality factors</i></li> </ul>	
<b>End of session</b>	<ul style="list-style-type: none"> <li>• Okay, how are we feeling? It was just a bit of an introduction model but it gives you a bit of a taste....</li> <li>• I wonder if we could go around with one word about how we feel after watching this, or what sheep!</li> <li>• I will go first</li> <li>• Also, I have a board up here with tokens, please have a look and take what you need</li> </ul>	<ul style="list-style-type: none"> <li>• Print tokens</li> <li>• Cut out tokens</li> <li>• Make token board</li> </ul>
<b>Option to complete Relaxation Activity</b>	<ul style="list-style-type: none"> <li>• So at the end of every session, you guys are more than welcome to head off now or you can stay for 5/10 minutes for a relaxation exercise which will be some guided mindfulness if you feel like that would be useful for you (5-10mins)</li> </ul>	

### Session 2 PWA Intervention

Activity	Script	Resources Needed/ To do
<b>Introduction</b>	<ul style="list-style-type: none"> <li>• Hi all, how are we doing? How did you feel after last week?</li> <li>• So lovely to see you all back here (<b>complete register</b>)</li> <li>• So today we will be thinking about avoidance and how this can sometimes encourage feelings of anxiety... so we will think about how we can support our children to step out of their comfort zone and cope with situations that may worry them</li> <li>• Then we will have a break!</li> <li>• Then we will come back and think about the importance of play</li> <li>• Does that sound okay?</li>   <li>• But first I wonder if we could go round and maybe say what sheep we feel like today or if you have any good news to share (as always you can say pass and we can move on!)</li> </ul>	<ul style="list-style-type: none"> <li>• Sheep pics</li> <li>• Ground rules</li> </ul>

	<ul style="list-style-type: none"> <li>• Just to say before we start, for each video I will give you notes that summarise everything so you don't have to make notes but you are more than welcome to make your own notes or scribble on these if that helps</li> </ul>	
<b>Module 2: Comfort Zone</b>	<ul style="list-style-type: none"> <li>• <i>Story of Village and Volcano</i> <ul style="list-style-type: none"> <li>○ Again, let me know if you would like me to try and send you this video!</li> <li>○ How do we feel about that??</li> </ul> </li> <li>• <i>Quiz</i> <ul style="list-style-type: none"> <li>○ Ask</li> </ul> </li> <li>• <i>Video</i></li> <li>• <i>Parent experiences</i> <ul style="list-style-type: none"> <li>○ Okay so we will see how the fictional parents got on with encouraging their children</li> <li>○ If you have any comments or thoughts as we go through please do let me know</li> <li>○ Anyone got any thoughts?</li> </ul> </li> <li>• <i>Bravery ladder intro</i> <ul style="list-style-type: none"> <li>○ Would anyone feel comfortable sharing whether this resonates with any of you or your children?</li> <li>○ Thank you... let's have a look at this bravery ladder</li> </ul> </li> <li>• <i>Bravery ladder 2</i> <ul style="list-style-type: none"> <li>○ Read out and then answer</li> </ul> </li> <li>• <i>Bravery ladder activity</i> <ul style="list-style-type: none"> <li>○ Read it out and do together</li> </ul> </li> <li>• <i>Bravery ladder eggs</i> <ul style="list-style-type: none"> <li>○ So there are a few premade bravery ladders that I have put on the table to please feel free to have a look or take some home</li> </ul> </li> <li>• <i>How to get your child on board</i> <ul style="list-style-type: none"> <li>○ So this section has some tips for helping your child get on board with the bravery ladder</li> <li>○ Open and discuss</li> </ul> </li> <li>• <i>Homework</i> <ul style="list-style-type: none"> <li>○ Think about ways to get your child out of their comfort zone</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Comfort zone module notes</li> <li>• Bravery ladder eggs</li> <li>• Paper to make bravery ladders</li> <li>• Print action plan template if sent (or make one!)</li> </ul>

	<ul style="list-style-type: none"> <li>○ Make a bravery ladder</li> <li>○ ^write ideas in action plan – okay so I wonder if we could make an action plan now</li> <li>○ Action: e.g. start bravery ladder</li> <li>○ When: after tea on wednesday (draw), do saturday</li> <li>○ What: draw bravery ladder and do step 1</li> <li>○ Extra notes e.g. dw</li> </ul>	
<b>Break</b>		
<b>Module 3: Playful Parent</b>	<p><i>(Approx. 15 minutes)</i></p> <ul style="list-style-type: none"> <li>• Intro</li> <li>• Type of play <ul style="list-style-type: none"> <li>○ Read out and discuss</li> </ul> </li> <li>• Child's Game <ul style="list-style-type: none"> <li>○ Any thoughts on that so far?</li> </ul> </li> <li>• Parent experiences</li> <li>• Why play is good for 7 confident thoughts</li> <li>• Quiz <ul style="list-style-type: none"> <li>○ Read out and ask to think about</li> </ul> </li> <li>• Homework <ul style="list-style-type: none"> <li>○ Write down actions from this session</li> <li>○ Anyone think they are going to try anything out from this? Maybe the child's game? Any ideas how you might squeeze that in?</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Playful parent module notes</li> </ul>
<b>End of session</b>	<ul style="list-style-type: none"> <li>• Okay, how are we feeling?</li> <li>• I wonder if we could go around with one word about how we feel after watching this, or what sheep!</li> <li>• I will go first</li> <li>• Also, I have a board up here with tokens, please have a look and take what you need</li> </ul>	<ul style="list-style-type: none"> <li>• Print missing tokens</li> <li>• Cut out missing tokens</li> <li>• Bring token board</li> </ul>
<b>Option to complete Relaxation Activity</b>	<ul style="list-style-type: none"> <li>• So you are more than welcome to head off now or you can stay for 5/10 minutes for a relaxation exercise which will be some guided mindfulness if you feel like that would be useful for you (5-10mins)</li> </ul>	

### Session 3 PWA Intervention

Activity	Script	Resources Needed/ To do
<b>Introduction</b>	<ul style="list-style-type: none"> <li>• Hi all, how are we doing? How did you feel after last week?</li> <li>• So lovely to see you all back here <b>(complete register)</b></li> <li>• So today I was thinking we can reflect on last week and see if anyone got a chance to try out any of the activities and then we will start our first video...</li> <li>• Which will be about how we can support our children with managing/ regulating their emotions</li> <li>• Then we will have a break! Tea and biscuits, as always!</li> <li>• Then we will come back and think about how we can support our children to develop what the intervention calls more 'good and brave behaviours'</li> <li>• Does that sound okay?</li> <li>• Just like last week, I have the summary notes printed for you but if you would like any paper or pens to make notes let me know</li>   <li>• But first I wonder if we could go round and maybe say what sheep we feel like today or if you have any good news to share (as always you can say pass and we can move on!)</li> </ul>	<ul style="list-style-type: none"> <li>• Sheep pics</li> <li>• Ground rules</li> <li>• Make a register &amp; homework column</li> </ul>
<b>Homework</b>	<ul style="list-style-type: none"> <li>• So last week we spoke about how we can encourage our children to get out of their comfort zone. I wonder if anyone tried making a bravery ladder or had a go at any of the activities? No pressure to share...</li> <li>• <i>(discuss)</i></li> <li>• The other activity you may have tried was playing with your child... maybe trying out the child's game... did anyone get a chance to do that?</li> <li>• <i>(discuss)</i></li> </ul>	<ul style="list-style-type: none"> <li>• Ask if they completed the homework!</li> </ul>
<b>Module 4: Emotion Coaching</b>	<p><i>(Approx 20 mins)</i></p> <ul style="list-style-type: none"> <li>• <i>Intro video</i> <ul style="list-style-type: none"> <li>○ Again, let me know if you would like me to try and send you this video!</li> <li>○ How do we feel about that??</li> </ul> </li> <li>• <i>Parent panel experiences of their parents managing their emotions</i></li> </ul>	<ul style="list-style-type: none"> <li>• module notes</li> <li>• action plan?</li> <li>• Print emotion coaching script template</li> </ul>

	<ul style="list-style-type: none"> <li>○ Ask after last parent... any thoughts or reflections on this?</li> <li>○ Everyone feeling okay?... as always, if you do need a moment please take it, it can be hard to reflect on our past experiences here</li> <li>• <i>Example of understanding child's emotion</i></li> <li>• <i>Emotions Quiz</i> <ul style="list-style-type: none"> <li>○ Raise your hand for which you think are unacceptable... read out</li> </ul> </li> <li>• <i>Video – all emotions okay</i> <ul style="list-style-type: none"> <li>○ Does that make sense so far?</li> </ul> </li> <li>• <i>Emotion Coaching tips</i> <ul style="list-style-type: none"> <li>○ Read out</li> </ul> </li> <li>• <i>Parent panel – emotion coaching</i> <ul style="list-style-type: none"> <li>○ Read it out and do together</li> </ul> </li> <li>• <i>Using Emotion Coaching</i> <ul style="list-style-type: none"> <li>○ Planning Emotion Coaching</li> <li>○ So, I wonder if we could have a think about situations that you may you have with your child that you could try emotion coaching with</li> <li>○ So we saw an example of homework</li> <li>○ And you could jot one down now and maybe an example of what you might say using emotion coaching</li> <li>○ We could maybe try one together?</li> <li>○ I have also made you little cheat sheets you can have in the kitchen or somewhere when you need a little reminder!</li> </ul> </li> <li>• <i>Homework</i> <ul style="list-style-type: none"> <li>○ <b>Try emotion coaching!</b></li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Print A5 emotion coaching cheat sheet and laminate</li> </ul>
<b>Break</b>		
<b>Module 5: Good and Brave Behaviour</b>	<p><i>(Approx. 15 minutes)</i></p> <ul style="list-style-type: none"> <li>• <i>Intro</i></li> <li>• <i>Praise video</i></li> <li>• <i>Tips for praise</i> <ul style="list-style-type: none"> <li>○ Read and discuss – these are all on your summary notes!</li> </ul> </li> <li>• <i>Rewards video</i></li> <li>• <i>Tips for rewards</i> <ul style="list-style-type: none"> <li>○ Read and discuss</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• module notes</li> <li>• star chart template</li> <li>• buy star stickers??</li> </ul>

	<ul style="list-style-type: none"> <li>• <i>Choosing good rewards</i> <ul style="list-style-type: none"> <li>○ Read and discuss</li> </ul> </li> <li>• <i>Quiz</i> <ul style="list-style-type: none"> <li>○ Read out and they could put their hand up</li> <li>○ Any other ideas??</li> </ul> </li> <li>• <i>Star charts</i> <ul style="list-style-type: none"> <li>○ Any thoughts on this? I learnt a lot from this when I first watched it</li> </ul> </li> <li>• <i>Star chart tips</i> <ul style="list-style-type: none"> <li>○ Read and discuss – I will whizz through these as they are on your sheet</li> </ul> </li> <li>• <i>Star chart template</i> <ul style="list-style-type: none"> <li>○ I have printed some templates off for your to look at...</li> </ul> </li> <li>• <i>7 confident thoughts</i> <ul style="list-style-type: none"> <li>○ Quiz together</li> </ul> </li> <li>• <i>Parent panel</i></li> <li>• <i>Spot the great praise and reward</i> <ul style="list-style-type: none"> <li>○ Quiz together</li> </ul> </li> <li>• <i>Homework</i> <ul style="list-style-type: none"> <li>○ Use the praise tips</li> <li>○ Anyone think they are going to try anything out from this? Star chart? Praise? Maybe jot down what you might want to do</li> </ul> </li> </ul>	
<b>End of session</b>	<ul style="list-style-type: none"> <li>• Okay, how are we feeling?</li> <li>• I wonder if we could go around with one word about how we feel after watching this, or what sheep!</li> <li>• I will go first</li> <li>• Also, I have a board up here with tokens, please have a look and take what you need</li> </ul>	<ul style="list-style-type: none"> <li>• Print missing tokens</li> <li>• Cut out missing tokens</li> <li>• Bring token board</li> </ul>
<b>Option to complete Relaxation Activity</b>	<ul style="list-style-type: none"> <li>• So you are more than welcome to head off now or you can stay for 5/10 minutes for a relaxation exercise which will be some guided mindfulness if you feel like that would be useful for you (5-10mins)</li> </ul>	

**Session 4 PWA Intervention**

Activity	Script	Resources Needed/ To do
<b>Introduction</b>	<ul style="list-style-type: none"> <li>• Hi all, how are we doing? How did you feel after last week?</li> <li>• So lovely to see you all back here (complete register)</li> <li>• So today I was thinking we can reflect on last week and see if anyone got a chance to try out any of the activities and then we will start our first video...</li> <li>• Which will be about how our physical health can affect our mental health</li> <li>• Then we will have a break! Tea and biscuits, as always!</li> <li>• Then we will come back and think about good and stress and this module is a bit more specific for parents who experience anxiety</li> <li>• Does that sound okay?</li> <li>• Just like last week, I have the summary notes printed for you but if you would like any paper or pens to make notes let me know</li>   <li>• But first I wonder if we could go round and maybe say what sheep we feel like today or if you have any good news to share (as always you can say pass and we can move on!)</li> </ul>	<ul style="list-style-type: none"> <li>• Sheep pics</li> <li>• Ground rules</li> <li>• Make a register &amp; homework column</li> </ul>
<b>Homework</b>	<ul style="list-style-type: none"> <li>• So last week we spoke about using emotion coaching, rewards and praise. I wonder if anyone tried out any emotion coaching? No pressure to share...</li> <li>• (discuss)</li> <li>• What about praise and rewards... did anyone get a chance to try anything differently, make a reward chart or anything?</li> <li>• (discuss)</li> </ul>	<ul style="list-style-type: none"> <li>• Ask if they completed the homework!</li> </ul>
<b>Module 6: Mind and Body</b>	<p>(Approx 20 mins)</p> <ul style="list-style-type: none"> <li>• Intro video</li> <li>• Exercise video</li> <li>• Parent panel videos <ul style="list-style-type: none"> <li>○ Any thoughts?</li> </ul> </li> <li>• Exercise Action Plan <ul style="list-style-type: none"> <li>○ Anyone feel like their children could do with more exercise and have any ideas for this? (could write on a flipchart)</li> </ul> </li> <li>• Sleep</li> <li>• Sleep quiz <ul style="list-style-type: none"> <li>○ Read out – these are things you may think about</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• module notes</li> <li>• flipchart</li> <li>• take a pic of flipchart to email</li> </ul>

	<ul style="list-style-type: none"> <li>• <i>Tips for sleep</i> <ul style="list-style-type: none"> <li>○ Read it out and discuss (on sheet too)</li> </ul> </li> <li>• <i>Sleep action plan</i> <ul style="list-style-type: none"> <li>○ Anyone feel like their children could do with more exercise and have any ideas for this? (could write on a flipchart)</li> </ul> </li> <li>• <i>Caffeine</i> <ul style="list-style-type: none"> <li>○ Full disclosure... my nan used to make me a coffee or hot chocolate every day after school so I am concerned...!</li> </ul> </li> <li>• <i>Caffeine Quiz</i> <ul style="list-style-type: none"> <li>○ Read out</li> </ul> </li> <li>• <i>Reducing caffeine intake</i></li> <li>• <i>Food</i></li> <li>• <i>Food Action plan</i> <ul style="list-style-type: none"> <li>○ Any ideas for how we could increase good bacteria in your child's gut? (write on flipchart)</li> </ul> </li> </ul>	
<b>Break</b>		
<b>Module 7: Good Stress Bad Stress</b>	<p><i>(Approx. 15 minutes)</i></p> <ul style="list-style-type: none"> <li>• <i>Intro</i> <ul style="list-style-type: none"> <li>○ Is everyone okay so far? Please do look after yourself as we go through this one, as Sam said, this one can feel a bit more challenging</li> </ul> </li> <li>• <i>Parent panel</i> <ul style="list-style-type: none"> <li>○ Any thoughts?</li> </ul> </li> <li>• <i>Video</i></li> <li>• <i>Good vs bad stress</i> <ul style="list-style-type: none"> <li>○ Read and discuss – these are all on your summary notes!</li> </ul> </li> <li>• <i>Good bad stress quiz</i></li> <li>• <i>Video on 7 confident thoughts</i> <ul style="list-style-type: none"> <li>○ Read and discuss</li> </ul> </li> <li>• <i>7 confident thoughts</i> <ul style="list-style-type: none"> <li>○ Quiz together</li> </ul> </li> <li>• <i>Parent panel x 2</i></li> <li>• <i>Rubbing corners off</i> <ul style="list-style-type: none"> <li>○ Any thoughts on this?</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• module notes</li> </ul>

	<ul style="list-style-type: none"> <li>• <i>Spotting overprotection</i> <ul style="list-style-type: none"> <li>○ Talk through</li> </ul> </li> <li>• <i>Rubbing corners off</i> <ul style="list-style-type: none"> <li>○ Talk through</li> </ul> </li> <li>• <i>When to be overprotective</i> <ul style="list-style-type: none"> <li>○ Talk through</li> </ul> </li> <li>• <i>Outro</i> <ul style="list-style-type: none"> <li>○ Remind to look at sheet gave in session 1- can resend</li> </ul> </li> <li>• <i>Homework</i> <ul style="list-style-type: none"> <li>○ Anyone think they are going to try anything out from this? Maybe jot down what you might want to do</li> </ul> </li> </ul>	
<b>End of session</b>	<ul style="list-style-type: none"> <li>• Okay, how are we feeling?</li> <li>• I wonder if we could go around with one word about how we feel after watching this, or what sheep!</li> <li>• I will go first</li> <li>• Also, I have a board up here with tokens, please have a look and take what you need</li> </ul>	<ul style="list-style-type: none"> <li>• Print missing tokens</li> <li>• Cut out missing tokens</li> <li>• Bring token board</li> </ul>
<b>Option to complete Relaxation Activity</b>	<ul style="list-style-type: none"> <li>• So you are more than welcome to head off now or you can stay for 5/10 minutes for a relaxation exercise which will be some guided mindfulness if you feel like that would be useful for you (5-10mins)</li> </ul>	

### Session 5 PWA Intervention

Activity	Script	Resources Needed/ To do
<b>Introduction</b>	<ul style="list-style-type: none"> <li>• Hi all, how are we doing? How did you feel after last week?</li> <li>• So lovely to see you all back here <b>(complete register)</b></li> <li>• So today I was thinking we can reflect on last week and see if anyone got a chance to try out any of the activities and then we will start our first video...</li> <li>• Which will be about our own personal hot spots so those things that we know can cause us particular anxiety and how we can try to reduce the impact that this may have on our children. This one, a bit like last week, might feel a bit trickier for some people so please do be kind to yourselves.</li> </ul>	<ul style="list-style-type: none"> <li>• Sheep pics</li> <li>• Ground rules</li> <li>• Make a register &amp; homework column</li> </ul>

	<ul style="list-style-type: none"> <li>• Then we will have a break! Tea and biscuits, as always!</li> <li>• Then we will come back and think about boundaries and setting limits to behaviours</li> <li>• Does that sound okay?</li> <li>• Just like last week, I have the summary notes printed for you but if you would like any paper or pens to make notes let me know</li>   <li>• But first I wonder if we could go round and maybe say what sheep we feel like today or if you have any good news to share (as always you can say pass and we can move on!)</li> </ul>	
<b>Homework</b>	<ul style="list-style-type: none"> <li>• So last week we spoke about using nutrition and good stress, bad stress and overprotection. I wonder if anyone tried anything new this week following the session? No pressure to share...</li> <li>• <i>(discuss)</i></li> </ul>	<ul style="list-style-type: none"> <li>• Ask if they completed the homework!</li> </ul>
<b>Module 8: Where are your hot spots</b>	<p><i>(Approx 30 mins)</i></p> <ul style="list-style-type: none"> <li>• <i>Intro video</i></li> <li>• <i>What are hot spots</i></li> <li>• <i>Parent panel videos</i> <ul style="list-style-type: none"> <li>○ Any thoughts?</li> </ul> </li> <li>• <i>Kids copy their parents</i> <ul style="list-style-type: none"> <li>○ ....</li> </ul> </li> <li>• <i>Role play videos</i> <ul style="list-style-type: none"> <li>○ Any thoughts on this? I reflected on how easy this is to do</li> </ul> </li> <li>• <i>Watch out for ears flapping</i> <ul style="list-style-type: none"> <li>○ Pause on 7 confident thoughts – any thoughts on these???</li> </ul> </li> <li>• <i>Compensating</i></li> <li>• <i>How to use compensation</i> <ul style="list-style-type: none"> <li>○ Anyone feel like their children could do with more exercise and have any ideas for this? (could write on a flipchart)</li> </ul> </li> <li>• <i>Summary</i> <ul style="list-style-type: none"> <li>○ Read out</li> </ul> </li> <li>• <i>Action plan</i></li> </ul>	<ul style="list-style-type: none"> <li>• module notes</li> <li>• make action plan templates to copy and print</li> </ul>

	<ul style="list-style-type: none"> <li>○ Anyone got anything they can see themselves using this with? Mine would be cats...I actually picked that up from my mum I think...</li> <li>• <i>Mind the gap</i></li> <li>• <i>Summary</i> <ul style="list-style-type: none"> <li>○ Read out</li> </ul> </li> <li>• <i>Perfectionism</i></li> <li>• <i>Perfectionism summary</i> <ul style="list-style-type: none"> <li>○ Read out</li> </ul> </li> <li>• <i>Perfectionism Action plan</i></li> <li>• <i>Finally</i> <ul style="list-style-type: none"> <li>○ Is everyone feeling okay? It is time for tea but if anyone wants to chat to me or needs some time out please do. You have the list of extra support, from week 1 and as always I can offer the relaxation time at the end of the day</li> </ul> </li> </ul>	
<b>Break</b>		
<b>Module 9: Boundaries and setting limits</b>	<p><i>(Approx. 15 minutes)</i></p> <ul style="list-style-type: none"> <li>• So, this is our final module together!! Thank you so much for all of your time so far and well done for completing these sessions</li> <li>• I will chat a little bit more about what will happen in our next session following this video</li> <li>• <i>Intro</i></li> <li>• <i>Common traps</i> <ul style="list-style-type: none"> <li>○ Read out and discuss</li> </ul> </li> <li>• <i>Tips for giving commands</i> <ul style="list-style-type: none"> <li>○ Read out and discuss</li> </ul> </li> <li>• <i>Parent Panel - consequences</i> <ul style="list-style-type: none"> <li>○ Any thoughts?</li> </ul> </li> <li>• <i>Summary</i></li> <li>• <i>Top tips for using consequences</i> <ul style="list-style-type: none"> <li>○ Read and discuss</li> </ul> </li> <li>• <i>Time out</i> <ul style="list-style-type: none"> <li>○ Does anyone use time out? (could skip – it is in their notes)</li> </ul> </li> <li>• <i>Time out top tips</i></li> </ul>	<ul style="list-style-type: none"> <li>• module notes</li> <li>• action plan template</li> </ul>

	<ul style="list-style-type: none"> <li>○ Read and discuss</li> <li>• <i>Finally</i> <ul style="list-style-type: none"> <li>○ Talk through</li> </ul> </li> <li>• <i>Action plan</i> <ul style="list-style-type: none"> <li>○ Go through</li> </ul> </li> </ul>	
<b>End of session</b>	<ul style="list-style-type: none"> <li>• Okay, how are we feeling?</li> <li>• So next session will be a little bit different, so we will complete those same questionnaires about your children’s level of anxiety again. And then we will do what is called a focus group. So I will basically be asking some questions about how you found the sessions and we can have a group discussion about it. This session is all about me finding out how helpful the sessions were for you and your families really. Does that sounds okay? We will also have some celebratory cake for completing all of the sessions together!!</li> <li>• It has been a heavier session today so I wont ask how everyone is feeling unless you would like to share but as always...</li> <li>• Also, I have a board up here with tokens, please have a look and take what you need</li> </ul>	<ul style="list-style-type: none"> <li>• Print missing tokens</li> <li>• Cut out missing tokens</li> <li>• Bring token board</li> </ul>
<b>Option to complete Relaxation Activity</b>	<ul style="list-style-type: none"> <li>• So you are more than welcome to head off now or you can stay for 5/10 minutes for a relaxation exercise which will be some guided mindfulness if you feel like that would be useful for you (5-10mins)</li> </ul>	

### Session 6/7 PWA Intervention

Activity	Script	Resources Needed/ To do
<b>Introduction</b>	<ul style="list-style-type: none"> <li>• So congratulations of completing all of the sessions together! It has been a pleasure... (// complete final video on hot spots, see session 5 plan)</li> <li>• Thank you for coming in for our final session today!</li> <li>• As I mentioned last week, today I am going to ask you to re-do the questionnaires you did in our first session together</li> <li>• We will then have a group discussion for the remainder of the session to support me to understand how you found the sessions</li> <li>• That all okay so far?</li> </ul>	

<b>Completion of SCAS-P or SCAS</b>	<ul style="list-style-type: none"> <li>• Complete</li> </ul>	<ul style="list-style-type: none"> <li>• Print SCAS-P</li> <li>• Print SCAS</li> <li>• Bring pens</li> </ul>
<b>Focus group</b>	<ul style="list-style-type: none"> <li>• See plan</li> </ul>	<ul style="list-style-type: none"> <li>• Video equipment</li> <li>• Trainee to make notes??</li> </ul>
<b>Debrief</b>	<ul style="list-style-type: none"> <li>• So that is everything... thank you so much for all of your time, honesty, openness and hard work over the past few weeks</li> <li>• Before you go, I will give you a debrief statement which just tells you a bit more about the study. Please do read this and you have my email if you have any questions.</li> </ul>	<ul style="list-style-type: none"> <li>• Print debrief statements</li> </ul>
<b>End of session</b>	<ul style="list-style-type: none"> <li>• For the final time! I have a board up here with tokens, please have a look and take what you need</li> </ul>	<ul style="list-style-type: none"> <li>• Print tokens</li> <li>• Cut out tokens</li> <li>• Make token board</li> </ul>

## Appendix H

### Participant Information Sheet

#### School of Psychology Information Sheet



The University of  
**Nottingham**

UNITED KINGDOM · CHINA · MALAYSIA

*A Mixed Methods Study Exploring the Effectiveness of a Parenting Intervention for Parents with Anxiety in Reducing Child Anxiety*

*Ethics Approval Number or Taught Project Archive Number: S1514*

*Researcher(s): Isabel Williams, [isabel.williams@nottingham.ac.uk](mailto:isabel.williams@nottingham.ac.uk)*

*Supervisor(s): Sarah Godwin, [sarah.godwin@nottingham.ac.uk](mailto:sarah.godwin@nottingham.ac.uk)*

This is an invitation to take part in a research study which investigates whether a parenting programme for parents with anxiety can reduce their children's anxiety. It will also explore parents' views of the parenting sessions.

Before you decide if you wish to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

#### **If you participate...**

- You will be asked to attend **7 weekly group parenting sessions** which will be ran by myself, a Trainee Educational Psychologist, and held at a local school.
- Each session will last between **1 hour – 1 hour 30 minutes**. The time of the session will be chosen based on the best time for most parents.

- The sessions will involve:
  - Completing a questionnaire about any anxiety your child may experience – before and after completing the parenting programme
  - Helping you to **help your child to:**
    - **Recognise and manage their emotions**
    - **Develop their confidence**
    - **Look after their mind and body**
  - **Support for you to:**
    - **Build boundaries for your child**
    - **Recognise good versus bad stress**
    - **Identify your hotspots and reduce the impact they may have on your child**
  - Opportunities for you to have a go at the skills you have been taught each week
  - Time to share your parenting experiences if you are comfortable doing so
  - A group discussion about how you found the parenting programme, in our final session together. This session will be audio and/or video recorded.

Altogether, this parenting programme will last **7 weeks (1 session per week), not including school holidays.**

Participation in this study is totally voluntary and you are under no obligation to take part. You are free to withdraw at any point before or during the study. All data collected will be kept confidential and used for research purposes only. It will be stored in compliance with the Data Protection Act.

***Please be reassured that information that I may be aware of through my work as a Trainee Educational Psychologist will be kept confidential and will not be shared within parenting sessions.***

If you have any questions or concerns please don't hesitate to ask now. We can also be contacted after your participation at the above address.

If you have any complaints about the study, please contact:  
Stephen Jackson (Chair of Ethics Committee)  
stephen.jackson@nottingham.ac.uk

### **Research participant privacy notice** **Privacy information for Research Participants**

For information about the University's obligations with respect to your data, who you can get in touch with and your rights as a data subject, please visit:

[www.nottingham.ac.uk/utilities/privacy/privacy.aspx](http://www.nottingham.ac.uk/utilities/privacy/privacy.aspx).

#### **Why we collect your personal data**

We collect personal data under the terms of the University's Royal Charter in our capacity as a teaching and research body to advance education and learning. Specific purposes for data collection on this occasion are:

- To explore:
  - The effectiveness of an adapted parenting intervention for parents with anxious cognitions, *Parenting with Anxiety: Helping Anxious Parents Raise Confident Children (PWA)* (Cartwright-Hatton, 2021, February 15 - 2023, April), in reducing child anxiety.
  - How parents perceived the intervention
- Together, the findings from this research will be used to inform the practice of Educational Psychologists. It aims to advance the profession's knowledge of how to support the mental health of children and young people of whom Educational Psychologists work with.

#### **Legal basis for processing your personal data under GDPR**

The legal basis for processing your personal data on this occasion is Article 6(1e) processing is necessary for the performance of a task carried out in the public interest

#### **How long we keep your data**

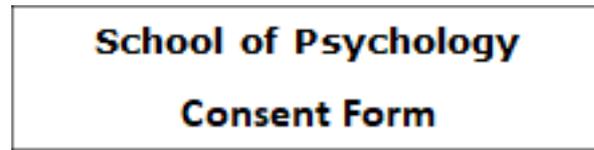
The University may store your data for up to 25 years and for a period of no less than 7 years after the research project finishes. The researchers who gathered or processed the data may also store the data indefinitely and reuse it in future research. Measures to safeguard your stored data include:

- Participant data will be anonymised
- Pseudonyms will be used to refer to participants
- Paper copies of raw data will be stored in a locked cabinet
- Digital copies of data will be password protected and kept on the researcher's personal laptop, password protected, for the time period outlined by the

University of Nottingham's ethical and data guidance, as well as data protection legislation, and then deleted

- Only the researcher, their supervisor and research supervisor will have access to the raw data, including the recording of the focus group.

**Appendix I**  
**Participant Consent Form**



**University of  
Nottingham**  
UK | CHINA | MALAYSIA

***A Mixed Methods Study Exploring the Effectiveness of a Parenting Intervention for  
Parents with Anxiety in Reducing Child Anxiety***

*Ethics Approval Number or Taught Project Archive Number: S1514*

*Researcher(s): Isabel Williams, [isabel.williams@nottingham.ac.uk](mailto:isabel.williams@nottingham.ac.uk)*

*Supervisor(s): Sarah Godwin, [sarah.godwin@nottingham.ac.uk](mailto:sarah.godwin@nottingham.ac.uk)*

The participant should answer these questions independently:

- Have you read and understood the Information Sheet?  
YES/NO
  
- Have you had the opportunity to ask questions about the study?  
YES/NO
  
- Have all your questions been answered satisfactorily (if applicable)? YES/NO
- Do you understand that you are free to withdraw from the study?  
YES/NO

(at any time and without giving a reason)

- I give permission for my data from this study to be shared with other researchers provided that my anonymity is completely protected. YES/NO
  
- Do you agree to take part in the study?  
YES/NO

“This study has been explained to me to my satisfaction, and I agree to take part. I understand that I am free to withdraw at any time.”

Signature of the Participant:

Date:

Name (in block capitals)

I have explained the study to the above participant and he/she has agreed to take part.

Signature of researcher:

Date:

## Appendix J

### PWA (Cartwright, 2021) Intervention Handouts



#### INTRODUCTION

#### MODULE SUMMARY

Welcome to the Raising Confident Children Course.

The course consists of this module and seven more. When you complete a module, you can start the next one straight away. However, we'd urge you to take your time. You will learn a lot of new ideas on this course, and they will need time to sink in, and time for you to practice them. You (and your children) will get the most out of the course if you do practice the ideas that you learn. So, leave at least a day or two between modules. However, this starter module is a bit different; it doesn't give you much to go away and try, so if you want to go straight on to the next module, that is fine.

We have made the course as fun and light-hearted as possible. However you may find that it touches on sensitive areas for you. If so, and you find yourself getting upset, please do seek support from a person in real life.

Above all, throughout this course, please try to be kind to yourself. We will keep reminding you of this - you do not have to be the perfect parent. In fact, there is no such thing as a perfect parent. You just need to be a **good enough** parent. And you are already a good parent - only good parents sign up for things like this. You will be given a lot of information in this course. If this leaves you feeling overwhelmed, please do not worry. You do not have to do all of it! Some parts of it will fit well with you and your circumstances, and others won't. It is fine to take your time, and to focus on some parts more than others.

In this module we want to teach you about two things: **The Fight-Flight Response, and The Seven Confident Thoughts.**

#### THE SEVEN CONFIDENT THOUGHTS

We know that confident children and anxious children think differently about the world. In fact, there are seven key differences. This course is all about getting your children to think like confident children. We call this the Seven Confident Thoughts, and this is what they look like:

- The world is a fairly safe place.
- I can cope with most things.
- Bad things don't usually happen to me.
- Bad things don't usually pop up out of the blue.
- I have some control over my life.
- Other people are okay.
- Other people respect me.

This course is all about different ways to get your child thinking about **The Seven Confident Thoughts.**

#### THE FIGHT FLIGHT RESPONSE

When we are very frightened by something, our body reacts very quickly, to help us to escape from the thing that is scaring us. As you have seen in this module, our body releases adrenalin, to get us ready to run away, or to fight off the enemy. This adrenalin makes a number of things happen:

- Makes us breathe quickly to get lots of oxygen into our bodies. This can make us feel breathless and tight-chested or light-headed. It can also make our mouth feel dry.
- Makes our heart pump blood around to our muscles. This can make us feel as if our heart is racing and make our muscles feel like jelly.
- Takes the bloody away from our digestive system. This can give us butterflies or make us feel sick.
- Turns certain bits of our brain on, and other bits off. This can make us feel odd and a bit out-of-body.
- All of this activity makes us feel hot and clammy and can make us look a bit pale.

These are not nice feelings. But, they are **normal**, and they are **harmless**. Sometimes when people have this 'fight-flight' response, they feel as if they are going to faint, or have a heart attack, or go mad.

But in fact, it is very rare to faint during fight-flight. We faint when our blood pressure is too low, and during the fight-flight response, our blood goes higher (just for a short while).

About **1 in 20** of us can go a bit faint when we are scared, particularly if we are in a situation where we might get cut or see blood. For instance, when having a blood test or injection. This is because our blood pressure temporarily goes a bit low. This is OK. If this happens to you, try using a technique called "applied tension" – this is where you tense and relax your large muscles in your bottom and legs – do this several times until your blood pressure is back up to normal and you feel better.

Some people feel as if they are going mad when they have the fight-flight response. Don't worry - you are not! The fight-flight response feels weird, but it is a completely **normal** human experience.

#### IMPORTANT THINGS TO REMEMBER

There are lots of things that go into deciding whether a child becomes anxious or confident – genes, school, friends, personality, parents, other family, neighbourhood, past bad and good experiences, and much more.

So, if your child shows signs of anxiety, please **do not** blame yourself.

However, as you have seen in this module, parents can make **some** difference. We don't think parents cause their children to be anxious, but we do think that they are in the best position to help their child grow in confidence. We think that parents who take this course are fantastic parents who are prepared to go out of their way to help their child grow up confident and happy.

After each module, we will give you something to go away and try. For this module, we'd like you to think about **The Seven Confident Thoughts**, and how you can start feeding them.

For example, how can you give your child a feeling that they have some control over their life?

#### DIG DEEPER

This short Ted Talk is a really fun one from an over-excitable Swedish doctor. It will challenge any belief you still have that the world is a terrible place.

[https://www.ted.com/talks/hans\\_and\\_ola\\_rosling\\_how\\_not\\_to\\_be\\_ignorant\\_about\\_the\\_world?referrer=playlist-the\\_best\\_hans\\_rosling\\_talks\\_yo#t-61768](https://www.ted.com/talks/hans_and_ola_rosling_how_not_to_be_ignorant_about_the_world?referrer=playlist-the_best_hans_rosling_talks_yo#t-61768)

**THE COMFORT ZONE**

**ACTION PLAN**

Action	When?	What?	Extra notes
X	X	X	

**MODULE SUMMARY**

This module is all about avoidance, and how this feeds anxiety. In this module, you will learn how to get your child to step out of their comfort zone and cope with situations that scare them.

**THE STORY OF THE DRAGON IN THE MOUNTAIN**

Once upon a time, a long, long, time ago, there was a little tribe of villagers. These villagers were poor, but they were happy, for they lived at the bottom of a huge extinct volcano. And, as you may know, volcanoes are very lush and fertile places. So, these villagers had the life of Riley. They would wake up in the morning, and go up the mountain to collect a wonderful feast. All sorts of things grew on this volcano – peach trees, chocolate Hobnob bushes... and the villagers would fill their baskets, eat their fill, and then sleep it off in the afternoon sun. Lovely.

But one day, something terrifying happened. There was a storm. But the villagers hadn't seen a storm like this before - this was no ordinary storm. The thunder crashed and the rain lashed the village. The lightning flashed and silhouetted the volcano against the dark night sky. The villagers were terrified! They huddled together for warmth and said: 'What is happening? 'What is happening to our mountain? Just then, one of the village elders spoke up "Ahhh, it is the dog in the mountain. He is angry with us for taking his food". There were gasps of horror from the villagers as they huddled together from fear and cold.

The next day, the sun rose, and it was time for the villagers to go up the mountain to collect their food... But no one dared go up the mountain... And the next day came, and still no one would dare go up the mountain, and the next week came, and the next month came, and the next year came, and still, no one dared go up the mountain.

As the years went by, the villagers scraped a living on the thin soils around the volcano. Life was not easy, but they survived, on a meagre diet of sprouts and goats cheese. And, as is the way with these things, as the years went by, the rumours about the volcano grew and grew. Soon, it was not a dog in the mountain, but a LION in the mountain. And then, it stopped being a lion in the mountain, and became a DRAGON in the mountain. And, eventually, it stopped being a dragon in the mountain, and became a FIRE-BREATHING, BABY-EATING, DRAGON IN THE MOUNTAIN, and there was NO WAY that anyone was going up there to get food.

Then, one year, the unthinkable happened. The rains did not come, and the crops failed. The villagers had nothing to eat, and soon they were on the verge of starvation. They called a village meeting, to decide what they should do. So, what should they do....?

Thats right, they HAVE to go up the mountain to find out whether there really is a dragon there. And, that is exactly what the villagers decided. They made one of the elders go up the mountain, to see if there really was a dragon. So, the old man started walking up the mountain. His legs were shaky, but he kept walking up the mountain. His chest was tight, he felt that he might faint, but still he walked, up, and up

the mountain. And soon, he reached the top... of... the... mountain....

But just as he reached the top of the mountain, there was a GINORMOUS...

Oh, how old are you..? There's no such thing as dragons. He filled his baskets with food, and climbed back down the mountain where they all had an enormous feast and lived happily ever after.

So, when we tell this story to children, what is our message? That's right. If you have a fear, you must go 'up the mountain'. You must test it out. And what happens if you don't test out a fear as soon as possible? That's right. It gets bigger and bigger and bigger until it is the size of a dragon.

So, the moral of our tale is that if you are scared of something, or your child is scared of something, you have to TEST OUT THAT FEAR". And it's best to test it out while it's still just a little fear.

### WHY AVOIDING SCARY THINGS IS A PROBLEM

- When we avoid scary things, it stops us learning that it will be OK. So, if a child is scared of cats and so never goes near a cat, they will never be able to find out that cats are unlikely to harm them.
- When we avoid scary things, it stops us learning the skills that we need to cope with fear. This means that we stay scared of this scary thing, and it also means that we don't have the skills to cope with new scary things in the future.
- If we avoid something because it feels scary, the fear gets bigger and bigger. For instance, many people who start out with fears of spiders end up with fears of cellars and sheds, and other dark and dusty places that might have spiders living in them.
- It feels so nice when we avoid scary things doesn't it? But, that lovely feeling of relief is a bit of a problem. It feels so nice that when we see the scary thing again, we are driven to avoid it again, and we never get over the fear.

So, we have learned that avoiding things feels nice, but makes us more scared in the long run.

How can you use this information to raise a confident child? There are 2 main things you can do...

- The first is to encourage your child out of their comfort zone - get them to do things that are just a little bit scary for them. For example, coax them into asking for their own sweets at the shop, encourage them to stroke a friendly dog, persuade them to do something on their own.
- The second is to really tackle any of their serious fears or phobias using our braver ladder.

### THE BRAVERY LADDER

Having something that really scares us - something that makes us feel so scared that we have to avoid it altogether is a real shame. Kids with phobias like this can end up missing out on all sorts of things. It feels pretty miserable too. If your child has a serious phobia like this, have a go at making your own bravery ladder or look at our list of ready - made ladders for common fears and phobias.

### DRAWING UP A BRAVERY LADDER

If you decide to design a bravery ladder of your own, this is how to do it:

- At the very bottom of the page, write down what your child can just about do now. For instance, the child might be able to look at drawings of dogs, but no more.
- At the very top of the page, write the goal for the child. This should be fairly ambitious. For

instance, in our example, it might be for the child to be able to stroke a friendly dog for a minute.

- Then fill in some steps in between. Start at the bottom and work up. Most Bravery Ladders have about 6 to 10 steps but it can be as many as needed.
- The first step should be pretty easy - it should be something that the child can already just about do. This ensures that the child has an early experience of success with the ladder.

For example:

7. Stroke a dog for a minute.
8. Briefly touch a larger dog.
9. Briefly touch a small, friendly dog.
10. Look at a real dog from a distance.
11. Look at a video of a dog.
12. Look at a photograph of a dog.
13. Look at a drawing of a dog.

---

#### HOW TO USE YOUR BRAVERY LADDER

- Explain to the child what you are doing.
- Get them involved in planning the ladder.
- Plan a nice reward for completing the ladder.
- Give your child lots of praise for trying each step, even if it doesn't go particularly well.
- You can repeat each step several times if you need to, until your child is really comfortable with it, before moving onto the next one.
- When you move up a step, pay attention to how the first attempt goes. If it goes really badly, consider making the step a bit easier. It's completely normal to end up tweaking the ladder as you go along.
- Should you try this when your child is tired, hungry, grumpy...? No! The best time is when they have a bit of energy - so give them a snack first, and try to find a time when they are fairly relaxed and happy.
- Ideally, do this when you are feeling fairly relaxed too. And have a snack when you give your child one - humans don't work well on an empty stomach.

## THE PLAYFUL PARENT

### ACTION PLAN

Action	When?	What?	Extra notes
--------	-------	-------	-------------

### MODULE SUMMARY

Play is really important to children's mental health. In an ideal world, your child would get lots of play, with at least some time every day playing with parents and with other children.

In the real world, it's not so easy. Schools have cut down on break times and they give more homework. Children don't play out on the street like they used to. Families have got smaller. All of these things mean that it's hard for children to get the play that they need.

There are six types of play. Try to make sure that your child gets plenty of each.

### THERE ARE SIX DIFFERENT TYPES OF PLAY

#### ADVENTUROUS PLAY

It is very important that we learn how to judge risks before we become adults. Children who don't learn this can end up feeling scared of things that aren't really dangerous or taking silly risks. So, how do we learn to judge risk?

Sadly, it's not something you can learn from a book or in the classroom. To learn to judge risk, you have got to get out there, and face some small risks when you are young. Having lots of time for adventurous play is brilliant for this.

But what do we mean by adventurous play? We mean play where you feel a bit scared, and there is a risk of getting a small injury - a graze or a bruise. Adventurous play is the sort of play you get in a playground with climbing frames, slides, swings, trees to climb, and so on. Children also get adventurous play when they are allowed to run around a field or a park without adults watching every step - getting into scrapes, and sorting themselves out.

In short, adventurous play is great for building confidence. It can feel scary letting your child go up to the top of that climbing frame, or out of sight for a few minutes, but if you can manage it, you are doing something that is really good for them.

#### UNSUPERVISED PLAY AND MAKING YOUR OWN FUN

Think back to when you were a child. Try to remember when you were playing and having really good fun. Have you got a picture in your mind? If so, were you being supervised by adults, or not...?

We have asked hundreds of people this question, and about 9 out of 10 say that they were not being supervised by adults! What does this tell us? It tells us that the most fun you can have as a child is away from the prying eyes of grown-ups. Of course, very small children need a grown up nearby, keeping an eye on things. But, for older children, try to give them a little freedom. Let them play where you can't always see them - in the garden, in their bedroom, or when they are a little older, away home altogether.

Also, many parents feel that they have to plan lots of interesting activities for their children - baking, making things, organised games, trips out. This is really nice, and shows an engaged, caring parent. BUT, make sure that your child has enough time for play where you have not organised anything - when they are making their own fun!

Children who often play away from grown-ups, and who have the chance to sort out their own play learn great skills - they learn to solve problems on their own, they learn how to assess risk, and they learn how to fill their spare time with fun.

---

### ROUGH AND TUMBLE PLAY

Do you enjoy watching rough and tumble play, or even joining in? If so, go for it - it's great for your kids. However, lots of parents hate watching it. If that's you - you are not alone! But, try to put up with it! Research shows that kids who are allowed to do rough and tumble play tend to be less aggressive and better behaved.

So, let your children do rough and tumble play - unless one of them is not enjoying it, or someone is at risk of getting badly hurt. The odd bruise or scratch is OK! But don't force it if your child doesn't like it - some children do, and some don't, and that's fine.

---

### PLAY WITH OTHER CHILDREN

When children play with other children, magic happens. They learn social skills they learn new words (including some we'd rather they didn't...) they learn to use their imagination and they grow as human beings.

Children need this. But in the past 20 years, time playing with other children has dropped and dropped - school playtimes have been cut or are filled with clubs and organised activities. Families are smaller, so there is less chance to play with brothers and sisters. Children don't play out in the street, like they used to. Some psychologists think this may be part of the reason that we are seeing an increase in mental health problems.

So, how can you help to put this right for your child? Try to find as many opportunities as possible for your child to play with other children. Sisters and brothers are fine, but if that isn't possible - perhaps the age gap is too large, or they don't get on well, or you have an only child - try really hard to find alternatives. Organise playdates after school and at weekends. If you use childcare, e.g. after school clubs, or holiday clubs, ask whether they include lots of time for free play - not just one organised activity after another.

---

### PLAYING ALONE

Playing alone is less important than playing with other children, but some children do still really need it. If you have a quieter child who enjoys playing alone, try to make sure that they have some time to do their own thing without being bothered by brothers and sisters.

---

### PLAY WITH PARENTS

We all lead such busy lives nowadays. It is easy for family life to end up as a constant round of work and chores, and nagging children to get dressed, do their homework, tidy up their mess. Where do we fit in the fun? But, when parents and children do spend regular time together, having fun, there are fewer arguments, and children are more likely to do as they are told. What's not to like?

---

### TRY THE CHILD'S GAME

There is a very special type of parent-child play called the Child's Game. It is great for children. Try it out yourself. This is how you do it:

- During the Child's Game, the object is to let your child have a lovely, relaxed time, with your full attention.
- Let your child choose what you play. (although try to nudge them towards something you can do together - ideally not a computer game!)
- Turn off the TV and put your phone on silent. This is all about your child - everything else can wait.
- Let them take charge. Kids don't get much chance to be in charge, so let them make up the rules for the next ten minutes, if possible.
- Make it a lovely, happy time. Try not to criticise if they do something wrong - let it go if you can. And don't try to turn it into teaching time - don't ask too many questions.
- Use lots of affection - strokes and cuddles and lots of compliments.

---

### PLAY AND THE SEVEN CONFIDENT THOUGHTS

Play is great for the Seven Confident Thoughts:

---

#### THE WORLD IS A PRETTY SAFE PLACE.

Play is really good for this one, as it is a great way of rehearsing life's little problems in a safe space before you have to deal with them in the real world. Play with parents is particularly good - it helps children to feel very safe and reassured.

---

#### I CAN COPE WITH MOST THINGS.

During play, children are always learning new skills - physical skills, social skills, thinking skills, risk assessment skills, and they will often use play to work through emotional issues. Therefore, all types of play are good for helping children feel that they can cope with the world.

---

#### BAD THINGS DON'T USUALLY HAPPEN TO ME.

Play with parents is particularly good for this one, particularly if parents are being careful not to criticise.

---

#### I HAVE SOME CONTROL OVER THE THINGS THAT HAPPEN TO ME.

Children actually have very little control over their lives, so this is a difficult thought to build. During play, however, children are in control, so this is very good for them. When parents play with their child, and let their child choose the activity, and let their children take charge of it, this really helps too.

---

#### PEOPLE ARE PRETTY NICE REALLY.

Play with parents allows the child at least ten minutes guaranteed positive interaction with another person. This unconditionally positive interaction starts to build this important confident thought. Play with other children also feeds this - even if there are occasional arguments!

---

#### OTHER PEOPLE RESPECT ME.

This can also be a difficult thought to build, but playing with other people builds strong social skills, which helps to forge this thought. Play time with parents also ensures that your child gets a dose of strong, clear messages that they are liked and respected.

#### DIG DEEPER

This short Ted talk is by well-known play researcher Peter Grey. He expands on why play is so good for children, and why the loss of play we see in our children today is so bad for their mental health.

<https://www.youtube.com/watch?v=Bg-GEzM7iTk>

## BE YOUR CHILD'S EMOTION COACH

### ACTION PLAN

Action	When?	What?	Extra notes
x	x	xx	xx

### MODULE SUMMARY

Have you taught your children to ride a bike? What about brushing their teeth? What about teaching them to manage their emotions? Most parents are stumped by this question - in Britain, we don't like to talk about emotions! But, we know that parents who are not afraid of their children's emotions, and who talk about their children's emotions, have children who manage their emotions well.

In this module we show you how to respond when your child has strong emotions. We help you to become an 'emotion coach'.

The key message is that any emotion is OK. There is no such thing as a bad emotion. All emotions are fine - even negative emotions, such as jealousy, anger, fear, sadness, frustration - they are all completely normal, and all completely fine for adults, and completely fine for children.

This is not the same as thinking that any behaviour is OK. So, it is OK to be scared, but not always OK to avoid the thing you are scared of. It is OK to be angry, but not OK to hit out. It is OK to be frustrated but might not be OK to give up. So the rule for this module is any emotion is OK, but any behaviour is not.

### HOW TO BE AN EMOTION COACH

#### 1. SPOT THE EMOTION

First look out for the emotion in your child e.g. sadness, frustration, anger, fear

#### 2. SHOW YOU'VE NOTICED

Let your child know that you have noticed they are feeling an emotion, and you understand. So, if a child has just shouted at his sister, calmly acknowledge this: "I can see that you are feeling very frustrated right now".

#### 3. LABEL THE EMOTION

It is really good to label the emotion that the child is feeling. This helps in two ways:

- It tells your child that you really have understood
- It helps your child to describe their emotions in the future. Children who have lots of words for describing emotions tend to manage their emotions better. In this example, you have helped the child to label their emotion as 'frustration'.

---

#### 4. LISTEN

Listen to see if your child has anything to say. They may surprise you. You do not need to agree with what they say or argue with it or solve any problems that it throws up. Just listen. If they don't want to talk, that's OK too.

---

#### 5. TRY TO SOLVE THE PROBLEM TOGETHER

How do children learn to solve problems? Yes, by doing it! This is one of those things that you can't learn from a book - you've just got to learn by doing it. And, it's one of those skills that can take a while to learn. Your child will need lots of practise, and to begin with, they will probably not be very good at it! It will take patience.

You begin by simply saying "what can we do to put this right?".

Then listen to see what they come up with. There are three possible outcomes here:

- They may come up with nothing. If so, that is OK and it's often fine for you to just offer some comfort. If the problem really does need solving, then you can offer some suggestions.
- They may come up with an idea that just won't work. If so, gently help them to see why it won't work, but don't criticise - they've taken an important first step by even trying. Then offer some suggestions of your own.
- They may come up with a great idea to solve the problem. In that case, tell them it's a great idea, and help them to put their plan into action.

---

#### 6. WHAT IF THE EMOTION LED TO SOME BAD BEHAVIOUR?

Any emotion is allowed, but any behaviour is not! So, if your child's emotion has led to some bad behaviour, what should you do?

- First, it's always good to explain to your child that the behaviour is not allowed and why.
- Then, say "what can we do to sort this out?" If you are in luck, they will come up with a great solution.
- If they don't, and in reality, mostly they won't, then you should use a consequence (psychologist word for a minor punishment) for the behaviour.

---

#### HOME PRACTICE

Before you start the next module, Have a go at some emotion coaching. You can just wait for your child to display some difficult emotion. Or, if your child has a particular situation that often triggers emotion for them, you can plan ahead using the action plan.

If you can use emotion coaching now and then, it will be really good for your children. You really don't have to use it all of the time. Sometimes you won't have the time or the energy and that is fine.

## GET MORE GOOD AND BRAVE BEHAVIOUR

### ACTION PLAN

Action	When?	What?	Extra notes
x	x	x	x

### MODULE SUMMARY

In this module, you learn some tips for getting more good behaviour from your children.

You can also use the tips you learn to get more brave behaviour from your children.

There are three main topics in this module: **Praise, Rewards and Star Charts.**

#### PRAISE

What happens to behaviour if you give it some praise...? You get more of it! So, praise is really great for getting more good behaviours and more brave behaviours.

But, you really want your praise to work well. You want bang for your buck! So here are our top tips.

##### 1. DON'T WAIT FOR PERFECTION

Do you have high standards? Perhaps a bit of a perfectionist? If so, you might be guilty of this one - waiting until your child does something perfectly before you praise. The problem is that your child might give up before they can do it perfectly. Try praising your child for trying hard to do something, rather than waiting for them to do it perfectly.

##### 2. GIVE PRAISE AS SOON AS POSSIBLE

If your child has done something you like, when should you praise them? Tomorrow, next Tuesday, a week on Friday...? Praise should be given ASAP, after the child has done what you wanted. The younger the child is, the more important this is. If the praise is given too late, the child will have forgotten what behaviour it was for, and the praise will lose its power.

##### 3. PRAISE WHAT YOU WANT MORE OF, NOT WHAT YOU WANT LESS OF

This is a very common mistake. Parents try to use praise for behaviours that they want less of e.g. "not fighting with your brother". The problem is, it is impossible to spot and praise behaviours that don't happen. So, this needs to be turned around, so that parents are praising, for example "playing nicely with your brother".

##### 4. SOUND POSITIVE

Sometimes, if we are feeling a bit low, it can sound like we don't mean it when we praise. If you are feeling flat, try extra hard to make your praise really sound positive.

---

## 5. SPECIFIC LABELLED PRAISE

Your boss comes in one day and says "Thanks, that was really brilliant!" and then disappears. Lovely! But are you going to do the behaviour again, to get more praise tomorrow? The problem is, you can't - because you don't know what the behaviour was. Your boss didn't tell you!

It's exactly the same with children. Often we just give a bit of nice but general praise, like 'well done' or 'good girl'. This might feel nice to the child, but it won't help them to do the good behaviour again in the future. Instead, try using **Specific Labelled Praise**. This is where you tell the child what you are praising them for. For example "Well done for getting on and doing your homework straight after school" or "Thank you for hanging your coat up on the peg" or "It's great that you remembered to brush your teeth without me even asking".

Specific Labelled Praise is great for two reasons. First, if the child doesn't know what behaviour they are being praised for, then they won't know which behaviour they need to do to get praise next time. For example, if you just say "Well Done", you think you are praising the child for playing quietly with his sister, but he thinks that he is being praised for the lovely drawing that he has just done on the wallpaper...

Second, giving general praise such as, 'well done' or 'good boy' can sound a bit empty. Do you really mean it? Have you really noticed what your child was doing? On the other hand, if you say: "Well done for tidying your toys away. You did it so fast, and the carpet looks really clear now" or "I really like the colours that you have chosen for your drawing, and you've made such an effort to keep your colouring in the lines" your child knows that you really have noticed them and their efforts.

---

## 6. THE STING IN THE TAIL

OK, hands up, who has ever said this to their child?: "Well done for tidying up your room. It took you ten minutes - I don't know why you can't do it every day."

We've all done it... But, which bit of that praise does the child remember...? It's the last bit - the Sting in the Tail. So, although it feels like you are praising your child, actually, you are criticising them. It actually makes it **less** likely that they will tidy their room next time. When you feel a Sting in the Tail coming out of your mouth, zip it in (like Zippy from Rainbow!).

---

## 7. PRAISE THE EFFORT, NOT THE ABILITY

There is now lots of research showing that children get more resilient if they are usually praised for their effort rather than their ability.

For example, if children get a lot of ability praise, such as: "Oh, wow, you are so clever!"; "You are so good at maths"; "Wow, you are so musical" then when they come up against a hurdle (e.g. a really hard piece of music, a low mark in a test) then they quickly become disheartened and can give up.

However, children who are often praised for their efforts, "Wow, you really did think long and hard about that story you just wrote"; "Those sums were difficult, but you really tried hard"; "That piece of music is tricky, but I love the way you just kept trying" develop real resilience. When things go wrong for them, they have learnt that they can succeed by trying harder.

## REWARDS

Rewards can be really useful, and here we will show you how to make your rewards work like magic.

But before we do, a word about **when** to use rewards. In the past, psychologists were very keen on rewards. We had parents using them for everything. Nowadays, we are a bit more careful...

I want you to imagine a situation...Your child, out of the blue, has decided to tidy up after dinner. They are in a jolly, helpful mood, and in their mind, they tidied up because "I'm a nice helpful person, who likes to do my bit for the family." You come in to find the table clear and the dishwasher running. You are astonished and very pleased!

You decide to offer a reward to get more of this wonderful behaviour, so you tell your child they will get £1 every time they clear up after dinner". So, tomorrow they clear up again. Marvellous! Or is it...? Why did they clear up this time? Well, they may have cleared up because "I will get extra pocket-money!" not because they wanted to be helpful and kind. When we reward a child for good behaviour, their thoughts about why they did that behaviour changes. And it doesn't always change in a good way.

BUT, we are not saying you should give up on rewards completely. Far from it! There are two main situations where rewards are actually really useful

### STUCK BEHAVIOURS

One time it is good to use rewards is for **Stuck Behaviours**. By this, we mean areas that your child is really struggling with. If a child needs to do something that is really difficult for them, sometimes the promise of a reward will get them going - for example, if a child needs to get over a serious fear or phobia - children are rarely motivated to do this without the promise of a lovely reward.

Another example is a child who has fallen behind at school and needs to put in some extra hard work to catch up. This is no fun, and very few children will be motivated to do this without the dangling of a very tasty carrot.

### NATURAL REWARDS

The second situation where rewards are useful, is **Natural Rewards**. The best rewards are the ones that appear to arise naturally because of the child's marvellous behaviour. For instance "You've got dressed so fast this morning, you've got time to play for ten minutes" or "Because you helped me to tidy up after dinner, I've got time to play with you for ten minutes!"

### TIPS FOR USING REWARDS

#### USE CLEAR PRAISE

Give plenty of clear praise at the same time as the reward, so your child knows exactly what behaviour earned the reward

---

#### GIVE THE REWARD AFTER THE BEHAVIOUR (NOT BEFORE)

If we gave you a biscuit right now, and said "OK, I've given you a biscuit because I want you to focus really hard on this module" what would you do...? If you are anything like us, you would eat the biscuit instantly, and it would then make no difference to how hard you focused on the module...Children are exactly the same. If you want a reward to change their behaviour, you have to give the reward **after** you've seen the good (or brave) behaviour.

---

#### GIVE THE REWARD AS SOON AS POSSIBLE AFTER THE BEHAVIOUR THAT YOU LIKED

Children have short memories, and the longer you leave the reward, the less they will link it with the good or brave behaviour. Give the reward as soon as you can.

---

#### ALWAYS REMEMBER TO GIVE THE REWARD

If you promise a reward, you must give it. If you don't, your child will not believe you when you promise a reward in future, and they won't work for the reward. It is important that children learn that they can trust what we say.

---

#### NEVER TAKE A REWARD AWAY

It is SO tempting to remove a reward as punishment for bad behaviour. But, what if your boss came in to work one day and said, "you did some good work last week, but you made some mistakes yesterday, so I've decided that you're not getting paid". You'd be livid! What are the odds of you staying in that job for long? Very slim! If a child can't be completely sure that they will get the reward and keep the reward, they will not make the effort. The golden rule is to **keep rewards and punishments completely separate**.

---

### CHOOSING GOOD REWARDS

---

#### REWARDS CAN BE FREE

Some of the best rewards are free - extra time playing with Dad; a game of football in the garden with Mum; staying up half an hour late to watch the match; choosing what to have for lunch.

Rewards that involve extra time with you are called **Social Rewards** and they work really well.

---

#### REWARDS SHOULD NOT BE EXPENSIVE

If rewards are expensive, your child might find it difficult to get motivated for smaller rewards in the future. Pound shops are good sources of cheap but exciting rewards. But, if you are using a star chart to collect up stars, you can have a bigger reward at the end of that.

## MODULE SUMMARY

### MIND AND BODY

People tend to think that good mental health comes just from the brain. But it doesn't. Looking after our body can make a big difference to how we feel in our head.

We will show you how **exercise, sleep, caffeine and food** can change your child's mental health - for better or for worse.

### EXERCISE

We all know that we should be getting lots of exercise to keep our bodies healthy. But did you know that exercise is really good for mental health too? Studies show that moderate exercise, a few times a week, is as good for anxiety as a short course of talking therapy!

And, we think that exercise is even more important for children's mental health. Children who get lots of exercise are happier, more confident and better behaved.

But, there is a problem... It is really hard for today's children to get enough exercise. When we were at school, we had a break in the morning and the afternoon, and a long play at lunchtime. We would often be sent out to run around a lovely, big playing field. Then, when we got home, we would run about with the local kids until it was time to come in for tea.

Many schools no longer have playing fields. The afternoon break has gone in most schools. Lunchtime is for clubs and catch-up lessons. In short, children are getting far less exercise than they used to.

Some people think this is why we are seeing such a rise in mental health problems in children.

### EXERCISE TIMETABLE

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

### ACTION PLAN - EXERCISE

Action	When?	What?	Extra notes
x	x	x	x

### SLEEP

How do you feel when you've not had enough sleep? Grumpy, jumpy, overwhelmed? Scientists now realise that getting enough sleep is very important to good mental health. Sleep experts suggest that adults need at least seven hours a night, even if they don't think they do.

But how much sleep do children need? That is a tricky question, because it is different for every child. It changes with age, but even children of the same age might need very different amounts. If you are not sure, ask yourself these questions:

- Does your child often fall asleep in the car?
- Is it often hard to wake your child up in the morning?
- Does your child often sleep in longer at the weekend?
- Does your child often fall asleep during the day (if they are over 4 years of age)?

If you answered **yes** to one question, your child might not be getting enough sleep. If you answered **yes** to more than one question, it is very likely that they are not getting enough sleep – see if you can get them to bed a bit earlier and have a look at our top tips for a good night's sleep.

#### **Routine**

Sleeping and waking run in cycles that are controlled by our bodies. So, if we try to go to sleep or wake up when our body is not expecting it, it causes problems. It's a bit boring, but the best thing we can do is have a really regular sleep-wake routine. This means going to bed at roughly the same time every day and waking up at roughly the same time every day. Ideally, this also includes weekends.

#### **Wind-Down Time**

Our brain needs to get the message that it's now time for bed, so make this good and clear! For the last hour before bed, make sure your children are doing relaxing things – maybe having a bath, reading, or listening to a story. Try to keep the lights low and the room quiet.

#### **Screens**

Screens (computers, tablets, phones, TVs) all give off a lot of blue light. Unfortunately, when our brain sees blue light, it thinks that it's sunshine and that it must be daytime. Time to wake up and be active! Try to avoid any screens in the hour before bed. If you must use a screen, turn the display to night-mode. This reduces the amount of blue light - the screen looks slightly pink.

#### **Light**

If we sleep in a room that is too light, our brain can detect this, and it doesn't like it. Some scientists think that if the room is too light, our brain doesn't go into deep sleep – it stays a tiny bit alert. You may have noticed this on summer mornings, when it is light at 5am and you wake up far too early. If possible, get some blackout blinds, or line the curtains with black-out material. Of course, lots of children are scared of the dark and don't want to go to sleep in a pitch-black room. If your child is like this, use the dimmest light you can find when they are falling asleep. Then, if possible, creep in later, when they are asleep, and turn it off.

#### **Food**

When we eat food, our body has to work quite hard to digest it. We don't want our bodies working that hard just before bed, so avoid eating half an hour before bed.

#### **Daytime Sleep**

Young children (up to the age of about three or four) need to sleep in the day. But after four, try to keep them awake all day. They will sleep much better at night.

## Exercise

Doing some exercise is great for getting a good night's sleep. But exercising just before bed can stop us falling asleep. Keep the last hour before bed quiet and calm if you can.

### ACTION PLAN - SLEEP

Action	When?	What?	Extra notes
x	x	x	x

### CAFFEINE

Long story short, caffeine is bad for children's brains. The jury is out on whether it's bad for adults, but we know that it's really not good for kids. It is best if children have no caffeine at all.

Caffeine can be found in all sorts of things, including:

- Cola and diet cola.
- Energy drinks (e.g. Red Bull, Monster).
- Coffee – even decaf coffee has some caffeine in.
- Tea, including green tea.
- Dark chocolate.

If you have decided to cut down caffeine for your child, just be careful to do it gradually - especially if they are used to having a lot of caffeine. Stopping caffeine too suddenly can lead to headaches, grumpiness and being unable to focus on schoolwork, although these will usually get better after a week or so.

### MOOD FOOD

Scientists are starting to pay attention to the link between food and mental health. What we eat, can really affect our mood.

You've probably heard all about the good and bad bacteria that live in our gut. Scientists have found out that having good bacteria helps us to make extra brain chemicals! And, even better, they make lovely, feel-good chemicals that we need to be happy and confident. So, how can you get more of this good bacteria into your gut and your children's guts? There are two main things to do:

- **Eats lots of good bacteria**

You can buy tablets with these in from health food shop, but you can also get them from live yoghurt (check it says Live on the carton) and from fermented foods such as kimchi and sauerkraut (make sure they have not been pasteurised as this kills the good bacteria).

- **Feed the good bacteria**

Once the good bacteria are in your gut, they need the right foods to keep them alive. They love wholegrains (e.g. wholemeal bread, brown rice and wholegrain pasta) and they adore fruit and veg.

Look after your gut, and it will look after you!

### ACTION PLAN - FOOD

Action	When?	What?	Extra notes
x	x	x	x

### DIG DEEPER

In this short Ted Talk, renowned sleep Doctor Matt Walker explains why getting enough sleep is your (and your child's) superpower.

[https://www.ted.com/talks/matt\\_walker\\_sleep\\_is\\_your\\_superpower?language=en](https://www.ted.com/talks/matt_walker_sleep_is_your_superpower?language=en)

In this short and very enthusiastic Ted Talk, neuroscientist Wendy Suzuki will convince you that exercise is the key to a happy life.

[https://www.ted.com/talks/wendy\\_suzuki\\_the\\_brain\\_changing\\_benefits\\_of\\_exercise?language=en#t-5540](https://www.ted.com/talks/wendy_suzuki_the_brain_changing_benefits_of_exercise?language=en#t-5540)

In in this short Ted Talk, British diver Leon Taylor shows how exercise saved him from a diagnosis of ADHD (and got him an Olympic medal).

<https://www.youtube.com/watch?v=rkZI2gsLUp4>

Want to know more about how your food affects your mood (and your children's mood)? Download this free booklet from the brilliant charity Anxiety UK.

<https://www.anxietyuk.org.uk/products/anxiety-condition/anxiety/nutrition-and-anxiety-a-self-help-guide/>

## PROTECTION AND OVERPROTECTION

### ACTION PLAN

Action	When?	What?	Extra notes
x	x	x	x

### MODULE SUMMARY

#### GOOD STRESS AND BAD STRESS

No one wants their children to be stressed and unhappy.

But, did you know that there are two types of stress that children experience, and only one of them is bad...? The bad type of stress is when frightening, bad things happen again and again, that you feel you have no control over. Children feel bad before they happen, bad while they're happening and bad after they've happened, and they have no way of stopping them. These are the sort of things you never get used to with practice.

But there is also a good sort of stress that children actually **need**. This good stress is the sort where it might feel bad before it happens or while it's happening, but afterwards it feels OK, or even good. An example of good stress is being in a show at school. This good stress actually helps our children's brains to develop. It gets their brains ready to cope with the bigger stresses of adult life. Children who don't have any of these good stresses can struggle as adults.

#### GOOD STRESS

##### **Climbing to the top of the climbing frame .**

This is a good stress. It teaches children how to assess risk and how to cope with feeling a bit scared. It also teaches physical skills for staying safe when you are high up and grows children's confidence.

##### **Fall outs with friends.**

As long as it isn't happening all the time, this is a good stress. It teaches children important social skills. It teaches that relationships can be put right and gives some skills for doing this. It teaches children skills for coping with feeling sad and upset.

##### **Sometimes doing homework without help and making mistakes in it.**

This teaches children how to keep focussed without help. It teaches them that they can make mistakes, and this is OK – this is good protection against perfectionism.

##### **Going on a sleepover.**

This teaches children that they can cope without you by their side. It teaches them to cope with a little bit of homesickness. This will help lots when they are older and go away on school trips.

**Taking up an activity where they could get hurt, e.g. gymnastics or martial arts.**

This teaches children how far they can push themselves without hurting themselves – what risks are safe and not safe. It will teach them that they can cope with a little bit of pain. It teaches them how to deal with the stress of competitions and grading exams. This is very useful for when they are older and have to take much more important exams.

**Doing something where they could skin their knees, like roller skating.**

We always say, “a scraped knee is a happy knee”. It teaches children how to assess risk and know when something is safe and not safe. It teaches children to cope with a little bit of fear. It teaches children to cope with a little bit of pain.

**Trying out for the school football team when they have got two left feet.**

Although your child might be disappointed at not getting in, this is actually good! It teaches children to cope with the nerves of trying out. It teaches them to cope with little failures, so they are ready to face bigger ones as adults.

**Playing in the mud and getting filthy.**

This teaches children that they can cope with being a bit dirty – it is a good way of warding off OCD. Dirt is also really good for building a strong immune system. Children who get dirty are less likely to suffer from asthma and eczema and some allergies.

**Having to help around the house.**

This helps children to grow into responsible, capable adults. Children who are expected to help out are also less likely to grow into entitled adults.

**Not always getting everything you want.**

We all like to spoil our children sometimes and that is fine. But it is good if they sometimes don't get everything they want. It teaches children to delay gratification. It teaches them about disappointment, and how to deal with it. This is an important skill!

---

**BAD STRESS**

**Hearing serious arguments between parents.**

This is a bad stress, especially if it happens lots or if the arguments are really nasty. It produces chemicals in children's brains that makes them more likely to grow up anxious. However, we all argue sometimes. Don't beat yourself up if it happens occasionally. In fact, if you have calm disagreements, and then sort these out in a calm, respectful way, this is teaching your child helpful conflict resolution skills.

**Seeing adults being violent.**

This is a really bad stress. It makes the world feel very unsafe and it can teach children to be violent. Try as hard as you can to stop your child from seeing adults being violent.

**Being called names such as 'lazy' or 'stupid'.**

When children are called cruel names, especially by parents, they store these names away. Later, they

start to use these same cruel names when they are talking to themselves. This is very damaging to self-esteem.

#### **Being bullied.**

Being bullied by anyone is really bad for mental health. Do try to protect your child from this sort of stress.

### **BENEFITS OF RUBBING THE CORNERS OFF OVERPROTECTION**

#### **CHILDREN LEARN VALUABLE SKILLS**

When parents cut down on overprotection, even a little bit, their children learn how to assess risks and how to cope with life's little problems. These are things that can't be learned from books, or in a classroom. They can only be learned by doing them.

#### **CHILDREN GROW IN CONFIDENCE**

Letting go a little really helps to boost the Seven Confident Thoughts.

#### **PARENTS FEEL GOOD**

Lots of parents have told us that when they do something really hard for the sake of their children, like dropping overprotection, they feel absolutely great afterwards.

#### **BEING IMPRESSED BY YOUR CHILDREN**

Parents often haven't had the chance to see how sensible their child can be. Most typically developing children have a very strong inbuilt survival mechanism and will not put themselves into very dangerous situations.

This may be different for some children who have difficulties, such as learning disabilities, Autistic Spectrum Conditions, or ADD/ADHD. But, if you have a typically developing child, let them show you how sensible they can be.

### **HOW TO REDUCE OVERPROTECTION**

#### **TALK TO OTHER PARENTS**

There is a rule of thumb that we use here: If two thirds of the parents in your kid's class think something is OK, then it is worth considering for your child.

#### **TALK TO YOUR CHILD'S TEACHER**

If your child has a helpful teacher, ask them what they think. For example, if a teacher thinks it's OK for your child to walk to school alone, it probably is.

#### **IF I WAS A CONFIDENT PARENT...**

What would you do if you were a confident parent...? Sometimes, putting yourselves in the shoes of

someone confident can give you the answer that you are looking for. So, ask yourself “what would I do if I was really confident...?”

---

#### BABY STEPS

It is **hard** to do the things we talk about in this module. When psychologists are helping people to get over fears and phobias, we don't do it all in one go. We do it gradually, helping our client to get over their fear little by little, using baby steps. This situation is just the same – you are tackling your fear that your child might come to harm. Be kind to yourself and do it little by little.

---

#### REMEMBER THE STATS

Can you remember the facts and figures that you learnt in the first module? If not, pop back and remind yourself how safe life is for British children growing up in the 21<sup>st</sup> Century. Kelly reminded herself of the incredibly low risk of stranger kidnapping when she was learning to let her children out of sight. Rachel reminds herself of the very low death rate in children when her daredevil daughter is climbing to the top of the highest climbing frame.

---

#### TEST OUT YOUR FEAR

When we are really anxious about something, our worries tell us all sorts of things that are not true! Try to really check out these worries. For example, Sanj decided to let his anxious 8-year old go to a party without him for the first time. It felt scary for both of them. Sanj used the experience to test out his fears. He did really well and discovered that Sophie coped really well, and did not come to any harm. He also found out that although he himself felt very nervous, he coped with this, and was not sick.

---

#### TRY THE 'BE CAREFUL' CHALLENGE

How often, in the course of one day, do you utter the following words: “**BE CAREFUL**”. Your challenge is to halve the number of times you say it. Give it a go!

---

#### BUT BE KIND TO YOURSELF

Cutting down on overprotection is hard. So, please remember to be kind to yourself. You **do not** have to become the most laid-back parent on earth. Just making small changes will really benefit your children. And, you **do not** have to do it all at once. Take it at your own pace and get some support from friends and family if you can.

---

#### WHEN IS IT OK TO BE VERY PROTECTIVE?

##### Road Safety

If there is one thing that is a risk to the safety of British children in the 21<sup>st</sup> Century, it is roads. Parents have our full permission to really go to town in training their children to be as safe as possible around roads. If this means letting them know how very dangerous the roads are, then that's OK.

##### The Media

The world would be a better, happier place if we were not constantly bombarded with stories that tell us that the world is a dangerous place, that awful things happen, often carried out by truly evil people. In

other words, much of the news media – newspapers and magazines, TV news, the internet – do their very best to chip away at the Seven Confident Thoughts. We think that children should be protected from these things for as long as possible. As a rule of thumb, the last year of primary school is a good time to start letting children have a little bit of access to the news. Before that, children barely need to know that ‘news’ even exists.

A good place to start children on news is BBC’s Newsround. They think very carefully about how they present difficult stories and have a child psychologist who advises on tricky areas. When your children start watching/reading the news, sit with them, to help them make sense of it. Parents should point out, very clearly, that the media presents a biased view of the world and is trying to make things seem as scary as possible.

#### **Social Media and the Internet**

Ideally, children under the age of about 13 wouldn’t have any access to social media and only very restricted access to the internet generally. Unfortunately, that’s not the world that we live in. So, these tips are aimed at primary school aged children. For advice on keeping older children safe, see the net-aware link below and in the Dig Deeper section at the end of this module.

1. Hold off getting your child their own device for as long as you can. However, there comes a point (and it seems to vary school by school) where almost all children will have one. When they get their first device, get agreement from them that they will use it safely and sensibly, and have a conversation about what that means.
2. Once your child has their own tablet, phone, or computer, tell them that they must ask you before they download any new apps or join any new sites. Better still, set up their device so that they cannot do this without you entering a password.
3. Most apps and social media sites have an age requirement, for example, users must be aged over 13. These rules are often flouted, but do try to enforce them.
4. When your child downloads a new app or joins a new site, dive straight into the app/site’s privacy settings and lock these down as tightly as you can. If you don’t know the site, look on the net-aware link below – it’s got info on all the most popular sites and apps. Annoyingly, companies can change their privacy settings with warning. Do an occasional check that your children’s apps and sites are still fully locked down.
5. Where possible, encourage your children to use their devices in communal areas, so that you can keep an eye on what they are doing.
6. Consider getting an overall security programme with parental controls for your child’s device. This will help to prevent your children from accidentally seeing inappropriate content. Some can also help you to enforce time limits and monitor the websites your child visits.
7. Follow your primary aged child’s online accounts, but do tell them that you are doing this.
8. Talk about the importance of keeping online friendships in the online world.
9. Make sure location is turned off on apps.
10. If your child is spending a lot of time online or gaming, consider imposing some time limits.

<https://www.net-aware.org.uk/>

## WHERE ARE YOUR HOTSPOTS?

### ACTION PLAN

Action	When?	What?	Extra notes
x	x	x	x

### MODULE SUMMARY

We've all got bits of ourselves that are not quite perfect, and, when you become a parent, those bits have a habit of coming along and poking their fingers into your parenting.

These not-quite-perfect bits of our personality, that interfere with our parenting, are called 'parenting hotspots'. **Every parent on earth** has hotspots. The best parents are not hotspot-free...they simply know where their hotspots are, and they watch out for them.

In this module, we talk about some of the main hotspots that can happen if you have a lot of anxiety in your life. When you find a hotspot, you **do not** need to obliterate it. The point is to be aware of the hotspot, then put a few simple measures in place to **reduce** its impact. It's fine and normal to have a few hotspots. Your job is not to remove them completely, but just to rub a few corners off them.

### KIDS COPY THEIR PARENTS

Parents are their children's first and best teachers! Your children will have learned all sorts of wonderful things from you. Unfortunately, children learn our bad habits too! This goes for all of us - not just anxious parents.

As you will have seen on our videos, when we feel really anxious, our fear can pour out of us. And if our children are nearby, they can learn our fears and worries.

When we are scared and worried, it is always really good to talk to another adult. But try to talk when **no children are nearby** and could overhear.

But there is some good news too! Luckily, just as children can learn to be scared by watching someone else be scared, they can learn to **be brave** by watching someone be brave. So, whenever you are feeling brave, and manage to do something that really scares you, let your child see you.

But what if there is something that scares you so much that you know you can never be brave about it? Fear not! There is a little trick that you can use for this... It is called 'Compensating'.

### COMPENSATING

So, children can 'catch' fears from seeing other people be scared. But, they can also learn to be brave by watching other people be brave. In particular, if children have a really good first experience of scary things it is much harder for them to 'catch' that fear later!

But how can you give your child a great first experience when you are scared? You delegate! Get someone who is not scared to do it for you.

Follow these simple steps...

### PICK A FEAR

---

Decide what fear you want to protect your children from. Perhaps you are afraid of dogs, and do not want to pass this on to your children.

### FIND YOUR HELPER

---

Find someone who is happy to play with the scary thing with your child. Ideally they should be:

- Someone who is very confident with the scary thing (e.g. totally happy with dogs – happy for dogs to jump up at them, lick them, etc.).
- Someone who has a good relationship with your child. Ideally, this would be someone that your child looks up to a bit, such as the other parent, a big sister, favourite uncle, etc.

### TELL THEM TO JUST HAVE FUN!

---

The person doing the compensating doesn't have to do anything special. They should just play with your child and the scary thing for twenty minutes or so. If possible, this should happen on several occasions.

### STAY OUT OF THE WAY!

---

It is probably best if you stay well out of the way while the compensating is happening. You won't be giving off good vibes!

### MIND THE GAP

In this section, we think about whether your anxiety might cause some gaps in your child's experience. Please remember here, that nobody is the perfect parent!

For instance, we've worked with many anxious parents who find that their shyness means their child misses out on going to busy, noisy places. We've worked with other parents whose OCD means that having friends round for playdates is tricky.

If you can spot these gaps, that is **great** because it means you can think of ways of filling them - often by getting other people to help.

You do not have to do it all by yourself, and, please remember, you do not have to destroy your hotspots - you just need to know where they are and rub the corners off a little.

### FIND YOUR CHILD'S GAP

---

Here is a list of common gaps that parents at our clinic have told us about. Have a look and see if any fit for you. But, we are all different, so you may be able to find other gaps that are particular to your family.

- We rarely have people round to play so my children miss out on 'playing host'.

- We don't have many visitors to the house, so my children don't learn how to deal with that.
- I can't go out in the dark, and so my child never does either. I don't want them to be scared of the dark.
- I can't trust people, even people I know fairly well. So, my child has never had a sleepover with friends.
- I can't go on buses or trains, so my children have never done that. This means they don't know how to do it and are a bit scared of it.
- I can't bear being in crowded places, which means my children don't ever go in them either.
- I can't go to supermarkets, so my children have never been in one either.
- I can't cope with lots of mess, so my children have never had a friend round to play.
- I like my children to be very clean because of my fear of germs. So, my children have never had the experience of getting really dirty or doing messy play.
- I am scared of dogs and avoid them at all costs. So, my children have no experience at all with dogs.
- I am scared of flying, so my children have never been on an aeroplane.
- I'm terrified of snakes, so we have never been to a zoo.

---

#### DECIDE WHETHER THIS A PROBLEM

Not all of the gaps that parents identify are problems. Is it a problem if a child has never been to a zoo? No – it's absolutely fine! Is it a problem that a child has never been on a plane? No, it's not a big problem at all – in fact, the environment will be thanking you!

But some gaps can cause problems. So, if your child has never (or hardly ever) been on a bus or train, that is possibly a problem. Children can feel very scared of things they have never done, and no one wants their child to be scared of using public transport. Similarly, they might be missing out on learning important social skills or life skills – a child who has never hosted a playdate may have some catching up on the social skills needed to be a good host. A child who has never been in a supermarket will not know how to find and use a trolley, find the goods they need, and how to pay at the end. They can pick these skills up as an adult, but it's much easier, and less scary, if you get a head start as a child.

---

#### START TO FILL THE GAPS

##### GET SOMEONE ELSE TO HELP FILL THE GAP

---

There is an old African saying that 'it takes a village to raise a child'. Children do best when there are lots of good people who have an influence in their lives. So, delegate! If you can't take them on trains, or out in the dark, or to parties, or to the supermarket, get someone else to do it.

##### BUT GO EASY ON YOURSELF!

---

Remember that you do not have to destroy your hotspots completely! You are just trying to rub the corners off. So, for example, if you decide to steel yourself and hold a playdate, do it as painlessly as you can. So, do as Maria did – you don't have to invite the whole class! Just pick one quiet, well-behaved child.

#### PERFECTIONISM

Every perfectionist that we have ever asked, has told us that they do not want their children to be perfectionists. They know that their own perfectionism can really hold them back sometimes. So, how do

you help your children to grow up with slightly more reasonable standards for themselves?

---

### SHOW YOURSELF BEING NOT QUITE PERFECT

One of the best things you can do is show your child that you can accept imperfection in yourself. You could:

- Deliberately make little mistakes and show that it's fine.
- Deliberately do things to a lower standard than usual.

When you do this, make sure your child has noticed. For example, upon leaving the kitchen a bit messy after dinner say, "That'll do for now, I don't feel like doing any more tidying right now."

---

### ACCEPT YOUR CHILD'S LITTLE FAILURES AND IMPERFECTIONS

- Look out for times when your child does a 'good enough' job and praise them for this.
- Avoid praising them for doing things perfectly.
- Avoid criticising them for doing things not quite perfectly.

---

### ENCOURAGE PROGRESS OVER PERFECTION

Schools are doing this nowadays and we think it's a really good idea. Instead of encouraging children to make their work perfect, they encourage them to think about just making progress. So, this piece of work does not have to be perfect, it just has to be a tiny bit better than the last one.

### DIG DEEPER

This inspiring Ted talk isn't directly about Mind the Gap. But, it is one of the best things we've ever seen about being a quiet, introverted person, which a lot of our parents are, and a lot of our parents beat themselves up for.

Yes, if you are very quiet, this might make one or two gaps for your child, (but you know how to deal with that now, right?) Now watch this, and revel in the marvelousness of the quiet person.

[https://www.ted.com/talks/susan\\_cain\\_the\\_power\\_of\\_introverts](https://www.ted.com/talks/susan_cain_the_power_of_introverts)

## BOUNDARY BUILDING : SETTING CLEAR LIMITS FOR CHILDREN

### ACTION PLAN

Action	When?	What?	Extra notes
x	x	x	x

### MODULE SUMMARY

All children do things that are annoying sometimes or refuse to do what they are told. In this module, we will show you how to deal with this without chipping away at the Seven Confident Thoughts.

In this module, we learn how to talk to children in a way that makes them most likely to comply. We call this setting limits. We also look at what you do if they don't comply. We call this this Consequences. We will also talk briefly about Time Out.

Do children need boundaries? Yes, they do. Happy, confident children tend to have parents who set a few clear, fair rules. These children feel safe, feel they can cope, and feel in control. In other words, they develop the Seven Confident Thoughts.

However, try not to have rules for absolutely everything - just for key areas that are important to you.

### TIPS FOR SETTING LIMITS

#### GIVE CLEAR COMMANDS

What is wrong with saying something like "Pull your socks up! Behave! How many times do I have to tell you...?" The problem is, it's not telling children what we want them to do. If you want a child to do something, tell them exactly what. So, say something like "please put your coat on now" or "I expect you to play kindly with your brother. Hitting is not allowed".

#### GET YOUR CHILD'S ATTENTION

You go to the bottom of the stairs and yell: "Tidy up your toys please!" What is the problem with this? The problem is that the child might not have heard. Plus, you've got no idea whether they have tidied up, and you won't know whether you need to follow up the command or praise the child for tidying up.

#### ONE COMMAND AT A TIME

"I want you to go upstairs, wash your face, brush your teeth, don't drop your towel on the floor, get into your pyjamas - the clean red ones in your bottom drawer, and don't forget to put your clothes in the laundry basket!"

What was the third thing on the list? Most adults can't remember - so it's too many orders for a young child. For young children, just one command at a time is best. As children get older, or a behaviour gets really well learned, two or possibly three commands can be used.

---

### tone of voice

Sometimes, when we are at our wits' end, this can show in our tone of voice. So, we plead with our children - "pleeeeeease tidy up your toys, pleeeeeease, for Daddy?". What is the problem with this? If we plead with our children, who is in charge...? That's right - the child!

Sometimes, instead, we might shout or yell. What is the problem with that? Shouting has a number of problems: it shows that we are losing control, and things can escalate into a full-scale argument. It's also frightening for children and can chip away at the Seven Confident Thoughts. Perhaps most importantly, it can teach children to shout to get what they want.

So, if possible, keep it calm but firm!

But, don't beat yourself up if you shout from time to time. Most parents do, and you do not have to be perfect!"

---

### QUESTIONS, QUESTIONS...

"Right can you put your toys away now please?" For many children, this will be fine. But for some children, they will simply say 'NO!'. If you've got one of these children, try saying "Put your toys away now!" instead.

---

### USE THE WORD 'NOW'

If you want something done now, let your child know.

Parents sometimes feel a bit rude saying "please set the table **now**". But, if you don't say "now", your child is free to decide when they do it.

---

## GOOD IDEAS FOR GIVING COMMANDS

Here are some of our favourite commands:

---

### WHEN-THEN COMMANDS

'When-Then' commands are like magic bullets. An example is, "**When** you have done your homework, **then** you will have time to watch TV". Your child is told what behaviour is expected, and what nice thing will follow. 'When-Then' commands are easy to understand, even by quite young children, and those with mild language difficulties. Think of some 'when-thens' that you could use with your child. It is important to keep it positive and to ensure that the "then" is a nice thing, not a punishment.

---

### CHOICES

No one likes being told what to do, and children are no exception. But, parents can soften the blow by giving choices or alternatives. For instance "do you want to wear the red socks or the blue ones?" This makes it clear that they need to put some socks on but gives them some control. Similarly, "you can't watch TV, but you can play with this game" is much more likely to get compliance than just telling the child to stop watching TV. Remember, feeling in **control** of your life is one of the Seven Confident Thoughts.

---

### FIVE-MINUTE WARNINGS

Children like a bit of notice when they've got to do something. That way, they can finish what they are doing, and get their head in the right place. So, where possible, try to give them a five-minute warning: "You've got five more minutes before it's time for pyjamas"; "Just letting you know that we will be leaving the park in five minutes". Children are much more likely to comply, and much more likely to come without a fuss, if you use the five-minute warning.

Using the five-minute-warning is also great for the Seven Confident Thoughts. It feeds strongly into "**I have some control over my life**" and "**Bad things don't pop up out of the blue**".

---

### COUNTING TO FIVE

Some children can need a bit of time to do as they are told. You see this lots, particularly in children who are prone to stubborn or impulsive behaviour, or those who do not process information quickly. If you dive in too fast, this does not allow the child to consider their response. So, if possible, give your child five seconds to do as you ask. So, for example, Mum has asked Joey to put away his ipad. Joey has flat refused. Mum gives a warning: "Joey, put away your ipad now, or I will put it away and you won't have it again until tomorrow". Joey still refuses. "OK, I'm going to count to five, and then it is going away..." Mum counts to five (fairly slowly). Joey has learnt that his Mum means what she says, and by the time she gets to five, he starts putting his Ipad away.

Another version of this appeals to children's fierce sense of independence. Children who have mastered skills like getting dressed and washing their hair usually hate having their parents do it for them. So, if a child is dragging their feet about doing this sort of thing, threatening to do it for them can move things along. For example: "Please get dressed by the time I count to five, or I will have to dress you."

---

## CONSEQUENCES

Most of us can remember a time when we were unfairly punished for something as a child. It felt terrible!

There are lots of things to think about when you are giving your child a consequence. But don't worry, there is one Golden Question to ask yourself, and if you always have this question in mind, it will help you get it right. **Am I giving this consequence to make myself feel better, or to help my child to learn?**

When we are angry with our children, it is easy to slip into harsh punishments that make us feel better, but don't help the child to learn better behaviour. If you can always pause and ask yourself "**Am I doing this to make myself feel better, or to help my child learn?**" you won't go far wrong.

---

### TOP TIPS FOR CONSEQUENCES

---

#### IF YOU CAN'T THINK OF A GOOD CONSEQUENCE STRAIGHT AWAY

If you threaten a consequence, you have to follow through with it! If you don't, your child will learn that they can ignore you. Nightmare! If you give a daft consequence, in the heat of the moment, it is fine to change it to something more sensible later. But try to not do this too much. If you can't think of a sensible consequence straight away, it's OK to do it later when you have calmed down.

### **DON'T MAKE A CONSEQUENCE TOO SEVERE**

---

The word 'discipline' actually means 'teaching' in Latin, and that is what it should do - teach the child how to behave. Research shows that if parents are too harsh, they just make their child scared, and feeling scared actually stops children from learning properly.

### **MAKE SURE THE CONSEQUENCE IS OVER AND DONE WITH QUICKLY**

---

If the child has to wait too long for the consequence, they may forget what the consequence was for, and won't learn from it. Also, children tend to feel quite angry with parents while consequences are hanging over them.

### **TRY TO MAKE SURE THAT YOUR CONSEQUENCES DON'T IMPACT ANYONE ELSE**

---

Try to make sure that your consequences don't impact on other members of the family. For example, cancelling a trip to the park for everyone, not just the child who has misbehaved. This is unfair on the other children and will chip away at their Seven Confident Thoughts.

### **AVOID NAME-CALLING**

---

It can be tempting to call children names when they have done something very annoying. For example, calling them 'lazy' or 'naughty' or 'stupid'. Try to avoid this. When people are called lots of names as a child, they end up calling themselves the same names when they are older. This can affect self-esteem and confidence.

### **AVOID USING THE BEDROOM FOR CONSEQUENCES**

---

Try not to use the bedroom for consequences. The bedroom should be a happy, relaxing place, so we don't want children associating it with punishment and upset.

### **TRY NOT TO HAND THE DISCIPLINE TO OTHER PEOPLE**

---

Sometimes we feel at our wits end with our children. It can be tempting to hand over discipline to other people - out partner, teachers, Santa! Try not to, as it can tell the child that you can't cope.

### **KEEP CONSEQUENCES PRIVATE**

---

Some anxious people say that their anxiety began when they were shamed or humiliated in public. So, try to keep consequences private, and not humiliating.

### **MAKE SURE THE CONSEQUENCE ISN'T FRIGHTENING**

---

Consequences aren't meant to be frightening. Consequences are meant to help children learn better behaviour, but fear actually stops children from learning properly.

### AVOID HARSH AND HARMFUL CONSEQUENCES

---

In the past, people used to use quite harsh punishments - sending the child to bed without dinner, for example. Nowadays, this is seen as unacceptable. Children should never be denied basic needs such as food, shelter, healthcare or education as a punishment.

### MAKE SURE YOUR CHILD CAN LEARN

---

Make sure that your consequence gives your child a chance to learn better behaviour. So, for instance, if you child comes in late and you ground them for a week, it's a whole week before they get to practice better timekeeping! Try grounding them for just one night, and then they can go out again, and practice being on time as soon as possible.

## TIME OUT

Time Out is one of those things that psychologists just can't seem to agree on! Some think it's great, used occasionally by loving parents. Others think it doesn't work and might even cause harm. The truth is probably somewhere in between - and it probably depends on the child. Some children will respond well to it, but for others, it's no use at all. We've included it here because lots of parents do find it useful. If you do find it useful, or you've tried all the other things we have suggested and are still struggling with behaviour, then we've got some Time Out tips for you. If you follow these, it will increase the chance of it working, and keep problems to a minimum. On the other hand, if you don't like Time Out, or it doesn't work for your family, feel free to skip it.

### WHEN SHOULD I USE TIME OUT?

Time Out can be used for behaviours that you can't ignore, such as dangerous behaviours or unkindness to other children. However, Time Out should only be used now and then. Try using the other techniques that we cover on this course first.

### HOW DOES TIME OUT WORK?

The aim of Time Out is to take the child out of a fun, interesting place, into a boring place for a few minutes. It works in two ways. First, it gives the child a chance to calm down. Second, it teaches them that if they want to stay in the fun, interesting place, then they need to behave nicely.

### WHERE DO I DO TIME OUT?

You need to choose the right place. This should ideally be:

- A boring place
- Not a scary place. Time Out isn't meant to be scary. It's just meant to be boring. When children are scared, they don't learn properly. So, pick a place that isn't too dark.
- Not their bedroom. The bedroom is meant to be a calm and happy place. If it is used for Time Out, it might become associated with sadness and stress.

- Good places include the bottom of the stairs or the hallway.

---

#### HOW DO I EXPLAIN TIME OUT TO MY CHILD?

If you've not used Time Out before, try to explain it to your child before the first time you use it.

Try telling them that there is a thing called 'Time Out' which will be used sometimes. They need to know what behaviours will earn them a time out. So, for instance, you might say "We will do Time Out if you do anything dangerous or if you hit anyone". They should know that you will take them to a quiet place, and they will have to stay there until you say that they can come out.

---

#### IS MY CHILD THE RIGHT AGE FOR TIME OUT?

Time Out usually works best between the ages of three and seven.

---

#### WHAT ARE THE RULES FOR TIME OUT?

- Time Out should last for 1 minute for each year of the child's life, up to a maximum of 5 minutes. So, for a three-year old, it would be three minutes, for a four-year old it would be four minutes, for a five-year-old, it would be five minutes, and for six and older, it would also be five minutes.
- Some people also think that the child also needs to stay in Time Out until they have been calm for a while. However, this can mean that time out lasts a very long time, and the research suggests that you don't need to do this.
- If the child leaves Time Out, calmly return them until they stay put. You don't need to add on any extra time if you do this.
- During Time Out, you should be nearby, keeping an eye on things. But try not to give your child any attention at all: no touching, no speaking, no eye contact, unless you absolutely have to.

---

#### WHAT SHOULD I DO AFTER TIME OUT?

Now is the time to make friends with your child again. Try to find something to praise ASAP, even if this is just praising your child for calming down. Then, forget about the problem behaviour and the Time Out. Sometimes children refuse to leave Time Out. This is just fine. Just leave them until they decide to come out.

## Appendix K

### Emotion Coaching Handout 1

#### Emotion Coaching Step

1) Spot the emotion 

2) Show you've noticed 

3) Label the emotion 

4) Listen 

5) Try to solve the problem together 

6) If the emotion led to challenging behaviour. 

**Appendix L**  
**Emotion Coaching Handout 2**

<b>Emotion Coaching Step</b>	<b>Script</b>
<b>1) Spot the emotion</b> 	e.g., <i>sadness, frustration, fear...</i>
<b>2) Show you've noticed</b> 	e.g., <i>"I can see that you may be feeling frustrated because you want a turn on the PlayStation, but your sister hasn't finished her game yet. I sometimes feel frustrated too when I want to do something but I have to wait my turn..."</i>
<b>3) Label the emotion</b> 	
<b>4) Listen</b> 	
<b>5) Try to solve the problem together</b> 	e.g., <i>"but we can't throw toys around because it is not safe. What could we do to make this better instead?"</i>
<b>6) If the emotion led to challenging behaviour...</b> 	

## Appendix M

### Reflexivity Boxes

#### Reflexivity box 1:

I reflect that I identify as someone who experiences anxiety and has done so from a young age. I also would like to be a parent and worry about passing my anxiety on to my children. I am therefore invested in finding ways to prevent IGT of anxiety. I am conscious of what such experiences and aspirations may bring to this research. I wonder if this may mean that I feel more passionately about supporting parents to reduce anxiogenic parenting and whether it may also influence my interpretation of the data. I have hopes that this intervention is successful in reducing parental perceptions of child anxiety. I am also hopeful that if it is not, I am able to adapt interventions alongside parents who experience anxiety so that it is. These hopes could influence my perceptions

#### Reflexivity box 2:

I find it uncomfortable to type in first person, not referring to myself as “the researcher”. Up until writing the qualitative procedure section of this chapter I have distanced myself from the research, using the term “researcher”. I wonder whether this may reflect a more positivist approach to data collection prior to beginning the embedded qualitative element of the research. I am enjoying leaning into the qualitative style of analysis and writing.

#### Reflexivity box 3:

When transcribing the data, it highlighted to me the tension I felt between being a TEP versus a researcher. I felt this tension throughout the process. I was conscious, as a researcher, that for treatment fidelity, I needed to follow the intervention closely. However, as a TEP, I often wanted to use my knowledge of psychology and helping skills to explore parents’ unique challenges more. When transcribing the data, I noticed that I wanted to support parents with scenarios that they presented (e.g., asking further questions) but was also aware, as a researcher, that I needed to guide the focus group to stay on topic.

**Reflexivity box 4:**

I felt anxious about completing RTA. I have more experience with quantitative versus qualitative data analysis and worried that I wouldn't get it "right", that I might misunderstand what I am supposed to do or miss codes. I found the sections on "managing anxiety within the TA process" in the Braun and Clarke (2022) book to be supportive. I found that taking breaks and working out of the house was useful in supporting me to avoid "analysis paralysis". Peer supervision supported me to feel as though the process was doable. I see the irony in how writing about reducing anxiety has increased my own!

**Reflexivity box 5:**

I reflect that even my inductive codes could be influenced by theory that I have read. The theory may bias my interpretations of parental perspectives. With this awareness, during coding round two, I asked myself whether the codes were purely inductive or deductive.

**Reflexivity box 6:**

Before beginning this phase, I felt as though my initial codes were sufficient. However, as I re-read the Braun and Clarke (2022) useful questions, I made several changes to ensure my themes were highlighting patterns in the data. It helped to ask myself "what pattern do these codes highlight?".

**Reflexivity box 7:**

I changed the name of the Help Me Out subtheme from "practical support" to "help me out" when writing it up. I was struggling to capture how I saw this subtheme as separate to parents perceiving the intervention as increasing their sense relatedness. Differently, this subtheme, to me, was about parents offering each other insight, and strategies – things that parents could do. As well as parents receiving support from their partners – parenting as a team.

**Reflexivity box 8:**

The Seeking Reassurance subtheme felt powerful to me. When reading the parents' perspectives, it felt that they frequently were asking whether they or their child was normal. I felt as though this subtheme captures the reality of anxious thinking and how that can translate into seeking reassurance from others, checking if everything and everyone is okay. Certainly, this is a feeling and behaviour that I relate to as a person who identifies as anxious.

**Reflexivity box 9:**

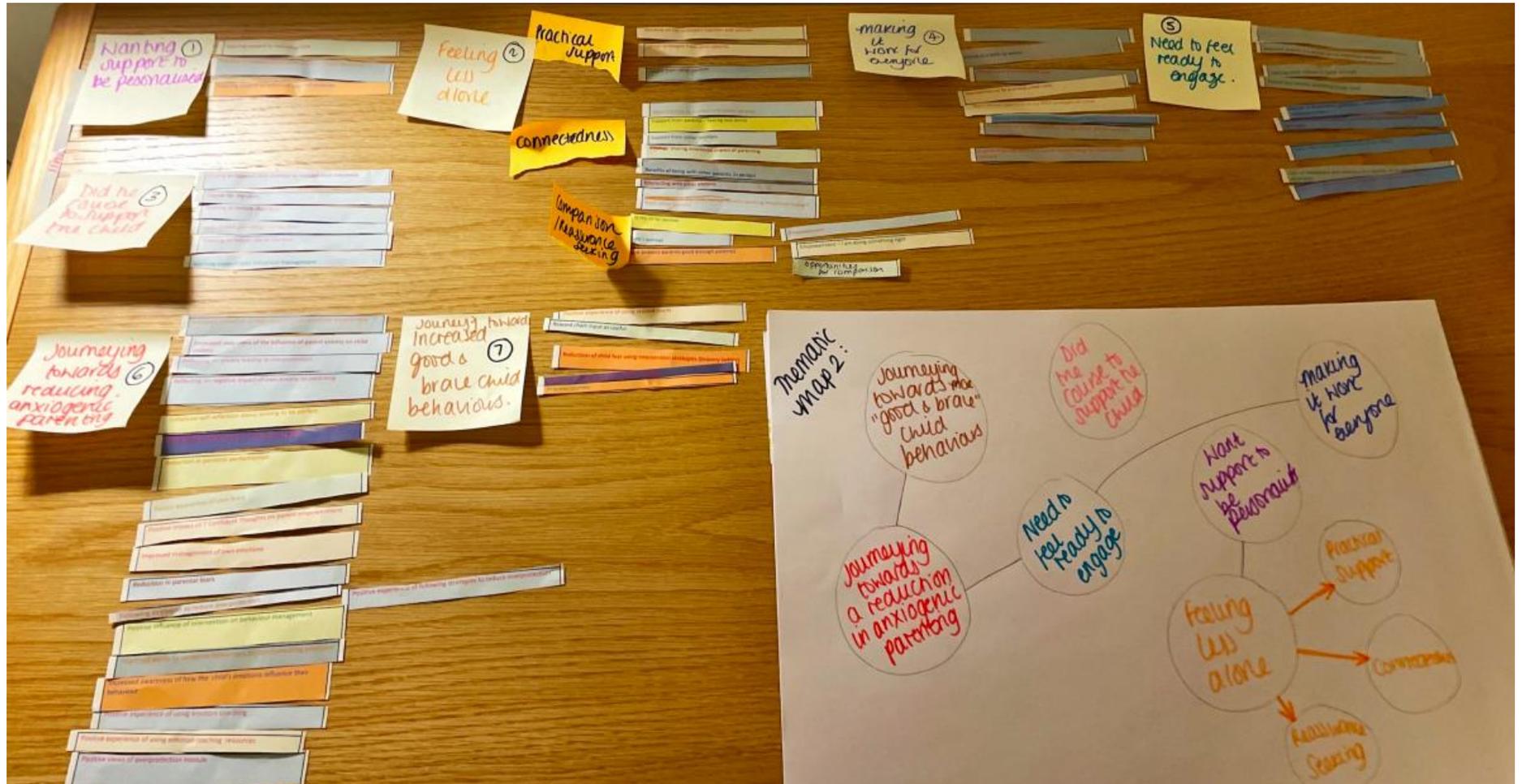
The codes which formed the Journeying Towards Reducing Anxiogenic Parenting subtheme were largely semantic and inductive. However, as I developed and refined my themes, I used more deductive, latent analysis, generated through the awareness of the theories of anxiogenic parenting behaviour, exploring the implicit meanings which may be derived from the group of codes.

**Reflexivity box 10:**

The Facilitating Engagement subthemes were originally separate themes, however, at write up, I felt as though they were both conveying how the parents perceived that parental engagement with the intervention could be facilitated. Therefore, I created the theme *facilitating engagement* with the two subthemes – *making it work for everyone* and being in the *right space for it*.



Appendix O  
RTA Phase Four Image



Appendix P

RTA Phase Four Thematic Map



## Appendix Q

### Ethical Approval



School of Psychology  
The University of Nottingham  
University Park  
Nottingham  
NG7 2RD

tel: +44 (0)115 846 7403 or (0)115 951 4344

SJ/tp

**Ref: S1514**

Monday 15<sup>th</sup> May 2023

Dear Isabel Williams & Sarah Godwin

#### **Ethics Committee Review**

Thank you for submitting an account of your proposed research 'A Mixed Methods Study Exploring the Effectiveness of a Parenting Intervention for Parents with Anxiety in Reducing Child Anxiety.'

That proposal has now been reviewed and we are pleased to tell you it has met with the Committee's approval.

#### **However:**

Please note the following comments from our reviewers.

#### **Reviewer One:**

- Several questionnaires/parent reports etc. ask for names (e.g. parent and child). To anonymize the data use ID numbers rather than names throughout the study.
- The debriefing form: check your language – will the target readership really be able to understand what you wrote there? The reviewer recommends that the form be written from scratch to make sure it is as clear as possible.

Independently of the Ethics Committee procedures, supervisors also have responsibilities for the risk assessment of projects as detailed in the safety pages of the University web site. Ethics Committee approval does not alter, replace, or remove those responsibilities, nor does it certify that they have been met.

Yours sincerely



*Professor Stephen Jackson*  
Chair, Ethics Committee

## Appendix R

### Additional Illustrative Quotes for Themes

**Table A8**

*Subthemes within the Valuing Peer Support Theme*

Subtheme	Illustrative Quotes
Increased Sense of Relatedness	<ul style="list-style-type: none"> <li>“I've actually just enjoyed meeting other parents.”</li> </ul>
Help Me Out	<ul style="list-style-type: none"> <li>“I think it's nice to get valuable insight from other parents as well.”</li> </ul>
Seeking Reassurance	<ul style="list-style-type: none"> <li>“And also seeing other friends struggling with similar situations like oh, it's not just me... because I have impression everyone has this perfect family, their kids are so well behaved and only mine is the crazy one.”</li> </ul>

**Table A9**

*Illustrative Quotes within the Journeying Towards Reducing Anxiogenic Parenting Theme*

Illustrative Quotes
<ul style="list-style-type: none"> <li>“I became more reflective during this course as well [...] I've been trying to be good and beautiful in front of other people, but now I'm thinking [...] let that beautiful part be to me and the other part to other people. [...] because if you are always centred on what others say, what others say then you have nothing left for your inside”</li> <li>“It did make me feel a bit better to know that I could sort of let him open his wings up a little bit more. [...] Eventually I do want to sort of let him go out and play with his friends for like an hour and then maybe up it to an hour and a half or and just take that step. And so I'd definitely say the overprotective one [...] that one was really helpful for me.”</li> </ul>

**Table A10**

*Subthemes within the Facilitating Engagement Theme*

Subtheme	Illustrative Quotes
Making it Work for Everyone	<ul style="list-style-type: none"> <li>• <i>“And I was a little bit late, and it was OK because just because you are at home, it's more flexible. Well, here umm you need to be on time, and you are afraid to let other people down because they're waiting for you and then it didn't work with my work. I had to again reschedule it and change it.”</i></li> <li>• <i>“I think mixture is always the best because [...] for me it was very stressful coming here because this one because I, I never know what he's gonna behave like...sometimes he will behave [...] sometimes it's like making noises [...]”</i></li> <li>• <i>“I did probably prefer the group, but it really helped doing it because I couldn't be here if you know what I mean”</i></li> <li>• <i>“It might be a difficult experience because of the language barrier [...] when it's online or on the phone. For me, it's more difficult to understand what people are saying [...] and also if camera is not on you can't see the emotions cause sometimes you can guess from the gestures and from your posture. [...] But when it's all online, it's more formal, and then you need to listen carefully.”</i></li> </ul>
Being in the Right Space for it	<ul style="list-style-type: none"> <li>• <i>You are afraid to let other people down because they're waiting for you [...] I feel very guilty for it. Well, at home you're more relaxed.”</i></li> <li>• <i>“I don't like being the centre of attention [...] so yeah, I did probably prefer the group, but it really helped doing it because I couldn't be here [...]”</i></li> <li>• <i>“So, for me, like stress the first time but then help push me to get out of the house.”</i></li> <li>• <i>“It's good to have also the link because [...] to like kind of go back and refresh because we're here, we talk about, but we go home and [...] I have some things stuck in my head, but sometimes I kind of lose the track as you get home you like get on your own routine and then you forgot you want to do that”</i></li> <li>• <i>“I think they just find it harder to open up”</i></li> <li>• <i>“He's not into all this kind of stuff [...] Whereas I'm like, I'm open to but he's like, no, I'll do it how I wanna do it. [...] So I know, I know he wouldn't come.”</i></li> <li>• <i>“I think with men they feel as if they're being told how to parent. [...] Whereas us Mums are just like oh, that's really good advice, I'll try that at home [...] But men are like what? No, I'm not going back there. They're just telling me what to do.”</i></li> </ul>