Integrating attachment-based and neurobiological approaches with Cognitive Behaviour Therapy: A mixed methods exploration of a novel intervention for childhood anxiety

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Declaration

I hereby declare that this project is entirely my own work, other than the counsel of my supervisors. Any contributions made by other authors have been recognized appropriately. The work herein has not been submitted for any academic award or part thereof at this or any other establishment.

________________________________
Amy O’Dea
11th April 2019
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Abstract

Introduction: The current study aimed to explore the feasibility of a novel integrative intervention for childhood anxiety, known as the Opposite of Worry (OOW) intervention. This approach incorporates attachment-based and neurobiological approaches, with Cognitive Behavioural Therapy (CBT). It consists of parent sessions and child sessions delivered in parallel.

Method: Seven parent-child pairs consented to take part in the study. The experiences of both parents and children were explored using a mixed methods approach. Semi-structured interviews were carried out with all parents and children. Quantitative data was gathered at three time points, using measures of anxiety, attachment, and emotion regulation.

Results: Qualitative analysis was carried out using Thematic Analysis. Seven parent themes were generated (‘A family affair’, ‘We’re all in the same boat’ ‘Attunement’, ‘Facing and feeling anxiety’, ‘Connection’, ‘Parent’s emotions’, and ‘Child’s expression of feelings’). Five child themes were also produced (‘Awareness of emotions’, ‘Fun’, ‘Coping strategies’, ‘Discomfort contemplating emotions’, and ‘Facing fears’). Quantitative analysis was completed using descriptive statistics. Trends were observed in terms of anxiety reduction and enhanced attachment.

Discussion: The current study generated preliminary findings in support of the OOW intervention; however, further research is required to establish the efficacy of this approach. The findings are discussed in the context of previous literature, and implications for clinical practice and future research are outlined.
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Chapter One: Introduction

1.1 Overview of Present Study
The aim of this study was to explore the feasibility of a novel integrative intervention for childhood anxiety, which incorporates attachment-based and neurobiological approaches, with Cognitive Behavioural Therapy (CBT). This intervention has been developed over a number of years in a Child and Family Psychology Service in Ireland. Clinicians on this team had drawn on a variety of resources and models over the years in their individual work with children and their families. They had found that many of these approaches worked very well in conjunction with CBT. With this in mind, they designed an integrative group intervention founded on practice-based evidence. This intervention is known as ‘The Opposite of Worry (OOW) Group’. The current study seeks to explore the experiences of both parents and children who engaged with the OOW group, using a mixed methods approach.

1.2 Thesis Structure
The current chapter will provide an overview of the thesis structure. Chapter two will outline literature in the area of childhood anxiety. Chapter three will illustrate the methodology used in relation to research design, data collection and data analysis. Chapter four will present the central research findings of the current study, and chapter five will discuss the research findings in the context of extant literature. Implications for research and clinical practice will also be discussed. More detailed chapter outlines are presented below.

1.2.1 Chapter Two: Literature Review
This chapter will provide a review of the existing literature in the area of childhood anxiety, particularly in terms of relevant theories, models and interventions. Aetiology and risk factors relevant to childhood anxiety will be outlined. As the current intervention largely draws on Attachment Theory, CBT, and a neurobiological model of anxiety, literature in each of these areas will be discussed. In considering the potentially valuable mechanisms of the current intervention, the constructs of emotion regulation and parent-child attachment will be presented in terms of their contribution to the development of anxiety. Following on from this, the OOW group intervention will be described in detail, with evidence outlined to support the choice of strategies and
models utilised. Finally this chapter concludes with an outline of the current study aims, research questions, and hypotheses.

1.2.2 Chapter Three: Methodology

In chapter three, the rationale for the research design and choice of methodological framework and measures will be discussed. Recruitment of participants, description of procedural stages, and approaches to data collection and analysis will also be outlined. Ethical issues will be highlighted, and reliability and validity will also be addressed. The chapter will conclude with reflections on the research process.

1.2.3 Chapter Four: Results

Chapter four will give a detailed summary of the current findings. Qualitative findings from the fourteen transcribed participant interviews (seven parent and seven child) will be presented. These findings have been synthesised into themes and subthemes using thematic analysis (Braun & Clarke, 2006). Each theme and subtheme will be discussed, with quotes and interpretative comments for illustration. Quantitative findings will also be presented.

1.2.4 Chapter Five: Discussion

Chapter five will endeavour to present the findings from chapter four, in the context of extant relevant literature. A critical reflection of the current study’s strengths and limitations will also be presented. Implications in relation to clinical practice and future research will be discussed. This final chapter will conclude with reflections on the research process as a whole, and a summary of the study.
Chapter Two: Literature Review

2.1 Chapter Introduction
This chapter will provide a review of the existing literature in the area of childhood anxiety, particularly in terms of relevant theories, models and interventions. It will begin with a definition of anxiety and childhood anxiety disorders. The aetiology of childhood anxiety will be outlined in terms of pertinent risk factors related to its development. A number of conceptual models of anxiety will then be outlined, with a rationale provided for the choice of models relevant to the current intervention. The current intervention largely draws on Attachment Theory, CBT, and a neurobiological model of anxiety. Attachment Theory will be discussed in the context of anxiety and the impact that parent-child attachment may have on intervention outcomes. The evidence for use of CBT as an intervention for childhood anxiety will be presented. Theoretical comparisons will be made between Attachment Theory and the Cognitive Behavioural model of anxiety. A neurobiological model of childhood anxiety will then be presented, and the value of incorporating neuroeducation into a therapeutic intervention will be discussed.

In considering the potentially valuable mechanisms of the current intervention, the constructs of emotion regulation and parent-child attachment are of particular interest. Emotion regulation will be discussed in terms of how it relates to attachment, and how each of these variables has a role in the development of anxiety. Following on from this, the OOW group intervention will be presented in detail, with evidence outlined to support the choice of strategies and models utilised. Finally the study aims and research questions will be described.

2.2 Definition of Anxiety
Anxiety can be defined as the body’s natural response to stress or perceived threat. The physiological sensations associated with anxiety can be understood in terms of the human ‘fight, flight or freeze’ response. When an individual perceives that they are in danger, their entire physical system produces short-term changes which serve the function of boosting the ability to run away, or to fight against the threat (Albano & Kendall, 2002). These bodily changes can be adaptive and essential to survival if one is faced with a physical threat. However, many of today’s threats and stressors are not ones that need to be physically fought against or ran from. Without this physical exertion, our bodies can hold onto these anxious sensations. Most people experience
some level of anxiety from time to time. Anxiety disorders can be distinguished from normative fear or anxiety, by considering the degree of impairment resulting from disruption to daily activities. They may also result in age-appropriate fears continuing beyond typical developmental periods. While temporary fear or anxiety can often be experienced as a result of stress, anxiety symptoms must be persistent for a significant time period (6 months or more) in order to meet criteria for a diagnosis of an Anxiety Disorder (American Psychiatric Association, 2013).

### 2.3 Childhood Anxiety Disorders

Anxiety disorders are the most frequent mental health disorder experienced by children (Higa-McMillan, Frances, Rith-Najarian, & Chorpita, 2016), with 6.5% of children expected to meet criteria for diagnosis at any one time (Polanczyk, Salum, Sugaya, Caye, & Rohde, 2015). Anxiety during childhood may take a number of different forms including social anxiety, separation anxiety, specific phobias, generalised anxiety disorder, post-traumatic stress disorder and panic disorder (Carr, 2006).

For most children, certain fears and worries can be appropriate to their developmental stage and they will naturally grow out of such fears, e.g. fear of the dark (National Scientific Council on the Developing Child, 2010). As children mature, they acquire the cognitive and social skills required to make predictions about their world, which can lead to a greater sense of control. As these abilities develop, many of the common childhood fears begin to fade away (National Scientific Council on the Developing Child, 2010). However when experienced at a clinical level, anxiety can prompt considerable distress in children and their families, and may obstruct their social and academic functioning (Woodward & Fergusson, 2001). Presence of one anxiety disorder may predispose a child to developing other psychological difficulties and functional impairment as they grow (Lee, Victor, James, Roach, & Bernstein, 2016). The aetiology of childhood anxiety disorders will now be discussed with reference to a number of pertinent risk factors.

#### 2.3.1 Aetiology and Risk Factors for Anxiety in Children

Anxiety disorders in children tend to emerge in the context of complex interactions between psychological, biological, and environmental variables. Many risk factors have been identified as contributing to childhood anxiety, including ambivalent attachment,
parental anxiety, parenting style, child’s behavioural inhibition, and experience of traumatic or stressful life events (Donovan & Spence, 2000).

A study by Warren, Huston, Egeland, and Sroufe (1997), examined the role of early attachment style on the development of anxiety disorders. They assessed children aged 1 year, and again when they were in their late teens. Results suggested that a pattern of ambivalent attachment at age 1 year predicted presence of anxiety disorder at later testing, irrespective of the effects of maternal anxiety and infant temperament.

Many studies have investigated the relation between parenting style and childhood anxiety, with an emphasis placed on three particular dimensions of parenting: acceptance, control, and modelling of anxious behaviours (Wood, McLeod, Sigman, Hwang, & Chu, 2003). The dimension of acceptance encapsulates a general approach to parenting in terms of responsiveness, acceptance of children’s behaviour and emotions, active listening, praise, etc. It has been suggested that, by showing acceptance when their child expresses a negative emotion, parents help to nurture emotion regulation by supporting their child to tolerate negative emotions (Gottman, Katz, & Hooven, 1997).

The parenting dimension of control includes a tendency to exert excessive control over children’s activities and routines, instructing children on how they should think or feel, and an oppressive style of decision making (Barber, 1996). Such aspects of parental control promote children’s dependence on their parents, which is thought to impact on children’s own sense of mastery as they develop. A poor sense of mastery can generate a negative cognitive bias whereby a child perceives events as being outside of their control, and this may play a role in the development of childhood anxiety (Chorpita & Barlow, 1998).

Parental modelling of anxious behaviour refers to the way in which a parent might support their child to catastrophise problems, while possible ways of coping or problem-solving strategies are ignored (Whaley, Pinto, & Sigman, 1999). Where this parenting practice is common, children may develop the belief that they cannot cope with problems and, as a result, are unlikely to engage with coping strategies that alleviate anxiety (Whaley et al., 1999).
With a multitude of risk factors exemplified in the literature, many theories and models have been proposed in order to explain the underlying processes of anxiety disorders. Some of these will now be discussed, followed by a rationale for the choice of models focused on in the current study.

2.4 Models of Anxiety

There are many models and theories that aim to provide an explanation for the development and maintenance of anxiety. Biological models of anxiety suggest that there is an underlying genetic component implicated in the development of anxiety disorders (Jacofsky, Santos, Khemlani-Patel, & Neziroglu, 2010). From this perspective, traits considered innate to an individual (such as temperament and certain personality characteristics), are regarded as predisposing factors in the development of anxiety disorders.

Building on this, the biopsychosocial model (Engel, 1977) proposes that an individual may be born with a genetic predisposition to experience heightened sensitivity to stress. However, this alone is insufficient to produce an anxiety disorder. The biopsychosocial model suggests that there are numerous, interconnected origins of anxiety disorders. These can generally be sorted into three main categories: biological causes, psychological causes, and environmental/social causes. Behaviour genetic studies estimate that 45% of Anxiety Sensitivity is inherited (Stein, Jang, & Livesley, 1999). Anxiety Sensitivity may be described as a trait-like cognitive vulnerability that magnifies an individual's anxiety level (Olatunji & Wolitzky-Taylor, 2009). If one considers that many children inherit this trait from parents who are also anxious, it is likely that their environmental experiences will be impacted by parental anxiety and modelling of fearful behaviour (Muris, Steerneman, Merckelbach, & Meesters, 1996). In this way, children of anxious parents are extremely vulnerable to developing an anxiety disorder, as they are impacted by both genetic and environmental risk factors in this way.

From a psychodynamic perspective, anxiety is thought to arise when an individual becomes aware of parts of their self, that they do not have the capacity to reflect upon, or to experience (Sedlak, 1985). Psychodynamic theory proposes that anxiety is often due to conflicting unconscious desires or fears that are expressed through maladaptive defence mechanisms (e.g. suppression, repression, anticipation, regression,
somatisation, passive aggression, dissociation). These defence mechanisms are thought to develop in the context of early environmental experiences (Freud, 1896). Cognitive behavioural models of anxiety suggest that anxiety develops in the context of a cycle of thoughts, behaviours, and emotions (Wells, 1995). Cognitions pertaining to the development of anxiety tend to be related to threat appraisal. Anxious individuals tend to overestimate the likelihood and severity of a threat, and often change their behaviour to avoid such a threat. Individuals may also have low self-efficacy in relation to their own coping abilities, leading to further negative cognitions.

Development of anxiety in children can also be understood in the context of Attachment Theory. Bowlby (1973), and Stayton and Ainsworth (1973) proposed that there is a link between child anxiety and attachment insecurity. Sroufe (1996) went on to describe separation distress as one of the earliest modes of an individual experiencing anxiety. The recurring experience of distress in the child-parent relationship can lead to the development of anxiety disorders later in childhood.

Neurobiology can also offer an explanation for anxiety, by providing a description of how the different brain regions function, and how these different regions develop over the lifespan of an individual. In terms of childhood anxiety, neurobiology explains how the more primitive parts of the brain (such as those involved in the fight, flight or freeze response) develop first, while the areas of the brain that control higher order functions (such as rational cognitive skills), develop much later in childhood, adolescence and early adulthood.

This chapter will now go on to examine the models/theories relevant to the current intervention in greater depth; these are Attachment Theory, CBT, and a neurobiological model of anxiety. These have been selected on the basis of their strong grounding in empirical evidence, as well as group facilitators’ practice-based evidence supporting their use in the treatment of childhood anxiety disorders.

2.5 Attachment Theory and Anxiety

Attachment Theory can be used to understand the development of childhood anxiety. Bowlby (1973) proposed that children who have a secure attachment to their primary caregiver tend to experience less anxiety than insecurely attached children. He put
forward the idea that children’s experiences of how their caregiver responds to their distress becomes internalized within the child as an internal working model (Bowlby, 1969). If a child continually experiences responsive care from a caregiver who is attuned to their needs, they will develop a secure attachment working model. If the caregiver’s responses to the child are insensitive, inconsistent, or absent, the child will develop an insecure attachment working model. These internal working models are significant as they influence the child’s ability to use their caregiver as both a secure base from which they can freely explore their environment and a safe haven to turn to for support during distress (Bowlby, 1988).

Children who have an insecure attachment to their caregiver(s) have not learned (through experience) that their needs will be met, and consequently tend to see the world and others as unsafe. Alternatively for securely attached children, their feeling of security and their perception of their caregiver as responsive and predictable, is thought to foster internal working models that entail more positive expectations in relation to the world and others (Erickson, Sroufe, & Egeland, 1985). Attachment styles are thought to have a crucial impact on a child’s ensuing development (Ainsworth, 1989). Those who are securely attached tend to respond more adaptively under stress, develop healthier relationships with others, and are more independent. Those who are insecurely attached have a tendency to experience lower self-esteem, are inconsistent in their relationships with others, and feel less able to cope in times of stress (Bowlby, 1977). Several meta-analyses have demonstrated that insecure attachment is linked to the development of anxiety (Colonnesi et al., 2011; Groh, Roisman, Van IJzendoorn, Bakermans-Kranenburg, & Fearon, 2012; Madigan, Brumariu, Villani, Atkinson, & Lyons-Ruth, 2016).

CBT for childhood anxiety will now be discussed. Following on from this, the theoretical parallels will be drawn between CBT and Attachment Theory, and consideration given to the impact of attachment on CBT efficacy.

2.6 CBT Intervention for Childhood Anxiety

CBT for childhood anxiety disorders typically incorporates psychoeducation, somatic management techniques, developmentally appropriate cognitive restructuring skills, exposure methods, and relapse prevention planning (Albano & Kendall, 2002). CBT has consistently been recognised as the preferred intervention for childhood anxiety disorders based on its empirically demonstrated efficacy (Higa-McMillan et al., 2016).
A recent review examining 50 years of anxiety treatment, established that CBT interventions are the most frequently used interventions for targeting anxiety in children (Higa-McMillan et al., 2016). A 2015 Cochrane Review showed that the average rate of remission for anxiety following CBT intervention is 58.9% (James, James, Cowdrey, Soler, & Choke, 2015). The authors found that there were limited studies of the longitudinal outcomes following remission from anxiety, and such studies demonstrated inconsistent results.

Many of the meta-analyses conducted to date lack consistency in terms of diagnostic outcomes reported (Warwick et al., 2017). For example some studies report remission of the primary anxiety disorder (the diagnosis impacting most on the child) as the outcome of interest (Spence, Donovan, & Brechman-Toussaint, 2000; Melfsen et al., 2011). Other studies look at outcomes that require a child to be free of all anxiety disorder diagnoses (Cobham, 2012). This distinction is key when considering that children and young people with anxiety disorders often present with other co-morbid anxiety diagnoses (Waite & Creswell, 2014).

Warwick et al. (2017) sought to address this inconsistency and conducted a meta-analysis to ascertain the effectiveness of CBT in terms of alleviation of all anxiety disorders. Their meta-analysis included 19 studies, 5 of which focused on participants who also presented with Autism Spectrum Disorder (ASD). Within these 5 ASD studies, 23.2% of participants who completed CBT demonstrated remission from all anxiety diagnoses. For the remaining 14 studies (where participants did not have an ASD), 60.7% of participants who completed CBT no longer met criteria for any anxiety diagnosis post treatment.

A recent Australian study conducted by Ruocco, Freeman, and McLean (2018), investigated the efficacy of a school-based cognitive-behavioural group intervention for anxiety in children. Results showed a significant reduction in the use of maladaptive strategies (behavioural avoidance) post-intervention. They also indicated an increased use of helpful cognitive strategies, such as cognitive restructuring. Parent, teacher and child reports all denoted significant decreases in anxiety and emotional distress. CBT will now be considered in terms of parallels with attachment theory.
2.7 Mapping Attachment Theory onto a CBT Framework

One of the goals of the attachment system is to foster an individual’s sense of security and safety in the world (Bowlby, 1982). Insecure attachment therefore can result in an individual feeling unsafe or threatened. In considering how this can map onto a CBT framework, it is key to note that a central component of the CBT model of anxiety is the concept of perceived personal vulnerability to threat (Beck, Emery, & Greenberg, 1985). Individuals who experience anxiety tend to overestimate the likelihood and severity of threats they will face, as well as underestimating their own ability to cope. These overestimated perceptions of threat are influenced by cognitive biases, namely attentional biases and interpretive biases. These in turn are influenced by core beliefs and assumptions fuelled by such beliefs.

Attachment theory has influenced the theoretical foundations of more contemporary cognitive models such as schema therapy (Young, Klosko, & Weishaar, 2003). While this implies there is a growing acknowledgment of the value of attachment theory, up to now repairing attachment relationships has not been integrated in CBT as an explicit outcome of therapy (Bosmans, 2016). However, it is noteworthy that more recent research has begun to close the conceptual gap between CBT and attachment theory. This is mainly due to the recognition of how secure internal working models seem to be made up of cognitive schemas and scripts, such as the secure base script (Steele et al., 2014), and expectations of others based on these scripts (trust in the availability of support from the caregiver). The impact of parent-child attachment on the effectiveness of CBT as an intervention for childhood anxiety will now be considered.

2.8 Impact of Attachment on CBT Effectiveness

Much of the literature on group interventions for childhood anxiety focuses on the use of a CBT model (Higa-McMillan et al., 2016) and substantial support has been found for CBT as an effective therapy for this presenting problem. A comprehensive review of meta-analyses regarding CBT efficacy (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012) indicated support for the use of CBT approaches in treatment of anxiety disorders in children and adolescents, with large effect sizes often observed (James, Soler, & Weatherall, 2005). However, other meta-analyses have indicated that effect sizes are often small to medium in size (Reynolds, Wilson, Austin, & Hooper, 2012; Weisz et al. 2013), and that there are high rates of relapse after end of treatment (James et al., 2015).
Bosmans (2016) suggested that the variability of effect sizes observed in studies evaluating CBT may be explained by considering the impact of the parent-child attachment. He proposed that this may explain some limited treatment effects of CBT, and that treatments targeting insecure parent-child attachment relationships could be integrated with CBT to enhance its outcomes. CBT for children and adolescents are, for the most part, divided into interventions aimed at children and interventions aimed at parents (Bosmans, 2016). For child-focused CBT, a review of meta-analyses (Hofmann et al., 2012) found large effect sizes for anxiety disorders. For parent-focused CBT, small to medium effect sizes were found in a number of reviews and meta-analyses (Furlong et al., 2012; Lundahl, Risser, & Lovejoy, 2006). It was hoped by clinicians that treatment effects may be improved upon by delivering a combination of child-focused CBT interventions and parent-focused CBT interventions. Yet, several studies and meta-analyses indicate that combining the two interventions does not significantly increase the effect of treatment (Eimecke, Pauschardt, & Mattejat, 2010; Ollendick et al. 2016; Thulin, Svirsky, Serlachius, Andersson, & Öst, 2014). In light of these findings, Bosmans (2016) proposed that critical elements of parent-child relationships (such as attachment), need to be repaired before anxiety treatment can be effective, and merely combining child-focused CBT with parent-focused CBT does not address this issue.

Walczak, Esbjørn, and Breinholst (2017) found that maternal attachment anxiety (fear of abandonment) significantly predicted the outcomes of CBT treatment for anxious children. They proposed that mothers with their own ambivalent attachment history and poor relationships may be motivated by their own need for emotional closeness, instead of the needs of their children. In this instance such closeness can involve greater dependency, enmeshment, and clinginess, which may impede the mothers’ capacity to support her child appropriately during therapeutic treatment. Goodman, Quas, Batterman-Faunce, Riddlesberger, and Kuhn (1997), previously demonstrated that mothers with high attachment anxiety are inclined to respond ineffectively to their child’s needs when they are experiencing their own distress. It has also been shown that maternal attachment anxiety can hinder the child’s exploration (Selcuk et al., 2010). This can be a result of the mother’s desire for extreme closeness, which may impede their ability to encourage the child’s autonomy (Mikulincer & Shaver, 2007).
2.9 Neurobiology of Anxiety in Children

In addition to Attachment Theory and a CBT model of anxiety, the current intervention also draws on a neurobiological model of anxiety. Fishbane (2013) used the term ‘neuroeducation’ to describe a specific form of psychoeducation relating to neurobiology. Miller (2016) went on to define neuroeducation as a didactic intervention that aims to reduce distress, by means of supporting clients to understand the underlying neurological processes associated with their mental functioning. This concept has also been described by Siegel (2012), who referred to it as “internal education”, while Badenoch (2008) used the term “brain talk” to describe it.

Neuroeducation can include teaching clients about the various regions and functions of the brain, using accessible terminology such as the upstairs brain and downstairs brain; or the reptilian brain, mammalian brain, and primate/human brain (Miller, 2016). Neurobiology provides an explanation of how the different brain regions function, and how these different regions develop over the lifespan of an individual. This can be particularly useful in terms of understanding anxiety in children, and can account for why cognitive strategies may not be effective during times of extreme distress.

The brain develops from the bottom up, from the simplest structure (brainstem) to the most complex (limbic, cortical) areas (Perry, 2009). The more primitive brainstem is the first structure to develop, and is involved in many unintentional, life-sustaining functions such as respiration, heart rate, digestion, modulating arousal, and aspects of the fight-flight-freeze response. These functions develop in utero, as they need to be present at birth to support life (Perry, 2009). Above the brain stem is the limbic area, the reactive, emotional, and reward-based region of the brain. The limbic region is involved in managing lower regions of the brain, therefore enhancing survival (Field, Beeson, & Jones, 2015). The ‘thinking brain’ (prefrontal cortex region) is involved in many executive functions such as logical reasoning, planning, as well as metacognition (thinking about thinking). This is the rational portion of the brain, and it is the last to develop. This region often does not reach maturity until the late 20’s (Jensen & Nutt, 2015). If one considers the order in which these brain regions develop, it is easy to understand why young children may throw tantrums, or find it difficult to be rational when they are distressed.
Much of the literature on neuroeducation focuses on its use with adult clients, with outcomes reported such as increased self-compassion, and a change in beliefs relating to their innate badness or weak character (Miller, 2016). In this way, it is likely that providing neuroeducation to parents could have a positive impact in terms of the empathy and compassion they feel for their child, while also allowing them to see their child has limited control over their difficult behaviour.

Another clinical implication of understanding the neurobiology of the brain, is that in order to have an effective impact on a higher function (such as socioemotional communication and cognitions), it is essential that the lower neural networks are well-regulated (Perry, 2009). Therefore a highly anxious, dysregulated child may not benefit from therapeutic input targeting social skills, self-esteem, or using logical thought. Based on this knowledge, use of repetitive motor activity appears to be an effective way to diminish anxiety, through repetitive and regulating neural input to the brainstem and neural networks (Perry, 2009).

Siegel (2001) proposed that development happens by means of the social world interacting with brain functions. He suggested that neural integration is facilitated through fostering secure attachments, and supports the development of the mind, emotional well-being, and psychological resilience. He highlighted that brain plasticity allows for the brain to be altered later in life, despite early experiences of insecure attachment. This is why interventions targeting parent-child attachment can be beneficial. It also explains how the experience of a secure attachment in a therapeutic relationship can lead to the creation of new neural pathways.

2.10 Mechanisms in the Development of Anxiety

The role of emotion regulation and attachment as mechanisms in the development of anxiety will now be outlined.

2.10.1 Emotion Regulation

The above literature suggests that attachment may be crucial to understanding the aetiology of anxiety symptoms, as well as being a possible target for intervention. However, other studies suggest that the association between parent-child attachment and childhood anxiety may be mediated by another variable; emotion regulation. There have been many definitions of emotion regulation proposed across the literature. Shields and
Cicchetti (1997) described emotion regulation as a person’s attempts to modulate their emotional arousal so that they may engage with their environment in an optimal manner.

Other definitions have given more attention to the mechanisms and processes that comprise emotion regulation. Gross (1998) characterizes emotion regulation as the processes that dictate which emotions are experienced, in addition to when and how they are expressed. Thompson (1994) proposed that the processes underlying emotion regulation are both extrinsic and intrinsic, and that they play a role in observing, appraising, and adjusting emotional responses for the purpose of goal attainment.

Eisenberg and Spinrad (2004) defined emotion regulation as:

> the process of initiating, avoiding, inhibiting, maintaining, or modulating the occurrence, form, intensity, or duration of internal feeling states, emotion-related physiological, attentional processes, motivational states, and/or the behavioral concomitants of emotion in the service of accomplishing affect-related biological or social adaptation or achieving individual goals (p. 338).

Mazefsky and White (2014), elaborated on this definition by proposing that emotion regulation is a means by which an individual manages the intensity of their emotions, either before an emotionally triggering event, or after it has occurred. This may occur at a conscious or unconscious level. When emotion regulation is adaptive, an individual uses effective coping strategies in managing difficult situations and emotions. However, maladaptive emotion regulation is often linked with psychopathology (Siener & Kerns, 2012). While many conceptualisations of emotion regulation have been proposed and employed, all of the definitions put forward have highlighted that the capacity to effectively manage one’s emotions with varying environmental stressors is vital to adaptive functioning (Durbin & Shafir, 2008).

### 2.10.2 Attachment, Emotion Regulation, and Anxiety

Attachment theory proposes a connection between attachment and emotion regulation. Emotion regulation is one of the goals of the attachment system given that children with a secure attachment to their primary caregiver are able to utilise the caregiver effectively to help them regulate their emotions (Bowlby, 1982).
Bender, Sømhovd, Pons, Reinholdt-Dunne, and Esbjørn (2015) demonstrated a significant indirect association between attachment security and anxiety, mediated by emotion dysregulation. Brumariu, Kerns, and Seibert (2012) showed that specific attachment styles are linked to childhood anxiety and that this relationship is mediated by emotion regulation difficulties. The findings of these studies led the authors to propose that attachment relationships may be related to childhood anxiety due to the effect that attachment relationships have on a child developing the ability to regulate their emotions.

Esbjørn, Bender, Reinholdt-Dunne, Munck, and Ollendick (2012) completed a review which examined the constructs of Attachment, Emotion Regulation, Anxiety, and their interrelations. They concluded that the evidence suggests a possible association between dysfunctional emotion regulation abilities and childhood anxiety disorders. In examining the existing empirical data the authors found that an insecure attachment style, especially an insecure-ambivalent attachment style, was associated with the development of ineffective emotion regulation strategies and anxiety disorders.

In summary, Attachment Theory offers a viable explanation for the aetiology of childhood anxiety. A number of studies and meta-analyses have corroborated this explanation. It has been proposed (Bosmans, 2016) that incorporating attachment interventions into treatment for anxiety may enhance outcomes. To date there have been limited published studies that evaluate the effectiveness of an attachment-based intervention in reducing childhood anxiety; those that do exist tend to focus on early childhood only. Huber, McMahon, and Sweller (2015) found a significant reduction in parent ratings of child internalizing symptoms following an attachment-based Circle of Security (COS) intervention. This study focused on children aged 1-7 who had been referred for emotional and/or behavioural issues.

Parent-Child Interaction Therapy (PCIT) is an attachment-based intervention (Allen, Timmer, & Urquiza, 2014), devised by Eyberg (1988) for treating disruptive behaviour problems in early childhood. Some studies have explored the use of PCIT in an adapted format, in the treatment of childhood anxiety disorders. The adapted approach was initially evaluated in relation to Separation Anxiety Disorder (Choate, Pincus, Eyberg, & Barlow, 2005). This was later extended to other anxiety disorders through the development of the CALM Programme (Coaching Approach behaviour and Leading by Modelling) by Comer et al. (2012). They found preliminary support for this modified
PCIT approach, for children presenting with separation anxiety disorder, social anxiety disorder, generalized anxiety disorder, and/or specific phobia. This approach was developed for younger children (aged 3 to 8), as it was proposed that children of this age were too young to engage with the cognitive demands of an intervention such as CBT.

The OOW intervention has been devised for older children (aged 8-10), and therefore incorporates age-appropriate elements of CBT, while also utilising attachment-based and neurobiological approaches. The OOW intervention is unique in this way, and the current study intends to address a gap in the literature by exploring the feasibility of this novel integrative group intervention. In addition, emotion regulation has been shown to mediate the relationship between attachment and childhood anxiety (Bender et al., 2015; Brumariu et al., 2012). This study is also interested in exploring the role that enhancing emotion regulation may play in reducing anxiety.

2.11 The Opposite of Worry Group Intervention (OOW)

The current study aims to explore the feasibility of the OOW group intervention for parents and children in relation to childhood anxiety management. This intervention is largely based on a book by Lawrence J. Cohen (2013) called ‘The Opposite of Worry’. The OOW is an attachment-based approach to anxiety, emphasising the parent-child relationship, whilst also incorporating some CBT. This intervention also draws on Dan Siegel and Tina Bryson’s work (‘The Whole Brain Child’) in terms of understanding and explaining the neurobiology of stress and emotional reactions (Siegel & Bryson, 2012). In addition to these elements, the OOW group also emphasises playfulness, mindfulness and body-based, physical activities in terms of reducing anxiety and building a stronger sense of security and emotional regulation in the child. The OOW intervention consists of 10 group sessions for parents and 6 for their children, which are run side by side.

While the OOW intervention is integrative and draws on many approaches, the central theme found in the content is that of enhancing the relationship and attunement between mother and child. In giving mothers the tools they need to become more empathic, calm and confident parents, the aim is that the child will become more skilled in terms of their own emotion regulation as a more ‘secure base’ is established and they see their
mother modelling calmness and coping. The elements that comprise this intervention will now be described, with reference to empirical evidence in support of their use in targeting childhood anxiety.

2.11.1. ‘The Opposite of Worry’ (Cohen, 2013)

One of the key resources that inspired the creation of this intervention is the book ‘The Opposite of Worry’ (Cohen, 2013). The following approaches and strategies were derived from this work and used in the OOW intervention.

*The Second Chicken: Parenting with Empathy*

Parents were taught about the notion of the ‘second chicken’. Cohen came up with this idea based on his own eighth-grade science experiments. He had noticed that if a chicken is immobilised by fear (by playing dead), it recovers more quickly if in the presence of another chicken that appears unafraid. However, if the chicken is in the presence of a second chicken who is also fearful, it will take much longer to recover. Later on in his career, as he worked with families and their anxious children, Cohen drew on this analogy as a way of understanding why children of anxious parents often struggled more with their own anxiety. The OOW intervention has drawn on this example as a way of teaching parents the importance of being a calm role model for their child. Cohen also spoke about the importance of having empathy for your child and the need to acknowledge any worry, despite the fact that it may seem trivial. Parents can sometimes dismiss their children’s worries as a way of easing their own discomfort at seeing their child in distress, e.g. ‘there’s no need to worry about that’. When a child is feeling scared, it helps if their parent can project a sense of calm confidence to them. This lets them know that even though they are scared and are not feeling safe or able to cope, the parent is feeling safe and has confidence in their child’s ability to cope. Through this attitude, the message the child receives is: “I get how scared you are and I know that you’re safe... I will help you to face this fear”. In the OOW intervention these ideas were taught using didactic approaches, group discussions, video content, and role plays.

*Relaxation and Roughhousing: The Body*

As described earlier, anxiety has a dramatic impact on the body in terms of the ‘fight, flight or freeze’ response. Cohen (2013) describes ways in which the body can be used
as a means to alleviate anxiety. He speaks about ‘roughhousing’ or rough and tumble play, as a means of regulating the child’s physical system while also creating moments of connection and playfulness between parent and child. Pellegrini (1987) proposed that rough and tumble play serves functions in terms of social-cognitive development and physical development in children. Pellis and Pellis (2007) conducted a study using laboratory rats, and their findings suggest that rough and tumble play or ‘play fighting’ employs neural mechanisms that are involved in the development of social competency. Lindsey and Colwell (2003) found that for boys, physical play was associated with emotional competence with peers.

A number of studies have demonstrated that rough and tumble play is related to the development of self-regulation, and that this is impacted by the quality of the parent-child relationship (Flanders et al., 2010; Paquette, 2004; Peterson & Flanders, 2005). Rough and tumble play was encouraged in both parent and child groups of OOW, with activity suggestions provided. Age appropriate relaxation and breathing techniques were also taught.

The Edge: Facing and Feeling

The OOW intervention used Cohen’s (2013) descriptions of the 4 ways that children can respond to anxiety. Three of these ways do not result in any long term learning or conquering of the fear. Flooding occurs when children are so overwhelmed by emotion that they cannot access their logical thinking. Rage, cowering, freezing, clinging, crying, hiding, agitation/hyperactivity, running away, and aggression are all examples of feeling flooded. These children have already gone over the Edge (the place where we face our fears), and they need to be pulled back. A child in this state needs comfort, soothing, and empathy from their caregiver.

Avoidance is when a child stays far away from the thing that scares them. If they successfully achieve this, they won’t feel any anxiety, but they won’t experience life either. When a child avoids their fear, learning cannot take place to help overcome the fear. Confidence cannot be built and no coping skills are learnt. White-knuckling occurs when a child essentially braces themselves through a situation (often due to being forced to go at a pace that is too fast). They may have to endure the situation, but they do everything they can to avoid enduring the feelings by gritting their teeth, clenching their fists, even closing their eyes. They don’t learn to feel safe as they don’t really experience the situation at all.
Facing and feeling is essentially akin to graded exposure, and this is the optimal response and the only one that allows any learning to take place. The child must approach the feared situation gradually and spend time at the Edge. They must experience their feelings of fear while keeping eye contact and accepting emotional support from someone they trust. They will then experience the fear reducing. The child learns that it is possible to feel scared and yet be safe. Parents attending OOW intervention used role play to practice how they could move their child closer to the Edge of their fear, in a way that felt safe and at the child’s pace. The importance of the child going through this process and feeling their emotions begin to ease over time, was highlighted.

*Parental self care: filling the empty cup*

Cohen (2013) used the analogy of an empty cup within every child that needs to be filled by their parents with love, affection, attention and security. He proposed that if parents do not look after themselves, they cannot look after their children as well as they might. In particular, when children are going through a difficult time and need more from their parents, it is important that parents are mindful of the need to fill their own cup. This idea was used to facilitate discussion with parents at the OOW group, in terms of their own self-care. Parents were asked to consider the barriers they faced in terms of caring for themselves. Cognitive strategies were taught to support parents in challenging their own negative thoughts around their child’s difficulties and their role as a parent.

Facilitators of the OOW group have utilised Cohen’s strategies in their clinical work with anxious children and their families over a number of years. In this way a body of practice based evidence has informed the incorporation of these strategies into the current intervention.

2.11.2 ‘The Whole Brain Child’ (Siegel & Bryson, 2012)

‘The Whole Brain Child’ (Siegel & Bryson, 2012) was another key resource utilised in the development of the OOW group. The following elements of this book were drawn on:

*The Upstairs and Downstairs Brain*

Parents in the OOW intervention were taught about the basic neurological functioning of their child’s brain, in order to give them a better understanding of why their child’s distress often cannot be alleviated through logic and reasoning. Siegel and Bryson
(2012) use the analogy of the brain being like a house with an upstairs and a downstairs. The downstairs part of the brain, encompassing the brain stem and limbic region, is the more primitive part. It is responsible for basic functions such as breathing and blinking, as well as fear responses and strong emotions. The upstairs part of the brain is made up of the cerebral cortex and is much more evolved than the downstairs brain. It controls higher order and analytical thinking.

Siegel and Bryson (2012) propose that integration of these two parts of the brain is important for an individual’s functioning but that, for children, this is a work in progress. Parents may become frustrated with their children when they cannot rationally respond in the face of an anxiety-provoking situation. During the OOW intervention, this idea was explained to parents in order to provide them with a better understanding of their child during a meltdown. They are not being stubborn or naughty; instead they are overwhelmed by the primitive fear response and unable to access logical thinking due to the immaturity of their developing brain.

Parents were taught strategies to help soothe their child’s downstairs brain so that they would be in a better frame of mind to access the upstairs brain and, in doing so, begin to integrate these two parts. Parents were taught that supporting their children to put feelings into words can help the upstairs and downstairs brain to work together as a team, so that their child can calm down and learn from their experiences in a positive way. By supporting their child to tell the story about what happened to them, they allow them the chance to put the jigsaw pieces together in their own mind. Parents were taught the importance of the child doing this for themselves, as opposed to having their parent doing it for them. By helping their child to put the pieces of the jigsaw together for himself, parents enable their child’s brain to develop and integrate.

*Name it to tame it*

Similar to the use of empathy as described by Cohen (2013), Siegel and Bryson (2012) suggest the strategy of ‘name it to tame it’; in other words naming and acknowledging a child’s emotions rather than dismissing or denying their fears and worries. This also promotes emotional literacy in children as they learn the language to describe the emotions they are experiencing.

Strategies described by Siegel and Bryson are grounded in neurobiological science (Siegel, 2010, 2012, 2015) and have been shown to be effective in promoting neural
integration. Through neural integration children can be more effective at employing cognitive strategies in times of heightened anxiety. Siegel also suggests that such neural integration plays a role in self-regulation.

2.11.3 CBT

Elements of CBT are incorporated throughout the OOW intervention. Psychoeducation on anxiety is provided to both parents and children. Relaxation techniques are also taught at both parent and child groups. The use of graded exposure strategies are adapted using the terminology ‘facing and feeling’ coined by Cohen (2013). In this way the process of graded exposure takes place within a parent-child relationship that exudes patience, warmth and support. Children are taught about cognitions, and encouraged to reflect on how different thoughts can make them feel either anxious or calm. Parents are also encouraged to consider their own thoughts. Cognitive strategies are taught to parents during a session on self-care, so that they may challenge any negative thoughts they have in relation to their parenting. As stated earlier, CBT has consistently received empirical support for its efficacy as an intervention for childhood anxiety (Higa-McMillan et al., 2016).

2.11.4 ‘Zones of Regulation’ (Kuypers, 2011)

The OOW intervention also utilised ‘Zones of Regulation’ (Kuypers, 2011). Based on a cognitive behavioural approach, learning tasks are used to help children recognise when they are in different states referred to as "zones". Each of the four zones is represented by a different colour. In the OOW intervention, children learned how to use strategies to stay in a zone or to move from one to another. They were taught relaxation, sensory strategies, and cognitive techniques so that they have a variety of methods to use to move between zones. Coloured Lego blocks were used as a way for children to communicate what zone they were in. Parents also received information about the Zones of Regulation so that they could support their children in using this framework.

The ‘Zones of Regulation’ is based on evidence in the areas of autism spectrum disorders, attention deficit disorders, and social-emotional theories (Kuypers, 2015). This framework integrates Systemizing Theory, Central Coherence Theory and Cognitive Behaviour Management. According to its author, currently ‘The Zones of Regulation’ is a practice based on evidence rather than an evidence based practice (Kuypers, 2015). Studies are underway to build the evidence base for this approach.
2.11.5 Theraplay (Booth & Jernberg, 2009)

Theraplay games (Booth & Jernberg, 2009) were utilised in both parent and child sessions of the OOW group intervention. These games aim to enhance the parent-child relationship through attachment-based play. Theraplay has been consistently shown to improve emotion regulation and enhance parent-child attachment (Lindaman & Lender, 2009). Siu (2009) completed a study to evaluate the effectiveness of Theraplay on reducing internalizing problems among young children. It was found that children engaging in Theraplay conditions demonstrated significantly fewer internalizing symptoms when compared to children in the waitlist group.

2.11.6 Circle of Security (Marvin, Cooper, Hoffman, & Powell, 2002)

The notion of ‘Shark Music’ as described in Circle of Security (COS; Marvin et al., 2002), was utilised in the OOW intervention in order to enhance the reflective functioning of parents and encourage them to notice their own triggers in their interactions with their children. The idea behind shark music is that parents may have their own issues that impact on their ability to be sensitive to their child’s distress. In the OOW intervention parents were shown a video clip of an ocean scene. On the first showing this clip was accompanied with calming music, while on the second showing it was paired with the music from the movie ‘Jaws’. Parents were asked to reflect on their experiences while watching these two versions of the clip. This metaphor was explained to the group and they were encouraged to think about their own shark music in relation to their children. What situations or behaviours were likely to trigger their shark music? How did it impact on their response to their child? Parents were instructed to spend time noticing their responses to their shark music over the next week and to use their new awareness of this process, in order to change their response.

This strategy is drawn from COS, an intervention which has received some preliminary empirical support. Mercer (2015) reviewed the research evidence, plausibility, theoretical background, and generalisability of COS. She concluded that COS interventions are emerging treatments that demonstrate weak empirical support, and require further study and evaluation. Subsequently, a meta-analysis was completed on ten studies of COS intervention (Yaholkoski, Hurl, & Theule, 2016). Findings indicated a significant large effect for the efficacy of COS for improved caregiver self-efficacy, and significant medium effects for child attachment security, quality of caregiving, and reduction of caregiver depression. While the COS intervention has demonstrated initial
promising results in terms of its efficacy, more research is required to establish a strong evidence base for this intervention. Consequently, the inclusion of ‘shark music’ from COS in the OOW intervention was based on clinicians’ own practice-based evidence.

2.12 Research Aim and Questions

The aim of the current study will now be outlined, along with research questions of interest and proposed hypotheses.

Research Aim

This study aims to explore the feasibility of a novel integrative intervention in reducing childhood anxiety. Due to the exploratory nature of this research, participants’ own reported experiences and opinions will be the main focus of this work. This study is interested in the experiences of both parents and children who engaged with the OOW intervention. The study is underpinned by the theoretical framework of Attachment Theory, which proposes a link between attachment and anxiety in children.

Research Questions

Using qualitative methods this study aims to answer the following questions:

- What were the common experiences of both mothers and children in terms of completing the OOW group intervention; what elements did they perceive as helpful or unhelpful to them?
- Has there been a subjectively noticeable change in the child’s anxiety (from both mother and child perspective), and how is this exemplified?
- Has there been a subjectively noticeable change in the relationship between the mother and child, and how is this exemplified?
- Has there been a subjectively noticeable change in the child’s capacity to regulate their emotions, and how is this exemplified?

Specific Hypotheses

Using quantitative methods, this study aims to test the following hypotheses:

- Child anxiety will be reduced following completion of OOW group intervention.
- Parent-child attachment will be enhanced following OOW group intervention.
- Children’s emotion regulation skills will increase following OOW group intervention.
Chapter Three: Methodology

3.1. Chapter Introduction

This chapter will begin by outlining the rationale for utilising a mixed methods approach in this study. Both qualitative and quantitative methodologies will be described, followed by information on the participants and research procedure. Both quantitative and qualitative data analysis processes will be described. Ethical considerations will be highlighted, and reliability and validity considerations shall also be discussed. The chapter will conclude with reflections on the research process.

3.2. Rationale for Methodology

Given that this study aimed to explore the feasibility of the OOW intervention, particularly in terms of the value of incorporating CBT with attachment-focused and neurobiological approaches, it was deemed that a mixed methods approach would be an effective way to demonstrate initial support for this intervention. In adopting a mixed methods approach, this study aimed for triangulation through multiple methods of data collection (semi-structured interviews and questionnaires), as well as multiple informants (parents and children). A triangulation approach aims for corroboration of results from different methods (Creswell & Plano Clark, 2007).

A mixed methodological approach is often chosen in order to compensate for the limitations of both quantitative and qualitative approaches (Guével, Pommier, & Jourdan, 2015). Creswell and Plano Clark (2007) proposed that utilising a mixed methods approach in research generates a better understanding than using qualitative or quantitative approaches alone. The current study was underpinned by Attachment Theory; both qualitative and quantitative research questions and hypotheses were generated in the context of this framework.

3.3. Qualitative Methodology

The qualitative element of this study employed a qualitative descriptive design through use of thematic analysis. Sandelowski (2000) argued that qualitative description is a valuable method of choice when seeking straight descriptions of phenomena.
3.3.1. Semi-structured interviews

In order to gather qualitative data, a series of semi-structured interviews were carried out with parents and children who attended the OOW group. Interview schedules (see Appendices C and D) for both parents and children were constructed by the researcher prior to the commencement of data collection. Interview questions were developed guided by the research questions posed by this study. The interview schedules were reviewed by the academic supervisor and by a Senior Clinical Psychologist who acted as field supervisor for the study. In addition to this, the facilitators of the children’s group (a Clinical Psychologist and a Play Therapist) provided input in devising the child interview schedule. They offered valuable information about their experiences of working with this group of children, and highlighted potential difficulties in eliciting information from them during an interview. Questions were phrased in an open-ended way in order to elicit more descriptive responses.

3.3.2. Thematic Analysis

Given the exploratory nature of this study, a number of qualitative methodological approaches were contemplated. Grounded theory (Charmaz, 2002) was one such approach considered in choosing a methodological framework for the current study. Grounded theory involves an inductive approach to creating hypotheses that are grounded in the data. Any pre-existing knowledge about the subject matter is intentionally withheld until initial data collection and analysis have been completed, in order to prevent any influence on the research findings (Elliott & Jordan, 2010). As the OOW intervention was devised from an Attachment Theory perspective, it was not possible to be truly inductive in this manner. In addition, the core aim of the study was to capture patterns across the data that may account for the efficacy of the OOW intervention, rather than attempting to develop a coherent theory that could account for their experiences. Taking these points into consideration, a grounded theory approach was deemed inappropriate in this instance.

The aim of the current study was to determine the most effective elements of the intervention, therefore identifying patterns across the total dataset was of utmost importance. Interpretative Phenomenological Analysis (IPA) places an idiographic focus on each participant, as well as looking at the patterns across participants. As an idiographic focus was not necessary to address the current study aims, it was deemed that thematic analysis was a more appropriate method.
Thematic analysis was chosen due to its ability to identify and analyse patterns of meaning in a dataset (Braun & Clarke, 2006). The aim of a thematic analysis is to highlight the most salient themes present across the data. Themes can contain manifest (explicit) or latent (implicit) content (Joffe, 2012). In addition to this, a theme can be considered in terms of whether it is drawn from a pre-existing theory brought to the research (deductive), or from the raw data itself (inductive). In thematic analysis, these often occur side by side, in that the researcher approaches the data with some preconceived ideas derived from theories, while also remaining open to new or unexpected concepts found in the data. High-quality qualitative work often involves a dual deductive/inductive and latent/manifest set of themes being used together (Joffe, 2012).

3.4. Quantitative Methodology

Quantitative methods were utilised in order to explore trends over time in the following variables: child’s anxiety, parent-child relationship, and child’s level of emotion regulation. Measures were chosen based on pre-established evidence of validity and reliability, suitability for the age range of the children participants (age 8-10), and length of administration time.

3.4.1. Quantitative Instruments

Quantitative data was collated using the following measures:

- **Demographic questionnaire**

A demographic questionnaire was devised (see Appendix E) in order to gather data pertaining to children’s and parents’ demographic information. This questionnaire asked the parent to outline any other difficulties experienced by the child, if they are taking any medication, if they are in receipt of resource hours at school, and if they are accessing any other services at present. Information pertaining to the home environment was also requested, e.g. number of children living in the home, and parent/caregivers relation to child.

- **Parenting Relationship Questionnaire (PRQ)**

The PRQ (Kamphaus & Reynolds, 2006) was utilised to measure any changes in the child-parent relationship over the course of the OOW intervention (see Appendix G). The PRQ was created to measure variables of family and parenting relationships.
considered to be important in healthy social and emotional child development. The PRQ is made up of the following scales: Attachment, Communication, Discipline Practices, Involvement, Parenting Confidence, Satisfaction with School, and Relational Frustration. The PRQ contains statements depicting common thoughts, beliefs, feelings, and situations that may be experienced by a parent/guardian when caring for their child. The questionnaire uses a Likert-type scale to allow parents to rate these statements (they choose from Never, Sometimes, Often, or Always).

The coefficient alpha statistic was used to measure internal consistency (Rubinic & Schwickrath, 2010). Reliabilities were found to be reasonably high for each scale; median scores ranged from .82 to .87. A test–retest reliability analysis was also conducted, with the PRQ administered to a sample and then re-administered approximately 1 month later. These reliability coefficients ranged from .72 to .81.

In considering validity of the PRQ, interscale correlations were mostly found to be moderate and in the expected directions (Rubinic & Schwickrath, 2010). Convergent validity was analysed by determining correlations between the PRQ and three other measures of parent-child relationship (Rubinic & Schwickrath, 2010); these measures were the Parent-Child Relationship Inventory (PCRI), the Parenting Stress Index (PSI), and the Stress Index for Parents of Adolescents (SIPA). Scores on the PRQ and PCRI demonstrated moderate to high correlations with one another. Correlations between scores on the PRQ and the PSI were also in the high to moderate range. In comparing the PRQ and the SIPA, moderate to strong correlations were found between the scales.

In choosing a psychometric measure of parent-child relationship/attachment, options were limited. Many tools for assessing this construct involve interview or observation. The other scale considered was the PCRI (Gerard, 1994). In comparison with the PRQ, this measure was found to be lacking in terms of failing to demonstrate internal consistency between some of its subscales (Coffman, Guerin, & Gottfried, 2006).

- Emotion Regulation Checklist (ERC)

The ERC (Shields & Cicchetti, 1997) was used to measure children’s ability to regulate their emotions (see Appendix H). It is a 24-item measure that is completed by a child’s parent or caregiver. Participants are asked to indicate how often a child demonstrates affective behaviours by using a four-point Likert scale. The ERC consists of two
subscales; the emotion regulation subscale examines processes that are fundamental to adaptive emotion regulation. These include social appropriateness of emotional displays, empathy composure, and emotional understanding. High scores on this subscale suggest that a child has greater capability to adapt their emotional arousal, allowing them to function in their environment to an optimal degree. The lability-negativity subscale examines arousal, reactivity, intensity of emotions, anger dysregulation, expression of negative emotions, and lability of mood. The ERC has demonstrated good construct and discriminant validity (Shields & Cicchetti, 1998). Cronbach’s alphas were .81 for the Emotion Regulation subscale and .95 for the Emotion Lability/Negativity subscale (Kim-Spoon, Cicchetti, & Rogosch, 2013). This measure was chosen as it was deemed a reliable and valid measure of child emotion regulation. Also it involves parent-report as opposed to child self-report, which was the required format for the current study. Other identified measures of emotion regulation in children involved child self-report e.g. Emotion Regulation Questionnaire (Gross & John, 2003), Child Emotion Management Scale (Zeman, Shipman, & Penza-Clyve, 2001).

▶ Spence Child Anxiety Scale for Parents (SCAS-P)

In order to measure child anxiety, the SCAS-P (Spence, 1999) was utilised. This is a 38-item parent-report measure of symptoms of anxiety for children and adolescents (see Appendix F). The SCAS-P is made up of six subscales: separation anxiety disorder, social phobia, obsessive-compulsive disorder, panic/agoraphobia, fear of physical injuries, and generalized anxiety disorder. Parents were asked to rate the 38 statements using a four-point Likert scale (0 = never, 1 = sometimes, 2 = often, 3 = always).

A study completed to examine the psychometric utility of the SCAS-P (in addition to its child self-report counterpart SCAS), found support for its reliability and validity and suggested that it was a valid measure in the assessment of childhood anxiety for both clinical and research purposes (Whiteside & Brown, 2008). It was demonstrated that the scales of the SCAS-P can distinguish children with anxiety disorders from community controls. In addition, convergent and divergent validity of the scales were evident by agreement between child (SCAS) and parent (SCAS-P) report (Whiteside & Brown, 2008; Nauta et al., 2004). The SCAS-P subscales demonstrated satisfactory to strong reliabilities in terms of internal consistency; alpha coefficients ranged from .79 to .84. The alpha coefficient for the SCAS-P total score was high at 0.93. These results provide
support for the use of the subscale and total scores for both clinical and research purposes. The SCAS-P demonstrated discriminant validity based on significant differences in mean scores on all subscale and total scores between the anxious and control groups.

A further study (Wang, Meng, Liu, & Liu, 2016) demonstrated acceptable internal consistency of the SCAS-P, with alpha coefficients ranging from .63 to .91. This study also demonstrated acceptable test-retest reliability ($r = .46-.72$). Congruent validity was demonstrated as significant correlations were found between father and mother reports ($r = .60-.71$) and between child and parent reports ($r = .25-.42$). In choosing a measure of anxiety, many scales were considered in terms of their appropriateness to the current population, administration time, and most importantly in terms of their reliability and validity. The SCAS-P was the most valuable measure based on the above criteria.

3.5. Participants

Participants were recruited on the basis of their attendance at the OOW intervention group. All parents and children invited to this group were attending the Child and Family Psychology Service at the time, and were offered a place in the intervention group due to the child experiencing a clinical level of anxiety. The inclusion criterion for this study was attendance at the OOW intervention group. No exclusion criteria were identified.

Nine parent/children pairs attended the OOW intervention group in January 2018; from this total there were seven who consented to participate in the current study. All of the child participants were aged between 8 and 10 years of age; two were female and five were male. All of the parent participants were female.

3.6. Procedure

The research procedure will now be outlined in detail.

3.6.1. Intervention

The OOW intervention was delivered over the course of 10 weeks, which commenced in mid January 2018. The intervention consisted of ten sessions for parents, and six sessions for children. The parent and child sessions were run simultaneously (with the child group commencing after the parents had completed their initial four sessions). Parent sessions were facilitated by two Senior Clinical Psychologists, while the child
sessions were facilitated by a Clinical Psychologist and a Play Therapist. Each session was 2 hours in duration.

3.6.2. Data Collection

The researcher attended the first parent session and presented an outline of the proposed study to those in attendance. All parents were provided with an information sheet and a consent form. Parents were given time to complete questionnaires during this first session. All parents were asked to complete the questionnaires (for clinical purposes), but parents were asked to specify by signing the consent form if they also wished for their data to be included in the research. Of the nine parents in attendance, seven consented to taking part in the study.

Parents were asked to complete a battery of psychometric measures as outlined above. These measures were administered to all participants at three time points;

1. Pre-intervention (January 2018)
2. Immediately post-intervention (April 2018)
3. Follow-up at 3 months post-intervention (July 2018)

The purpose of including a further data collection point at 3 months post-intervention was to determine whether any changes demonstrated post-intervention had been maintained over time. It also gave time to allow for strategies and learning to be embedded in participants’ everyday lives.

Seven parents and seven children completed a semi structured interview following completion of the intervention. Semi-structured interview protocols were used to gather qualitative data. All interviews were audio-recorded and subsequently transcribed. Interviews took place over the course of 3 days in April 2018.

3.7. Data Analysis

3.7.1. Qualitative Data Analysis

All fourteen semi structured interviews were transcribed and formatted in Microsoft Word by creating two columns; one for the transcribed interview and one for codes. Braun & Clarke’s (2006) six-step framework was utilised to complete Thematic Analysis. These steps are outlined in table 1 below. This process of analysis took place
over an extended time period. The researcher endeavoured to become increasingly familiar with the data, through listening to the audio recordings while reading transcripts, and allowing ample time for reflection throughout the process.

Table 1: *Steps of Thematic Analysis (Braun & Clarke, 2006)*

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>Become familiar with the data; listening to audio files of interviews, reading through transcripts and taking note of potential items of interest.</td>
</tr>
<tr>
<td>Step 2</td>
<td>Generate initial codes across the entire dataset. Codes refer to the most basic segment of the raw data that can be assessed in a meaningful way regarding the topic of interest.</td>
</tr>
<tr>
<td>Step 3</td>
<td>Search for themes across the dataset; this phase involves sorting the different codes into possible themes, and assembling all the relevant coded extracts of data within the themes that have been identified.</td>
</tr>
<tr>
<td>Step 4</td>
<td>Review themes; produce map of provisional themes and subthemes and relationships between them (“thematic map”)</td>
</tr>
<tr>
<td>Step 5</td>
<td>Define/name themes; this involves identifying the essence of each theme, and establishing what feature of the data each theme encapsulates.</td>
</tr>
<tr>
<td>Step 6</td>
<td>Write-up; provide a concise, coherent, logical, explanation of the story told by the data. Present adequate evidence of themes by using data extracts to illustrate the prevalence of the theme.</td>
</tr>
</tbody>
</table>

**3.7.2 Quantitative Data Analysis**

One participant failed to return the post-intervention and follow-up measures. She was unable to be reached, despite multiple attempts to make contact via letter and phone. Consequently, quantitative analysis was performed using data from the remaining six participants. A data file was created using IBM SPSS Statistics Version 25. The quantitative data were entered, and descriptive statistics were obtained.
3.8 Ethical Considerations

Ethical approval for the present study was obtained from the relevant research ethics committee (see Appendix L). This application process facilitated consideration of pertinent ethical issues, and the Psychological Society of Ireland (2011) ‘Code of Professional Ethics’ was utilised to inform proposed research practices.

3.8.1 Informed Consent/Assent

Both parents and children were provided with information as to the study and their role within it, what was expected of them and how it could be beneficial. For the parents this took place during the introductory session of the intervention group. Consent was sought at this time and consent forms (see Appendix A) along with pre-intervention measures were returned to the researchers at the end of this session. As the children were only participating in the interview element of the study (post intervention), the study information was provided and child assent (see Appendix B) was sought after the intervention was complete, and in advance of the semi-structured interviews taking place. It was emphasised that opting out of the research would not have any impact on their entitlement to attend the group, nor impact their ability to avail of psychology services. The above procedures relating to consent and assent were discussed in detail with the research ethics committee prior to ethical approval being granted (see Appendix L).

3.8.2. Confidentiality and Anonymity

The confidentiality and anonymity of participants was preserved through use of pseudonyms in interview transcripts. The primary researcher had sole access to the coding sheet recording pseudonyms. All identifying information relating to participants, their children and any named professionals was changed or removed from transcripts. Prior to their involvement in the study, participants were made aware of limits to confidentiality in relation to maintaining their own safety and that of others. This was reiterated verbally at the beginning of each interview. Interviews were recorded using a digital audio recorder. The audio files were transferred to an encrypted USB stick following each interview and were subsequently transferred to a password-protected computer. All audio files were encrypted and password protected. Once audio files were securely stored in this manner, the original files were deleted from the digital audio recorder. Transcripts were viewed solely by the primary researcher, while some extracts
from transcripts were viewed by the research supervisor in order to support the supervisory process.

3.8.3 Potential Distress

There were minimal risks associated with participation. However, there was a possibility that it may have been distressing for the parent to consider some of the questions within the psychometric measures, particularly those related to their own relationship with the child and the child’s experience of anxiety and emotions. In addition, there was a possibility that the children may have experienced some anxiety in attending an interview with the researcher. A play-based introduction to the interviews was utilised in order to settle the children and make them as comfortable as possible.

3.9 Considerations of reliability, validity and rigour

3.9.1 Reliability and Validity

Reliability can be defined as the degree to which measures are free from error and therefore yield consistent results (Field, 2009). Validity refers to whether an instrument measures what it was designed to measure (Field, 2009). Reliability and validity are two concepts that are particularly important to quantitative research. Evidence of the reliability and validity of this study’s quantitative measures are outlined above in the descriptions of each measure. As qualitative research produces data at a greater level of depth and detail, different criteria must be applied to ensure trustworthiness.

3.9.2 Trustworthiness and Rigour

Nowell, Norris, White, and Moules (2017) suggested a framework for producing credible and trustworthy qualitative research. They incorporated Lincoln and Guba’s (1985) concept of trustworthiness (credibility, transferability, dependability, and confirmability) into Braun and Clarke’s (2006) six steps of thematic analysis. They also suggested that a reflexive audit trail be demonstrated by qualitative researchers.

Credibility relates to the fit between participants’ views and how they are represented by the researcher (Tobin & Begley, 2004). The researcher strived to ensure credibility within the current study by utilising a number of techniques recommended by Lincoln and Guba (1985), such as prolonged engagement with the data, data collection triangulation, and peer debriefing with supervisor to ensure an external check on the research process.
The researcher has provided in-depth descriptions of the research process, so that those who may wish to transfer findings to their own service can ascertain study transferability (Lincoln & Guba, 1985). To increase dependability of the current study, it is vital that the research process is traceable, logical, and documented clearly (Tobin & Begley, 2004). The researcher aimed to achieve this through use of audit trail and reflective journal.

The study endeavoured to achieve confirmability by verifying that the researcher’s interpretations were evidently obtained from the data. The researcher has demonstrated how conclusions and interpretations have been reached (Tobin & Begley, 2004). The researcher provided an audit trail by including the rationale for theoretical, methodological, and analytical decisions throughout the study, to ensure that others can understand the choices made (Koch, 2006). The audit trail also included keeping records of the raw data, field notes, transcripts, and a reflective journal of the research process.

3.10. Reflections on the research process

Reflecting on the research process, the researcher was struck by the challenge of removing the ‘clinician hat’ and replacing it with the ‘researcher hat’. Working as a Trainee Clinical Psychologist, the researcher is accustomed to providing validation, guidance and their own reflections to the individuals with whom they are working. At times during the interview process, it was challenging to hold back from offering advice or strategies. It is possible that some of this can be attributed to feelings of gratitude towards participants and wanting to be helpful where possible. The researcher was mindful that their own contributions to the interview could impact on participant responses, and a neutral stance was utilised when discussing topics relating to the research questions of interest.

In order to assist with recruitment, while also getting a direct sense of what the OOW intervention entails, the researcher attended a number of the parent sessions. The role of the researcher was made explicit to participants from the outset, so that they were not misperceived as being another group facilitator. However, at times the researcher was required to assist the group facilitators in modelling role plays in front of the group. On reflection, the researcher’s presence at some of the intervention sessions may have led to biased responses from participants. If they associated the researcher with the group
facilitators, they may not have wanted to offend by answering negatively about their experiences.
Chapter Four: Results

4.1 Chapter introduction
This chapter will be divided into 3 sections; parent qualitative results, child qualitative results, and quantitative results.

4.2 Parent qualitative results
After several months of transcribing, reading, coding and collating the interview data, a number of themes were identified from the seven parent interviews. Themes and subthemes will be presented to summarise the relevant findings, with participant quotations utilised for illustration. Please note that the use of three full stops in participant quotes denotes the removal of some text, in order to aid the clarity of the point being expressed. Words in brackets are used to note the context of the quotation, if not explicitly stated in the specific quotation used.

4.2.1 Overview of parent themes
Table 2 presents the themes identified within the parent qualitative data. ‘A family affair’ relates to participants’ experiences of the intervention being relevant to their family as a whole, not just the child experiencing anxiety. ‘We’re all in the same boat’ concerns mothers’ experiences of having shared, common experiences with other group members. ‘Attunement’ concerns the development of parental capacity to be reactive to their child’s needs. This seemed to occur through acknowledging the emotions of the child, looking beneath the surface to gain a better understanding of the child’s behaviour, responding by soothing when the child initially exhibits distress, and getting in their child’s shoes in order to empathise with their experience.

‘Facing and feeling’ relates to the children approaching feared situations in a paced manner. It includes the children’s growing ability to tolerate being in anxiety-provoking situations, and the parent supporting the child to the edge of their anxiety by ensuring that they push themselves out of their comfort zone in a manageable way. The theme of ‘Connection’ pertains to the enhanced connectedness between mothers and children, which was contributed to by increased quality one-to-one time, and use of physical touch between mother and child. ‘Parent’s emotions’ encompasses the mothers’ evolving awareness of their own emotions, as well as a recognition of the impact that their own emotions may have on their children. Finally, ‘Child’s expression of feelings’ concerns the children verbalising and opening up about their emotions. This is facilitated through their newfound emotional language, and their growing ability to
recognise and name their feelings, which are nurtured by their mother’s receptive listening.

Table 2: 
*Summary of themes and subthemes from parent data*

<table>
<thead>
<tr>
<th>Themes</th>
<th>Subthemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A family affair</td>
<td></td>
</tr>
<tr>
<td>We’re all in the same boat</td>
<td></td>
</tr>
<tr>
<td>Attunement</td>
<td>Acknowledging emotions</td>
</tr>
<tr>
<td></td>
<td>Looking beneath the surface</td>
</tr>
<tr>
<td></td>
<td>Soothe first</td>
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<tr>
<td></td>
<td>Getting in child’s shoes</td>
</tr>
<tr>
<td>Facing and feeling anxiety</td>
<td>Tolerating the edge</td>
</tr>
<tr>
<td></td>
<td>Supporting child to the edge</td>
</tr>
<tr>
<td>Connection</td>
<td>Quality one-to-one time</td>
</tr>
<tr>
<td></td>
<td>Physical touch</td>
</tr>
<tr>
<td></td>
<td>Enhanced communication</td>
</tr>
<tr>
<td>Parent’s emotions</td>
<td>Awareness of own emotions as parent</td>
</tr>
<tr>
<td></td>
<td>Impact of parent emotions on child</td>
</tr>
<tr>
<td>Child’s expression of feelings</td>
<td>A new language</td>
</tr>
<tr>
<td></td>
<td>Recognising and naming feelings</td>
</tr>
<tr>
<td></td>
<td>A receptive listener</td>
</tr>
</tbody>
</table>

4.3 Theme: A family affair

Most parent participants reported that they found it beneficial to apply their learning from the group to all of their children, not merely the child who had been referred due to anxiety.

‘It makes you more aware of lots of different things in the house, not just the one child d’you know, everything really you know’ {Laura}
‘[I have] a lot more better understanding, even the techniques we learned, you know the empathy and you know, even with the other two [children in family]’
{Carol}

One mother commented that her child’s anxiety impacted upon one of his siblings in a way that led to him engaging in attention seeking behaviour. She reported that acknowledging this child’s feelings was beneficial.

‘I find it [acknowledging and naming emotions] brilliant for my other son as well, you know, I do, because ahh, because he never got as much attention as John because John always needed more help and ahh so he would overreact to things to get the attention’ {Rachel}

Some mothers also reflected on how having a child with anxiety has an impact on the family as a whole, in terms of the unpredictability faced by both parents and siblings.

‘It makes life very difficult for us at home, all three of us, the rest of us, when…’cause we don’t know, he’s up and down and you don’t know what’s coming next really’ {Rachel}

Karen reflected on how this is changing since she attended the OOW group, due to the skills she has acquired to manage her daughter’s anxiety. She reported feeling better equipped to support her child in facing a feared situation, such as a family outing, where giving in to avoidance would mean everyone missing out on the experience.

‘it’s difficult you know when you have 2 other children, and like, she, you know, can have an outburst and it can change the day for everybody…you know when there was…two other girls looking forward to what they were going to do, so being able to deal with that situation and not say “right I’m going home, I can’t do this” …and to have the kinda tools to kinda calm her and get us all into a place where we can just move on’ {Karen}

Some children took it upon themselves to share their learning about emotions with their siblings.

‘he’d even say things like amm, at home with his sister ‘oh you’re in the red zone now’, d’you know what I mean’ {Laura}
Tom’s younger sister Mary also experienced some anxiety and Tom, a child who had been extremely withdrawn, has started to teach Mary about how to talk about her feelings.

‘Mary has the same thing...Tom’s trying to help her and show her with the Lego and what it means, to try and see if she’ll help...she’s the same, she won’t express...so he seems to be helping her as well which before he wouldn’t even interact like’ {Tanya}

This has served to enhance the relationship between the two siblings, as well as giving Tom a sense of mastery as a role model for his younger sister.

‘the two of em have gotten very close now the last couple of weeks as well and...before they wouldn’t even interact like, so I think it was because they were both feeling the same thing and they couldn’t talk, they were clashing but now since Tom’s able to talk, he’s trying to explain to Mary to talk...it just makes him feel special as well cause he’s the bigger brother now that’s going to help her like’

{Tanya}

4.4 Theme: We’re all in the same boat

Most parent participants reported that it was positive to feel a sense of having common experiences with others, due to meeting people in the group whose children had similar difficulties.

‘knowing that there was other kids there as well that had obviously the same problems, it was great’ {Tanya}

‘I think because we are all in a kind of similar situation it’s nice to share our experiences’ {Helen}

This awareness of others being ‘in the same boat’ had the effect of normalising mothers’ own experiences of parenting an anxious child.

‘you kind of got a feel of how...it’s normal, not normal but d’you know what I mean, there’s many people going through the same sort of things...for different reasons but kind of the children are acting out in the same, similar ways’

{Karen}
Some parents felt that this was something they did not often experience in day to day life, as people tend to keep their problems private.

‘it kinda showed me that there were other parents who were struggling as well because when you’re at the school gate or your kids are talking to other kids nobody knows what struggles are happening in other families’ {Susan}

One mother reported that she had always felt she was the only one who was struggling to cope with her child’s difficulties, but attending the group showed her she was not alone.

‘I actually thought I was alone in feeling, not being able to cope and what have you, and as we talked about it...it became obvious that everyone has problems coping, even the most well-adjusted person with the most fabulous family support network around you, it is difficult because you know if you have a child who has behavioural issues and anxiety’ {Susan}

Some parents reported that their child had a similar experience of thinking ‘I am not the only one experiencing this’.

‘John liked his group as well in that he got to meet kids similar to himself and he loved that cause he doesn’t feel that in school at all, he always [says]‘there’s nobody like me’, so he loved that’ {Rachel}

4.5 Theme: Attunement

The theme of ‘attunement’ concerns the enhanced ability of mothers to tune into their child’s needs. This theme is made up of four subthemes which contributed to enhanced attunement between mother and child. Each of these is exemplified below; acknowledging emotions, looking beneath the surface, soothe first, and getting in child’s shoes.

4.5.1 Acknowledging emotions

All mothers expressed that they had experienced a change since attending OOW, in terms of how they acknowledged or validated their child’s emotions. Some mothers reported that using this strategy was useful in terms of calming their child.

‘But just me acknowledging...whatever he’s feeling at that time, it just really brings him down really fast I find, much faster than before’ {Rachel}
Some parent participants noted that acknowledging their child’s emotions seemed to facilitate more open communication and understanding between parent and child.

‘the bit that helps the most is...just acknowledging the fear or naming the emotion, just those simple little things has really helped me connect with him better in that he, he will then be more open to talk to me because he feels ‘oh she understands me’ you know, “she’s got what I’m feeling”’ {Rachel}

Mothers reported moving away from trying to alter their child’s emotion by attempting to rationalise with them. Most parents identified with the adoption of a more accepting and empathic stance.

‘before I would’ve been trying to explain that to him on an intellectual level ‘look it’s unfortunate you can’t go to that but we’d already booked to go to nana’s so you can’t go to that event or whatever’ whereas now I’d sort of start with the empathy that “I understand, I know it’s upsetting, I’d be upset too if I couldn’t go to something I was really looking forward to”’ {Susan}

Some parents admitted to previously being dismissive of their child’s feelings, which could be attributed to the parent’s own discomfort with their child’s negative affect and a desire to ‘fix’ or ‘make things better’, which seems to come more naturally than sitting with a difficult emotion.

‘[I would have previously said] ‘don’t be worrying about it’ but now you kinda go “yeah well that is, or must have felt awful, I wouldn’t like if it was said to me so I can understand how you don’t like it”. We tend to just kinda go “ahh stop sure you’re grand don’t be worrying about that kinda thing”’ {Laura}

By acknowledging their child’s emotions as opposed to trying to change them, parents became more attuned to their child’s emotional experience.

4.5.2 Looking beneath the surface

All mothers reported that they gained a greater understanding of the factors contributing to their child’s behaviour, and how little control children can have at times when they are experiencing overwhelming anxiety.
‘I think it’s helped myself and his dad because we’re more aware of the fact that he can’t control it, that’s just the way his brain works so we have to kind of adjust how we deal with him’ {Susan}

This newfound understanding, particularly of the neuroscience behind anxiety, informed parents as to why certain responses may not be helpful e.g. trying to use logic when the child is already totally overwhelmed by anxiety.

‘the kids just can’t help it, no more than we can help it ourselves when we’re reacting at a basic level as opposed to at an intellectual level...if your child is sort of average or above intelligence you expect them to kinda get that they’re being irrational so the fact that [the OOW group] did break it down, that it was sort of explaining that when they’re in the throes of that big emotion that it’s their reptilian brain has kicked in as opposed to the intellectual side of things’ {Susan}

In looking beneath the surface for the causes of the child’s behaviour, many mothers felt more compassion and empathy for the child, and no longer attributed their behaviour to merely being naughty.

‘it’s just an outburst of, she doesn’t know what else to do with her fear. I kind of have a better understanding of that and I suppose, understand that she’s not being bold...she doesn’t think about it [aggressive behaviour], no no she doesn’t think about it and it’s literally like “I’m scared, don’t make me do this” you know’ {Karen}

Karen reported that having an increased understanding of the causes of her daughter’s challenging behaviour, allowed her to adapt her response.

‘definitely she needs empathy and you know a soothing and all that...we’re more aware that that’s what’s needed to be done, more than the ‘don’t ever do that again’ kind of a, you know, you know giving out kind of a thing, now I know she still has to be told ‘you can’t hit people’ and whatever, but at the same time there’s an understanding that, you know, there was a reason behind it’ {Karen}

This again exemplifies a greater attunement between mother and child, as the mother demonstrates an understanding of why her child is distressed, and what her child needs in that moment.
4.5.3 Soothe first

Linked to an increased understanding of how their child’s brain reacts in stressful situations, parents reported a new awareness of the importance of using a soothing approach as their first response.

‘the message all the way through was calm first, calm first and then try it with the other, the causative things later on’ {Susan}

‘I was fascinated by the whole soothing thing d’you know what I mean because it’s not our instant and initial reaction to soothe somebody like that, but it definitely helps and even the touch, the soothing, everything is calmed down’ {Laura}

‘whenever he feels stressed or upset, then I should comfort him first and not just tell him to do things you know, before…I was trying to fix the problem, [I would say] ’just do what I told you to do’... but now I know that, it’s not the best way to approach things’ {Helen}

Parents expressed a recognition that using logic and rationalising with their child is often ineffective, particularly if they are still in a heightened state of distress.

‘you know the empathy and you know, the comforting and the understanding that when they’re in a state that you can’t reason with them you just have to comfort them’ {Carol}

‘I am more kind of aware of the fact that sometimes when the kids are upset...that they’re just in the middle of a big emotion and that they need to work maybe, just come out the other side before we can kind of deal with what’s causing it’ {Susan}

4.5.4 Getting in child’s shoes

Most parents reported experiencing greater empathy for their child as a result of attending OOW intervention group. Some used their own difficult experiences of childhood in order to gain insight into their child’s distress.

‘he’s a mirror image of me, so that’s why I think I try to soothe him now and try think back to when I was younger and those kind of things really frightened me
you know. I try to nearly put myself in his shoes and try get the feeling you know’ {Laura}

‘I was shy, not as shy as him but still shy…ah yeah it does help me to understand him’ {Helen}

‘it could be something maybe like not wanting to go back to school d’you know what I mean and like [I would previously say] “you have to, end of, no matter what”, whereas now you say “I know, it’s horrible, I was like that when I was a child”’ {Laura}

Laura reflected on how her age and life experience shape how she views situations, and how she tries to bear this in mind in order to empathise with her son’s experience of the world.

‘you just become more aware of his feelings and kind of, not get down to his level, but maybe get down to…I’m in my mid-forties I’ve an awful lot of, you know, experience behind me, just get down to, well he’s only 10, understand where he’s coming from and try and just help him through the little scenarios he’s going through’ {Laura}

Using empathy appeared to be a key part in how parents verbally acknowledged their child’s emotions. Not only did they verbalise an understanding of their child’s emotions, but they communicated to the child that they would feel similar if they were in that situation.

‘now I’d sort of start with the empathy that “I understand, I know it’s upsetting, I’d be upset too if I couldn’t go to something I was really looking forward to”’

{Susan}

Karen found that using empathy was helpful in supporting her daughter with uncomfortable daily medical procedures. Karen described how she now uses empathy instead of trying to rationalise with her child as to the importance of the procedures in terms of her health.

‘I try to empathise with her kinda saying “I know how you feel and I know this is terrible” and you know we try and do all that sort of thing whereas before we
didn’t…it was kinda like “you have to have this done” and you know “it’s really important for you to”’ {Karen}

4.6 Theme: Facing and feeling anxiety

The theme of ‘facing and feeling anxiety’ concerns the way in which children are exposed to anxiety provoking situations in a gradual way. In doing so children often learn that the feared situation is not as frightening as they had imagined, or they may learn that they have the ability to cope with the situation despite its challenges. This theme is made up of two subthemes that were discussed in relation to ‘facing and feeling anxiety’; tolerating the edge, and supporting the child to the edge.

4.6.1 Tolerating the edge

Many parents reported that their child now seemed to have a better tolerance for being in anxiety provoking situations.

‘he’ll stay, he’ll do things, he will do them, he mightn’t want to do them but he’ll do them…he’s getting better’ {Laura}

‘He will go [to feared activity] and once he’s there in the middle of the horses, it’s fine’ {Rachel}

‘[My] friends call round, he’ll stay in the room longer than he used to and he’ll chat to them for a few minutes you know’ {Laura}

Helen described her son’s improved tolerance for feared situations, as resulting from an increase in bravery.

‘he is becoming a bit more courageous, adventurous in certain social situations…like maybe interacting a bit more with his peers, you know…with his classmates and he’s, he was doing this speech and drama class in school and ammm there was like a poem reading competition and he managed to get on the stage and tell his poem’ {Helen}

Laura expressed that she saw an increase in her son’s confidence as a result of gradually encouraging him to tolerate more feared situations.
‘things he does without us definitely builds his confidence...“run in and get milk while I wait outside in the car for you” or going to the other boy’s house, going to a party’ {Laura}

4.6.2 Supporting child to the edge

Parents expressed an understanding of the importance of their role in supporting their child to approach more anxiety provoking situations. Rachel’s son John had recently developed a great fear of horse riding, as a result of falling off a horse several times. Horse riding was an activity that really relaxed John, and Rachel encouraged him to continue attending despite his feelings of significant anticipatory anxiety.

‘we nearly have to force him to go every Saturday but then he’s buzzing by the end of it, and I’m trying to get him to connect the two, you know how he felt at the start to the end...we can’t let him give it up, it’s just too important for him, and it does relax him, it does’ {Rachel}

Helen reflected on how she had previously tended to push her son Joe into situations he feared, without any use of empathy or pacing.

‘before I suppose I was kind of like getting, just upset and would just push him to do things without kinda understanding him properly...I would just push him, “just you have to do it”... and after this group I think I kind of understand him better now, and now I know I shouldn’t be just pushing the child…there’s another way of achieving what I want to achieve with him’ {Helen}

She went on to express a new understanding that her child needs to face his fears in a gradual way, as opposed to being thrown into an extremely overwhelming situation. She supported Joe to achieve this on one occasion, by liaising with his school.

‘he had to say a poem in front of his class and I asked the teacher not to put him in front of the whole class because it would be too stressful for him and try maybe, I mean he could tell, this poem to his teacher, and then maybe to a couple of his classmates that he feels comfortable with, so kind of like do it gradually, or take it in stages’ {Helen}
4.7 Theme: Connection

The theme of ‘connection’ describes the improvement in connection between mothers and their children. This theme is made up of three subthemes that contributed to increased connection between mother and child, each of which will be exemplified below; quality one-to-one time, physical touch, and enhanced communication.

4.7.1 Quality one-to-one time

Many parents spoke about how they are now making quality one-to-one time with their child a priority.

‘I am a lot more aware now of how much time I’m spending with her, and trying to spend time, and trying to, you know, carve out like an afternoon or an hour even or something, to do something together’ {Carol}

Carol reported a change in terms of the bond she feels with her daughter now that they are spending more time together. This was something she had felt to be lacking as a result of a traumatic birth and postnatal depression.

‘we’ve definitely bonded a bit more and we’re definitely, and I do think it’s from me, like it’s definitely down to me…because I never had that kind of thing of little girl, playing with the make-up and I never, I didn’t do that, I never did that with her so I’m doing it more now, yeah hair and things like that’ {Carol}

Some mothers reflected on the challenge of carving out this special time with their child, due to demands from siblings.

‘I have maybe realised that his sister was getting so much time because she’s so much louder, so much more vocal, you know small things, I think I’ve become more aware of what to do to make him feel better that it’s not just always about her’ {Laura}

‘I do spend more time with her above in, when she’s in bed you know what I mean, we have little chats and things like that but then you’ve got the boys going “why do you spend so much time in her room?”’ (laughing)’ {Carol}

Rachel reported using an activity that relaxes her son for their daily one-to-one time. This gives him a space in which he feels relaxed and facilitates more communication between them.
‘the ball throwing that we were doing [in the OOW sessions]...we now do that for 5 minutes before he goes out the door, and he goes out smiling and that’s a big difference and I know how important it is for him so we, we make sure we do it and like it’s such a simple little thing but he sits and chats with me like...that’s when he was telling me this morning that he was so anxious all week long’ {Rachel}

Laura also found that purposefully spending more time together one-to-one has facilitated her son to open up more about his worries.

‘I find sometimes if you sit with him just at the side of the bed at night time, only for a minute, if he’s anything to say he’ll say it’ {Laura}

For Tanya, the change in the amount of time spent with her son Tom has been striking. Tom had completely withdrawn from the rest of the family, spending all of his time alone in his bedroom. Since attending the OOW group, Tanya reported that he is now initiating quality time with her and his dad.

‘it kinda brought us closer cause as I said before he wouldn’t talk but now he knows he can come and talk to me and he’s been coming down, sitting down beside us, cuddling into us when before he wouldn’t come out of his room, you’d barely get two words out of him...you know so he’s starting to interact more with me now’ {Tanya}

4.7.2 Physical touch

Some parents reflected on how they now use more physical touch in their interactions with their child, and demonstrated an awareness of the value of this.

‘how important it is just to give him a hug, to look at him, just to, just all these very simple little things’ {Rachel}

Rachel described how the use of physical touch has always had a relaxing effect on her son John, and how attending the OOW group reminded her of strategies that had worked previously.

‘when he was, I’d say about 3 or 4, I used to just give him, when he used to get really wound up, if I caught him in time I could sit him on my knee and just very slow massage and he’d be comatose, he would just, his chin would be open
nearly dribbling, he just, he just needs that, it really just calms him down, it does so I suppose the course, everything reminds…brings you back and reminds you “oh yeah that did work”’ {Rachel}

Some parents observed that their child had become more affectionate and was seeking out more physical touch from them.

‘she has started now, she’s kinda started to come now and go like this like (gestures) for a cuddle, do you know what I mean so that’s big as well’ {Carol}

‘he’s the only boy you know and it’s great cause he never, he never liked hugs or anything like that but now he’ll come up looking for em, so it’s great, yeah it’s just brought us closer anyway so it did’ {Tanya}

### 4.7.3 Enhanced communication

Most parents reported a change in how they now communicate with their child, which has led to an improved connection between them. Susan spoke about a dramatic change to her relationship with son David, which she attributed to gaining a greater understanding of his behaviour and communicating with him as an equal.

‘we’ve had an adversarial relationship for a long time because I’m very strong willed, he’s very strong willed and I realised there was stuff that was outside of his control and then kind of things mellowed off a bit...I suppose the fact that I dealt with him as an equal kind of made him feel a lot better about himself about how the two of us get on with each other’ {Susan}

Many parents described how they had altered their communication style with their child by reducing their use of questions. Some parents had previously interrogated their children about what was causing them distress.

‘I kinda just try to tell him that I’m there to support him so let him know that I’m listening to him so when he’s ready to talk, he’ll talk, which before there was like “can you just tell me what’s wrong?” straight out, but now it’s kinda his pace’ {Tanya}

‘before like if she was even bouncing once I’d be like “why? what’s wrong? Tell me what’s wrong, there’s something wrong” and she’d be like “there’s nothing
Carol spoke about how her daughter Sarah used to fabricate answers to her questions as she had felt she could not express the truth; that she did not know what was worrying her. As Carol reduced her use of questions, Sarah began to express herself more freely in her communication with her mother.

‘I was asking her loads, and she would eventually give an answer just to shut me up. One of the things was the bedtime and she said like “oh I’m afraid somebody’s going to break in”…and then kind of into the course then she was like “I’m not actually afraid of that, but because you keep asking me what’s wrong and I don’t know”, so she told me something to stop me from asking’ {Carol}

4.8 Theme: Parent’s emotions

The theme of ‘parent’s emotions’ is made up of two subthemes each of which will be exemplified below; the first subtheme relates to parent’s awareness of their own emotions, and the second concerns their awareness of the impact their emotions can have on their child.

4.8.1 Awareness of own emotions as parent

All parents reflected on how they had developed greater awareness of their own emotions, and how they can impact on their ability to respond to their child.

‘I was probably a bit too pushy and I would sometimes shout at him and…where I could just probably just take a couple of seconds, walk away and calm down. Sometimes I feel like a dragon so I need to walk around you know before I can say something or do something…I think I feel like I’m more equipped to deal with the situations now and I do feel a bit calmer’ {Helen}

‘I’m a lot calmer, aammm I suppose it dealt with, the course dealt with my own stresses, I was probably anxious myself but I wouldn’t have termed it ‘anxious’, I would’ve deemed myself kind of a very stressed and nervous person’ {Carol}

Some mothers expressed a greater awareness of what tends to trigger their own anxiety as a parent, and how they can manage such feelings.
'we all have that shark music no matter what, we all have it for different situations and it’s to try to do the count to 10 before you react’ {Laura}

‘if Tom’s messing in school or I get a phonecall [from school] I’m thinking “oh what’s after happening, what’s he after doing”, but now it’s kinda like, just relax and kind of d’you know there’s so many techniques they’ve showed you in how to relax and the breathing’ {Tanya}

‘she’d be crying going up to bed and kind of saying ammm “don’t leave” or “can somebody sleep with me?”’, it was like “no you have to sleep in your own bed” and sometimes it was hard, as they were calling it the shark music…that was challenging now, to manage my own shark music’ {Carol}

Tanya reported that using deep breathing was particularly useful in terms of how she manages her own emotions in stressful situations. She expressed that this strategy left her better equipped to cope in a crisis.

‘now it’s easier to calm myself now as, cause I know how to, as in before I wouldn’t have, you know. I mean the other day Mary set the microwave on fire, it was a complete accident but you know it was like before I would’ve went mad but I just calmed down and says “d’you know it’s fine I’ll sort it” and it was d’you know, from learning from the group…your breathing, just relax, calm down yourself and then you’re able to help’ {Tanya}

4.8.2 Impact of parent emotions on child

In addition to a growing awareness of their own emotions and triggers, many parents demonstrated an awareness of the impact their own emotions can have on their child. Most mothers reported that their child tends to respond better to a calm approach from their parent.

‘I probably am more aware of being, just just just bringing down my emotions and just being really calm around him, because I know the calmer I am with him the better, the better the response’ {Rachel}

Karen’s daughter required daily injections due to a chronic medical condition. Previously, these procedures had caused a lot of distress for both parents and child. Karen noted that keeping calm has been an extremely useful tool for both her and her husband, in supporting their daughter through this.
Karen described how she would previously lose her temper or panic, which seemed to exacerbate her child’s distress.

‟it made you think about your own responses to your child which kinda made you think “well maybe I’m kind of partly adding to things sometimes by the way I act” so it’s made me think more of how I act in the situation so trying not to fly off the handle...I’m more stepping back and actually thinking “right I’m only gonna make this worse by kicking off and giving out” and you know my response has to be calm to get a calm response from her’ {Karen}

Susan expressed an understanding of how her approach impacts on the response she receives from her son David. She noted how taking a calmer approach led to better interactions with David, and reduced his defensiveness with her.

‟I find with David what you give, if you give him a less than very understanding, calm approach, if you don’t do that with him he’ll just push back like...he’ll have a negative, grumpy response to the most innocent statement. It’s like it’s his default but if you keep being kinda calm and understanding he’ll have to, basically he runs out of steam. Like there’s nothing to feed the aggression or the crossness...since I’ve done the course, because I’m calmer with him, he feels less defensive with me’ {Susan}

Laura spoke about the importance of catching herself becoming stressed in the moment before it impacts on her response to her child.

‟it’s to stop yourself you know, because like that, we’re all rushing out the door… and ye all have to be somewhere on time and then something happens d’you know, it’s to just, and it’s so true, calm down, react quietly and it only takes a minute’ {Laura}

4.9 Theme: Child’s expression of feelings

The theme of ‘child’s expression of feelings’ is made up of three subthemes. The first subtheme relates to the child acquiring a new language in terms of verbalising their
feelings. The term ‘feelings’ is used to capture emotions, as well as the physical feelings or sensations associated with emotions. The second subtheme relates to the child’s growing ability to recognise and name how they are feeling. The third subtheme concerns changes in how the parent listens to their child, which encourages the child to open up.

4.9.1 A new language

Most parents described a change in terms of how their child speaks about their emotions. The OOW intervention provided a new language to the children which described emotional states in terms of different zones. Most parents reported that their child had taken this language on board and were using it when speaking about their emotions.

‘the little changes have been good because he can start saying “look I’m in this zone” or “you’re pushing me into the zone”, amm like that’s a good thing in itself’ {Susan}

‘he’d even say things like amm, at home with his sister “oh you’re in the red zone now”, d’you know what I mean’ {Laura}

‘he did get good at going “I’m in the red zone at the moment, I’m not feeling good”...so he had got it into his head’ {Rachel}

For Tanya’s son Tom, who struggles to express himself verbally, the use of coloured Lego pieces to represent the zones gave him a way of communicating his emotions to others without using words.

‘he can show me now how he’s feeling by giving me a piece of Lego and it’s absolutely brilliant because he’s always a quiet boy, he’s very shy, he won’t talk. Now I think if he didn’t have the Lego with him he wouldn’t say anything but if the Lego is close enough to him he’ll come and tell us so I mean it is a slow progress but there’s a big difference already’ {Tanya}

4.9.2 Recognising and naming feelings

Most parents reported that their child demonstrated a growing ability to recognise different emotions that they experience, as well as an ability to name their feelings.
‘since the course, he’s more likely to say “I’m cross” or “I’m annoyed with you” which is great because if he gets it out at least then I know what I’m dealing with and it’s good for him to be able to recognise it’ {Susan}

‘it makes it easier when she does name it and we know what we’re dealing with because again we don’t know if she’s feeling like that, is it because she has a pain in her knee, or she’s sad, or is she tired, and you don’t really know which one you’re dealing with so it’s good that she’s more expressive’ {Karen}

‘then he’ll come out and say “oh I’m angry because this happened” or “I’m angry because that happened”...before he wouldn’t even tell me, I’d have to find out from somewhere else, so now it’s just a big difference like’ {Tanya}

Rachel described her son John’s growing awareness and how he can now link his emotions or feelings to a particular event, and verbalise this.

‘he says “you know I’ve been anxious all week”, I said “what’s been making you anxious?”’, I knew what it was, and he said “it’s the horse riding” and ah we talked about it again’ {Rachel}

Some parents noted that their children were now speaking about the bodily sensations they experience when feeling anxious.

‘He says it’s like something is stuck in his throat, it was like that time getting bullied at the horse riding and that’s how he described it...and then after we had resolved the whole thing he says “I feel like it’s gone”’ {Rachel}

‘she is recognising that she feels differently than normal and she’s able to say it “I feel differently” or “I feel funny in my tummy” is usually what she says, so for her to actually be able to say that’ {Carol}

Some parents reflected on how their child had previously been affected by their inability to recognise or name their feelings. Carol’s daughter Sarah has demonstrated a reduction in tics since she began speaking more about her feelings.

‘I think maybe that is why she’s not bouncing because she’s able to verbalise it, whereas before she wasn’t able to verbalise it’ {Carol}
Tanya reflected on how her son Tom had hid his feelings previously, which led to him having to deal with very difficult situations on his own.

‘yeah it’s making him feel more comfortable so it is, because he knows how to express it, whereas before he was hiding and the anxiety then got very high because he didn’t, he wasn’t being able to express anything...he will carry the whole lot and I mean he was bullied in school there a couple of weeks ago and he wouldn’t tell anyone...no matter what happens in school now he’s coming up to tell me so it’s great’ {Tanya}

Karen recalled the level of distress her daughter Jane would display previously when she could not articulate her feelings.

‘she’d just sit and she’d be biting her hands or amm kinda screaming and you know just crying and all that sort of thing and she wouldn’t actually tell you. You know you’d be going “well what’s wrong? what can we do to help you?”’. You wouldn’t really get much from her of how she was feeling so I suppose yeah she’s actually more now saying “well I feel sad” or “I feel tired” or you know we’ll get more kind of answers’ {Karen}

4.9.3 A receptive listener

Some parents perceived their child as feeling more understood by their parent now, as a result of a more empathic approach. This may have also contributed to the child opening up more about their feelings.

‘he will then be more open to talk to me because he feels “oh she understands me” you know, “she’s got what I’m feeling”...I think he trusts me more, just because he feels I understand him more. I just feel that’s a bit stronger alright’ {Rachel}

‘just to kind of give him the support that he needs [by saying] “yes it must feel horrible”, “that must be awful”, “you must not have felt very good when that happened”, you know all these little things and I think it helps them d’you know what I mean because they’re saying “well I think she gets it”’ {Laura}

Tanya reflected on the improvement in her ability to listen to her son, and attributed this to going at his pace. She felt that this facilitated him to open up more.
‘He feels like he can talk to me because he knows I can listen, d’you know we’re there to listen now where it’s not rushing him’ {Tanya}

4.10 Child qualitative results

Child qualitative results will now be presented. After transcribing, reading, coding and collating the child interview data, a number of themes were identified from the seven child interviews. Themes will be presented to summarise the relevant findings, with participant quotations utilised for illustration.

4.10.1 Overview of child themes

Table 3 presents the themes identified within the child qualitative data. The first theme ‘awareness of emotions’ captures ways in which children exemplified their awareness of emotions, both through their knowledge of teachings from the OOW group, and by providing their own examples. The theme of ‘fun’ came through each of the child interviews, and appeared to be an important motivator for attendance of the OOW group. The theme of ‘coping strategies’ relates to the children’s understanding and use of different coping strategies to manage their emotions. The theme of ‘discomfort contemplating emotions’ encompasses the way in which children experienced certain group activities as uncomfortable, when they involved reflecting on their own emotions. Finally the theme of ‘facing fears’ pertains to ways in which the children had been pushing themselves to tolerate anxiety provoking situations.

Table 3: Summary of themes from child data

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<td>Awareness of emotions</td>
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<td>Fun</td>
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<td>Coping strategies</td>
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<td>Discomfort contemplating emotions</td>
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<td>Facing fears</td>
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4.11 Awareness of emotions

Most of the children demonstrated some awareness of their own emotions. Many could articulate typical triggers for certain emotions they experience.

‘well I am angry when my sister annoys me’ {Tom}

‘I don’t like rushing. Mummy always does it and then I get all panicky, to do stuff really quickly’ {Sarah}

‘sometimes if I’m really tired I feel really sad and angry just for no reason, and sometimes I feel really frustrated when I’m doing stuff usually if I’m making something, and it’s not working out, I get really frustrated and angry, or sometimes if I’m doing my homework and I don’t really understand it’ {Jane}

Most children could describe how emotions are categorized into zones, as taught at the OOW group. Some children could describe their own emotional experience using the zones.

‘mmm the green zone is when you’re happy and the yellow zone is when you’re frustrated, and the blue zone is when you’re tired, sick and bored, and the red zone is when you’re angry’ {Joe}

‘amm probably green [current zone], yeah but I might be a bit in blue because I’m a little tired and I also might be in yellow because I’m really excited because amm, we went away to Belfast recently for my big sisters confirmation so my dog had to stay with my granny and granddad, and we’re going to get her back tomorrow’ {Jane}

Some of the children were able to reflect on how their emotions made them feel in their body. Sarah displayed an emerging awareness of her feelings, particularly bodily sensations, and how these are impacted by particular situations.

‘Yeah and sometimes when we’re walking on the street and there’s people there and they have cups in front of them, that they need money or something or if they’re selling something, I feel a bit amm, a little bit weird inside that I didn’t like do something for them’ {Sarah}
Some of the children demonstrated an ability to link their knowledge of how emotions can impact the body, with choosing appropriate coping strategies to manage these sensations.

‘the breathing [is important] because when you’re angry or upset you don’t get much oxygen’ {David}

‘for me it is the signs that you are stressed and stuff like if you have sweaty palms or something which I have all the time basically and like heart racing and stuff. I think those signs actually, so now when I feel those stuff I’m just like “ah I’m stressed, how am I gonna deal with this? Ok I’ll just do some breathing”’
{John}

4.12 Fun

All of the children spoke about their experience of the group as being a fun and enjoyable experience. For most, this was the first thing they spoke about when asked about what they liked about attending. They listed games, art, and snacks as their favourite parts of the group.

‘well we got to play like fun games, like the ball game, and I liked the ammm, it was zoom, erk and splash, and we got to do clay, and we got to have a break with sweets and stuff, and we got to draw and colour, and we got to do Lego, and when we were drawing and colouring we got to use this glittery glue’
{Sarah}

‘[the most important thing about going to the group] that I enjoyed it’ {Tom}

‘it was fun’ {David}

‘Well two good things, the first one is about our snacks, the biscuits and the chocolate and the second good thing was ahh (pause) the second thing was that I just liked it’ {Joe}

‘ I really liked when we were making the stuff out of clay, we had to make something for amm the blue [zone] and something for the red out of clay, and
then for the Lego we were just allowed make whatever we wanted, and I liked playing the games’ {Jane}

4.13 Coping strategies

Many of the children expressed knowledge of how certain coping strategies can be used in order to deal with difficult emotions. John was able to articulate a number of coping strategies that he uses, and reflected that different strategies might be needed for different emotions.

‘well basically nothing works for me when I’m angry, only being around horses and stuff” {John}

‘ah you know passing the ball, ahhh yeah, when we were starting it I was like “oh this is very relaxing” and stuff ...whenever I’m very stressed now me and my mom just play the ball and it relaxes me’ {John}

Sarah also articulated an understanding of coping strategies that can be helpful for dealing with emotions, and reported that she had found something that was working effectively for her.

‘well you can do something that you love doing. Reading [helps when I’m feeling big feelings], it takes my mind off stuff. Before I used to absolutely hate reading, I wouldn’t go near a book, but now I love reading. I think if you’re worried like focus on what you like doing to take your mind off it and to do your breathing and stuff” {Sarah}

Jane reported that breathing strategies taught in the OOW group can be helpful to her when she is experiencing overwhelming emotions.

‘sometimes the breaths can help a little...we learned the mountain pose and the dragon breath’ {Jane}

Patrick expressed that the most important thing he had learned about how to cope with his emotions, was that he could talk to other people about how he is feeling.
‘Amm always if you’re feeling angry, worried or scared, always just tell somebody’ {Patrick}

4.14 Discomfort contemplating emotions

Some of the children reported that it was challenging to engage in activities that required them to think about their emotions. This resulted in some discomfort and some of the children did not like this aspect of the OOW group.

‘[I didn’t like] all the writing and writing with markers, ahh like ahh feelings, writing stuff down, what makes us relaxed, what makes us stressed’ {David}

Sarah articulated her discomfort quite clearly and mentioned different elements of the activities that she found difficult.

‘well I didn’t really like when we had to draw the picture, like a picture of the zone because like, the green or the red thing, and then we had to write it down... yeah a bit [uncomfortable] and I didn’t like that we had to write what it was and like where do you feel ammm like ammm whatever it was, or amm what would your face look like, I didn’t really like doing that’ {Sarah}

4.15 Facing fears

Some children reflected on their ability to tolerate anxiety provoking situations. Sarah spoke about the challenges of facing her fear of sleeping alone. Her mother implemented an intervention where she gradually increased the time in between checking on Sarah. Sarah reported that she was resistant to this approach at the time but now she is glad that she did it.

‘mammy just said 10 minutes to me so then she went up higher and then I asked her why did she go over time and she said that they told her to go up higher and I said that I wanted to go back to ten but she said no, and I wanted to go back to ten but she said no, so I keep having to go up higher but I feel good about it now’ {Sarah}
John spoke about facing his fears at horse riding. Although this is a very enjoyable activity for John, some recent falls have led to him experiencing anxiety before his lessons. John spoke about facing up to this fear.

‘[when I feel afraid at horse riding] I just breathe, stroke the horse, and just go for it’ {John}

4.16 Quantitative results

Quantitative results were generated using IBM SPSS Statistics Version 25.

4.16.1 Overview of quantitative results

An overview of the results yielded from statistical analyses will now be presented. First, changes in anxiety symptoms will be explored, followed by changes in parent-child relationship/attachment. Finally, changes in emotion regulation will be explored. Due to the small sample size, trends in the data will be examined for each variable of interest, using descriptive statistics, and graphical representations. Boxplots will be utilised to demonstrate the distribution of the data, and to identify any outliers, which may have a large impact due to the small sample size. Line charts will be presented in order to further scrutinise scores at an individual participant level.

4.17 An examination of anxiety symptom level over time

Child anxiety was measured using the SCAS-P (Spence, 1999). This measure generated a total anxiety score, in addition to 6 subscale scores for the following: panic attack/agoraphobia, separation anxiety disorder, physical injury fears, social phobia, obsessive-compulsive disorder, and generalized anxiety disorder. Means and standard deviations were examined for each of these variables, in order to explore any trends in the data over time. These are presented in table 4 below. Mean scores on separation anxiety, social phobia, obsessive compulsive disorder, generalised anxiety disorder, and total anxiety, decreased from time 1 to time 3. Mean scores on panic attack/agoraphobia, and physical injury fears were shown to increase from time 1 to time 3. Total anxiety scores will now be explored further using graphical representation. Boxplots and line charts for the other anxiety subscales are presented in Appendix M.
Table 4: Mean (SD) scores for subscales of SCAS-P scores at time 1 (pre intervention), time 2 (post intervention), and time 3 (3 months post intervention)

<table>
<thead>
<tr>
<th>Time</th>
<th>Panic Attack/ Agoraphobia</th>
<th>Separation Anxiety</th>
<th>Physical Injury Fears</th>
<th>Social Phobia</th>
<th>Obsessive Compulsive Disorder</th>
<th>Generalised Anxiety Disorder</th>
<th>Total Anxiety</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3.60 (4.16)</td>
<td>8.83 (4.17)</td>
<td>4.33 (2.58)</td>
<td>8.17 (4.17)</td>
<td>3.67 (2.50)</td>
<td>8.20 (3.49)</td>
<td>37.67 (12.19)</td>
</tr>
<tr>
<td>2</td>
<td>4.50 (3.67)</td>
<td>8.33 (3.44)</td>
<td>5.33 (3.44)</td>
<td>7.60 (2.70)</td>
<td>3.83 (2.23)</td>
<td>8.83 (2.32)</td>
<td>36.5 (10.97)</td>
</tr>
<tr>
<td>3</td>
<td>5.00 (5.14)</td>
<td>7.33 (5.05)</td>
<td>5.00 (3.74)</td>
<td>6.17 (3.06)</td>
<td>2.50 (2.26)</td>
<td>7.67 (4.03)</td>
<td>33.67 (18.49)</td>
</tr>
</tbody>
</table>

4.17.1 Total anxiety

Figure 1 demonstrates the median scores and interquartile ranges (IQR) for total anxiety at each time of measurement. Although the median scores did not differ greatly, the change in terms of IQR reflected a difference in how the individual scores were distributed. There was greater variation in scores at time 3 (median = 33.5, IQR = 21 – 51), in comparison to time 1 (median = 35.5, IQR = 33 – 47).

Figure 1: Median scores and interquartile ranges for Total Anxiety at time 1 (pre intervention), time 2 (post intervention), and time 3 (3 months post intervention)

This change in distribution indicated that participants’ scores were more widely spread around the median at time 3, due to some participants scoring higher and some...
participants scoring lower. To explore each participant’s scores in greater detail, a line chart (figure 2) was produced in order to track individual scores over time. This figure illustrates that 67% of participants demonstrated a decrease in total anxiety score from time 1 to time 3, with 33% demonstrating an increase in total anxiety over time.

![Participants' Anxiety scores over time](image)

**Figure 2: Changes in participants’ Total Anxiety scores over time**

Different patterns of scores were observed for different participants. Some children demonstrated a gradual decrease in anxiety. Some children experienced a decrease in anxiety following the intervention, and went on to demonstrate an increase in anxiety at 3 month follow up. Others initially experienced an increase in anxiety post intervention, followed by a decrease at 3 month follow-up.

**4.18 An examination of the parent-child relationship over time**

The parent-child relationship was explored using the PRQ (Kamphaus & Reynolds, 2006). This measure is comprised of 7 subscales; attachment, communication, discipline practices, involvement, parenting confidence, satisfaction with school, and relational frustration. Means and standard deviations were examined for each of these variables, in order to explore any trends in the data over time. These are presented in table 5 below.

Mean scores on attachment, communication, discipline practices, involvement, and parenting confidence increased from time 1 to time 3. Mean scores on school satisfaction and relational frustration decreased from time 1 to time 3. Attachment scores will now be explored further using graphical representation, as this variable is of
particular interest to the current study. Boxplots and line charts for the other PRQ subscales are presented in Appendix N.

**Table 5: Mean (SD) scores for PRQ subscales over time**

<table>
<thead>
<tr>
<th></th>
<th>Attachment</th>
<th>Communication</th>
<th>Discipline Practices</th>
<th>Involvement</th>
<th>Parenting Confidence</th>
<th>Satisfaction with school</th>
<th>Relational Frustration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time 1</td>
<td>48.33</td>
<td>44.33</td>
<td>35.17</td>
<td>46.00</td>
<td>42.67</td>
<td>51.17</td>
<td>54.67</td>
</tr>
<tr>
<td></td>
<td>(9.14)</td>
<td>(11.06)</td>
<td>(11.03)</td>
<td>(5.90)</td>
<td>(13.71)</td>
<td>(7.17)</td>
<td>(10.63)</td>
</tr>
<tr>
<td>Time 2</td>
<td>51.17</td>
<td>41.17</td>
<td>38.33</td>
<td>52.17</td>
<td>42.83</td>
<td>46.50</td>
<td>54.83</td>
</tr>
<tr>
<td></td>
<td>(8.75)</td>
<td>(6.31)</td>
<td>(14.76)</td>
<td>(9.22)</td>
<td>(8.47)</td>
<td>(7.09)</td>
<td>(9.70)</td>
</tr>
<tr>
<td>Time 3</td>
<td>52.17</td>
<td>45.67</td>
<td>36.17</td>
<td>50.50</td>
<td>45.50</td>
<td>49.00</td>
<td>54.33</td>
</tr>
</tbody>
</table>

**4.18.1 Attachment**

Figure 3 demonstrates the median scores and IQRs for attachment at each time of measurement. The median increased from time 1 (median = 45.5, IQR = 42 – 52) to time 2 (median = 53, IQR = 44 – 58), and subsequently decreased at time 3 (median = 50.5, IQR = 46 – 63). However, when the IQR is considered, there appears to be a trend of scores increasing over time.

![Figure 3: Median scores and interquartile ranges for Attachment at time 1 (pre intervention), time 2 (post intervention), and time 3 (3 months post intervention)](image-url)
A line chart (figure 4) was produced so that individual scores over time could be examined. This figure illustrates that 67% of participants demonstrated an increase in attachment score from time 1 to time 3, with 33% demonstrating a decrease in attachment over time.

**Figure 4: Changes in participants’ Attachment scores over time**

As with anxiety, different patterns of scores were observed among the participants. Some children demonstrated a gradual increase or decrease in attachment. Some children initially experienced an increase in attachment post intervention, followed by a decrease at 3 month follow-up. Others experienced a decrease in attachment following the intervention, and went on to demonstrate an increase in attachment at 3 month follow up.

4.19 An examination of emotion regulation subscales over time

Emotion regulation was measured by the ERC (Shields & Cicchetti, 1997). This measure is made up of 2 subscales; emotion regulation and emotional lability. Means and standard deviations were examined for each of these variables, in order to explore any trends in the data over time. These are presented in table 6 below.
Mean scores for both variables decreased from time 1 to time 3. Emotion regulation will now be explored further using graphical representation, as this variable is of particular interest to the current study. Boxplot and line chart for emotional lability are presented in Appendix O.

4.19.1 Emotion Regulation

Figure 5 demonstrates the median scores and IQRs for emotion regulation at each time of measurement. The median decreased from time 1 (median = 25, IQR = 22 – 26) to time 2 (median = 22.5, IQR = 20 – 25), and subsequently increased at time 3 (median = 24, IQR = 23 – 26). Overall the median remained lower at time 3 when compared with time 1; however the IQR has increased slightly.

Figure 5: Median scores and interquartile ranges for Emotion Regulation at time 1 (pre intervention), time 2 (post intervention), and time 3 (3 months post intervention)
A line chart (figure 6) was produced so that individual scores could be tracked across time points. This figure illustrates that 33% of participants demonstrated an increase in emotion regulation score from time 1 to time 3, with 66% demonstrating a decrease in emotion regulation over time. Many of these changes in score were very small e.g. 1 or 2 points in the difference.

![Participants' Emotion Regulation scores over time](image)

*Figure 6: Changes in participants’ Emotion Regulation scores over time*

### 4.20 Chapter Summary

Qualitative and quantitative findings have been presented in detail. In the following chapter, these findings will be discussed in relation to existing relevant literature.
Chapter Five: Discussion

5.1 Chapter Introduction
This chapter provides a critical discussion of the study’s findings. These findings will be presented with reference to relevant existing literature. The strengths and limitations of the current study will be considered, followed by some critical reflections on the overall research process. Possible implications for clinical practice will be discussed, as well as potential opportunities for future research. Finally the chapter draws to an end, with a brief conclusion regarding the overall study.

5.2 Summary of Findings
The aim of the current study was to explore the feasibility of a novel integrative intervention in reducing childhood anxiety, utilising a mixed methods approach. Of particular interest were the participants’ experiences of engaging with the intervention, and their experiences of how it impacted on their lives. Qualitative methods produced rich insights into the experiences of both mothers and children who attended the OOW intervention. While there was diversity of individual experiences, distinct thematic patterns became evident during researcher engagement with the data. These themes will now be discussed further.

As outlined in the previous chapter, the qualitative component of this study generated seven parent themes (‘A family affair’, ‘We’re all in the same boat’ ‘Attunement’, ‘Facing and feeling anxiety’, ‘Connection’, ‘Parent’s emotions’, and ‘Child’s expression of feelings’) and five child themes (‘Awareness of emotions’, ‘Fun’, ‘Coping strategies’, ‘Discomfort contemplating emotions’, and ‘Facing fears’). Quantitative results suggest an increase in parental involvement, and a decrease in child emotional lability, after completing the OOW intervention. It is important to note that these quantitative results represent trends in a small sample, which cannot be generalised to a wider population.

In considering the results in their entirety, the most salient change seems to have been in terms of child expression of emotions. This is reflected in both parent and child themes, as well as in quantitative findings. The children learned a new language to express emotions, during the OOW group. This improvement in how the children can articulate their emotions to their parents, appears to have led to increased connection and attunement between parent and child. At the same time, increased connection and
attunement seem to be linked to the child’s expression of emotions, as they contribute to a dynamic where the child feels understood and listened to. This seems to facilitate the child to open up more. Parent awareness of their own emotions and of the potential impact they may have on their child, has also affected the way in which parents interact with their children. A calmer approach has been adopted, which may also facilitate the child’s ability to open up about their emotions. A thematic map is presented in Appendix K, which visually displays each of the main themes and how they relate to one another.

Based on the current findings, it could be argued that the OOW intervention is more holistic in terms of outcomes, when compared to CBT alone. A traditional CBT approach typically targets outcomes such as increasing a child’s ability to use cognitive strategies and reducing behavioural avoidance. However, the current findings suggest that the OOW intervention reduced behavioural avoidance while also contributing to enhanced connection and attunement between parent and child. The OOW intervention can be described as building up protective factors and resilience, as opposed to being overly problem focused. In using this framework, parents are challenged to think about their child’s problems from another perspective e.g. ‘what is going right that I can build on?’

5.3 Parent themes
Each of the parent themes will now be discussed in the context of existing literature.

5.3.1 A family affair
Most parent participants noted that that their learning from the group was applicable to how they parent all of their children, not merely the child who had been referred due to anxiety. Dia and Harrington (2006) suggested that the family environment may be linked to the development of anxiety disorders in children, in addition to possible genetic predisposing factors. In their study of psychosocial functioning of siblings of children with an anxiety disorder, they found that 12 % of siblings had been diagnosed with an anxiety disorder by a mental health professional. Of those siblings without a mental health diagnosis, 54% had at least one elevated scale score on the Child Behavior Checklist (Achenbach & Rescorla, 2001).
These findings are interesting if we consider how the participants of the current study found intervention strategies useful for parenting their other children. While the siblings may not have presented with a clinical level of anxiety, it is possible that family functioning and parenting style were also impacting upon them. Parents of clinically anxious children are often overprotective, provide excessive reassurance, and may interact with their children in an adverse manner (Eisen, Kearney, & Schaefer, 1995). This may affect overall family functioning and sibling relationships. It is likely that parents’ learning from the OOW intervention contributed to better family functioning, through the enhancement of parental awareness of emotions (both their own and that of their child), and by learning ways to validate and empathise with their child’s emotions.

5.3.2 We’re all in the same boat
Most parents reported that they found the group beneficial in terms of providing an opportunity to connect with other parents of anxious children. This allowed them to feel a sense of shared experience with others and reduced feelings of isolation. Participation in a group allows parents to meet and converse with others who share the same experiences and stresses (Law, King, Stewart, & King, 2002).

Many previous studies have demonstrated the advantages of group interventions or support groups in this regard. Gartner (1984) found the benefits of being part of a group included a diminished sense of isolation, help with coping, and emotional support. A study conducted by Biegel and Yamatami (1987) found that catharsis, mutual affirmation and empathy were described as the most frequent experiences in self-help groups for family members of individuals suffering with mental illness. Koroloff and Friesen (1991) found that parent-to-parent support is of great value to families of children presenting with emotional disorders. Participants reported that this support plays a role in how they cope with the challenge of bringing up their child. These findings are in harmony with the parents’ reports in the current study.

This theme appears to be relevant to most forms of group intervention, support group, or self-help group, as opposed to being specific to the current intervention under evaluation. The identification of this theme demonstrates the added value of delivering the OOW intervention using a group format, as opposed to using individual intervention. There may be a particular value to this, given that the OOW intervention asks parents to reflect on the impact of their own emotions on their child. By doing this
in a group setting, parents’ experiences are normalised through social comparison with their peers.

5.3.3 Attunement
The theme of ‘attunement’ was used to capture the enhancement of mothers’ ability to tune in to their child’s needs. This ‘attunement’ was contributed to by mothers’ acknowledging their child’s emotions, looking beneath the surface of their child’s behaviour, soothing first before trying to rationalise, and mothers’ experiencing and expressing empathy for their child. The theme of attunement will be examined now in the context of previous literature, with reference to subthemes where relevant.

In considering the subtheme of ‘Acknowledging emotions’, a study by Brumariu and Kerns (2015) demonstrated the importance of mother and child emotion-related communication behaviours in explaining variance in child anxiety. Their findings indicated that mothers of more anxious children had a tendency to invalidate their child's emotions, an action that showed significant links with child anxiety. Mothers of more anxious children also had a tendency to demonstrate less warmth and interest in their child during emotionally laden conversations, which also had a strong association with child anxiety. The authors of this study highlighted that the construct of maternal warmth in this instance, includes elements of parental emotion socialisation that suggest maternal attunement to the child's emotions. In terms of the current study, such warmth could be said to be exemplified through parental validation of their child’s emotions, and through use of soothing and empathy in response to their child’s anxiety.

In terms of ‘looking beneath the surface’, parents’ increased knowledge (particularly in terms of the neurobiology of anxiety) has facilitated greater reflection and curiosity with regard to their child’s behaviour. As mentioned in Chapter 2, evidence supporting neuroeducation (with adult clients) has cited outcomes such as increased self-compassion, and a change in beliefs relating to their innate badness or weak character (Miller, 2016). Current findings support the hypothesis that providing neuroeducation to parents can have a positive impact in terms of the empathy and compassion they feel for their child, while also allowing them to see their child has limited control over their behaviour at times of distress. This enhanced understanding of how anxiety impacts upon their child’s brain, allows parents to be more attuned to their child’s needs in these moments. This understanding and attunement results in a more supportive response, as
parents recognise that their child requires soothing at these times, as opposed to logical argument, reassurance or dismissal.

The increased ability to feel and express empathy for their child has also contributed to better attunement. Bowlby (1940) suggested that by helping a mother to identify and evoke emotions from her own childhood, she can become gradually more sympathetic and tolerant of the same emotions in her child. This idea was exemplified in the current study, as parents drew on their own experiences of childhood in order to empathise with how their child was feeling.

5.3.4 Facing and feeling anxiety

The theme of ‘facing and feeling anxiety’ concerns the way in which children are exposed to anxiety provoking situations in a gradual way. Two important elements of this were described by parents; the way their child tolerates being at the edge of their comfort zone, and how the parent supports the child to this edge. Such support involves achieving a balance between complete avoidance, and forcing a child to face a feared stimulus.

Cohen (2013) described the four ways that children can respond to anxiety. These are flooding, avoidance, white-knuckling, and facing and feeling (as presented in detail in Chapter 2, p. 17). Facing and feeling is the optimal response as it is the only one that allows any learning to take place. The child must approach the feared situation gradually and experience their feelings of fear, while receiving support from someone they trust. This is necessary in order for them to feel a reduction in fear.

Facing and feeling is essentially describing graded exposure, which is considered a key element of CBT in terms of reducing anxiety symptoms (Kendall et al., 2005). Kendall and colleagues suggested that counter-conditioning, extinction, habituation, cognitive change, and coping skills development, are all methods that may mediate the association between graded exposure and reduction in anxiety symptoms.

In terms of intervention outcomes, it is extremely positive that parent participants reported an increase in their child’s tolerance for feared situations, as well as an increase in their own ability to gently push their child in this direction, in a supportive manner. Evidence suggests that this reduction in behavioural avoidance should lead to a reduction in anxiety symptoms (Stallard, 2014).
Parents can have a large influence on how anxiety is maintained, particularly if they condone their child’s avoidance of feared stimuli. Anxious parents, in particular, may attempt to protect their child from experiencing anxiety-provoking situations, as they are more likely to interpret such situations as threatening (Lester, Field, Oliver, & Cartwright-Hatton, 2009). In this way, they may actively encourage or permit avoidance, and inadvertently perpetuate their child’s fears.

5.3.5 Connection
The theme of ‘connection’ describes the improvement in connection between mothers and their children. This theme is made up of three subthemes that contributed to increased connection between mother and child; quality one-to-one time, physical touch, and enhanced communication.

Many parents reported spending more one-to-one time with their child. This increase in quality time is important due to the connection between parental time investments in children and children’s well-being (Sayer, Bianchi & Robinson, 2004). Creating this special time with their child was reported to contribute to a closer bond for some participants.

Increased physical touch was also reported, which also appeared to contribute to increased parent-child connection. Theraplay games were a component of the OOW intervention, and use of touch is a key characteristic of the Theraplay approach. Theraplay reproduces typical parent-child interactions, placing emphasis on the importance of touch, consistent, attuned responses, and co-regulation of the child. Jernberg (1979) observed patterns of interactions in hundreds of parent-child relationships. Based on these observations, she proposed that mutual touch is a fundamental element of healthy child development. Field (1995, 2001) confirmed this hypothesis with extensive research studies.

5.3.6 Parent’s emotions
Parent’s expressed a greater awareness of their own emotional state and how this may impact negatively on their child. They reported adoption of a calmer parenting approach in light of this newfound awareness. Studies have found that parent modelling of anxious behaviour may teach children to assign similar levels of fear and anxiety to comparable events (Muris et al., 1996). Parental modelling of anxious behaviour may also have a role in the development of children's threat perception biases, and contribute
to a sense of low personal control. An experimental study found that mother’s facial expressions of fear and disgust led to a short-term increase in avoidant behaviour, for 15–20 month old children exposed to two unknown, fear-relevant objects (Gerull & Rapee, 2002). Observations of interactions between mothers and their children (both presenting with an anxiety disorder), found that mothers modelled a fearful cognitive style by using catastrophic language that conveyed expectation of negative outcomes and a lack of personal control (Whaley et al., 1999; Moore, Whaley, & Sigman, 2004). Parents in the current study reported a new-found awareness of the impact of such modelling of anxiety.

The theme of ‘parent emotions’ from the current study can be seen to overlap with an existing construct from the literature on attachment, known as parental reflective functioning. Parental reflective functioning has been conceptualised as the parent's ability to reflect upon their own internal mental experience, as well as that of their child (Slade, 2005). This construct was initially described by Fonagy and colleagues in 1991, and they continued to build on it over the decade that followed. A fundamental component of parental reflective functioning involves the parent’s ability to step aside from their own emotional experience, so that they may reflect on their child’s individual intentions at times of conflict or stress (Slade, Bernbach, Grienenberger, Levy, & Locker, 2002). Increasing this ability in parent participants was essentially one of the goals of the OOW intervention. The concept of ‘shark music’ was taught to support parents in achieving the first step; moving aside from their own parental experience. In addition, a neurobiological explanation of how the child’s anxious brain functions was utilised to address the second step; assisting parents to reflect on the reasons underlying their child’s behaviour. The theme of ‘parent emotions’ illustrates how parent participants successfully took these concepts on board, and implemented them in their parenting approach.

5.3.7 Child’s expression of feelings
The theme of ‘child’s expression of feelings’ encompassed three subthemes. The first related to the child acquiring a new language in terms of verbalising their feelings. The second related to the child’s growing ability to recognise and name how they are feeling, and the third concerned changes in how the parent listens to their child, which encourages the child to open up.
Having the ability to understand and speak about their emotions, assists children in predicting the emotions and behaviours of others (Olson, Astington, & Harris, 1988), which is positive in terms of their social interactions with others. Kopp (1989) proposed that language provides children with a medium for coping with emotions and contributes to more adaptive emotion regulation. Through language, children can express their emotions to others, and in doing so they elicit feedback about ways to manage them. By understanding their own emotions, children can begin to comprehend the links between events and emotions. This can enhance their ability to cope with emotions, as well as their ability to deal with conflict with others (Greenberg & Kusché, 1993; Kopp, 1989).

It has been shown that the parent-child relationship not only contributes to the child’s emotions, but provides the context within which children gain awareness of their emotions and how to manage them (Cole, Martin, & Dennis, 2004). This can account for the subtheme of ‘a receptive listener’, which encapsulates the way in which parents facilitate their child’s expression of emotions. Supportive parental reactions to children’s expression of negative affect have been shown to be related to better socio-emotional skills in children (Eisenberg, Cumberland, & Spinrad, 1998). On the other hand, dismissive parental responses can have a harmful impact on a child’s socio-emotional wellbeing, as well as reducing their ability to self-regulate their emotions (Lunkenheimer, Shields, & Cortina, 2007).

5.4 Child themes
Each of the child themes will now be discussed in the context of existing literature.

5.4.1 Awareness of emotions
Children demonstrated an enhanced awareness of their emotions and most were able to discuss their emotions during the interview. Emotion understanding has been shown to have links with social competence and positive peer relations, both of which contribute to ongoing successful adjustment (Denham, McKinley, Couchoud, & Holt, 1990). Having an awareness of one’s emotions is also a crucial prerequisite to healthy emotion regulation (Füstös, Gramann, Herbert, & Pollatos, 2012).
5.4.2 Fun
All of the child participants reported that the OOW group was a fun experience. Many mentioned that the games they played were enjoyable. Having fun and playing are key to a child’s development, while also being extremely motivating (Hromek & Roffey, 2009). Play gives children opportunities for developing many cognitive skills such as language, problem solving and hypothesis testing (Smilansky & Shefatya, 1990; Vygotsky, 1976). Experiencing positive emotions, as one does when having fun, can broaden an individual’s capacity for learning (Fredrickson & Joiner, 2002). This is hugely beneficial when devising an intervention for children, as incorporating fun activities serves to motivate children, while also enhancing their ability to learn. Fun is a crucial aspect of the process of play, as it leads to more creativity and flexibility in terms how the child’s brain functions. (Prouty, 2000).

5.4.3 Coping strategies
Many of the children expressed knowledge of how certain coping strategies can be used in order to deal with difficult emotions. One of the key taught strategies utilised was deep breathing exercises. Physiological reactivity contributes significantly to childhood anxiety disorders, resulting in the child experiencing hyper-arousal when faced with anxiety-provoking stimuli (Weems, Zakem, Costa, Cannon, & Watts, 2005). On the other hand, physiological regulation can be described as the ability to regulate levels of arousal in the body (Dworkin, 1993). Breathing is one of the most primary functions of the body, and has been shown to have a key role in physiological regulation (Craig, 2008). Relaxation exercises that include deep breathing are central to many evidence-based psychological therapies for anxiety (Silverman, Pina, & Viswesvaran, 2008), and have been shown to alleviate stress and tension (Sovik, 2000). Child participants demonstrated some awareness of the value of deep breathing, and linked the use of coping strategies directly to anxiety-provoking situations. This is of paramount importance in terms of increasing their own control and independence during times of heightened anxiety.

5.4.4 Discomfort contemplating emotions
Many of the child participants expressed a sense of unease or discomfort during group tasks that involved contemplating emotions. This finding fits with what we know about the role of avoidance, and emotional avoidance in particular, in the perpetuation of anxiety disorders. Emotional avoidance can be understood as reluctance to experience
unpleasant internal feelings and sensations. It has been proposed as a primary process of emotion regulation pertaining to anxiety disorders (Hayes, Strosahl & Wilson, 1999).

Individuals with anxiety learn that they can reduce experiences of unpleasant emotions by avoiding anxiety provoking stimuli. This is a key maintaining factor in anxiety disorders because individuals do not have the opportunity to learn that the feared stimulus is not so bad, or that they can actually tolerate it. With this in mind, it makes sense that child participants experienced some discomfort in contemplating their emotions during group tasks. It is likely that they typically tend to avoid thinking about or experiencing unpleasant emotions. The discomfort reported by some of the children could be considered a necessary element of pushing themselves to the edge of their comfort zone, as described in the parent theme of ‘facing and feeling anxiety’, and the child theme of ‘facing fears’.

5.4.5 Facing fears
As with the parent theme of ‘facing and feeling anxiety’, the child theme of ‘facing fears’ can be understood in the context of CBT literature on graded exposure. Children reported recognition of the need to face their fears. This can be considered a very positive outcome, as gradually facing fears is associated with a reduction in anxiety symptoms over time (Stallard, 2014). Some children were also able to link the use of coping strategies with increasing their ability to tolerate feared situations.

5.5 Quantitative findings
The quantitative findings will now be discussed in the context of the existing literature. It is important to note that, due to the small sample size, these findings cannot be generalised to a wider population. Trends were observed for the variables of interest, using descriptive statistics and graphical representations of the data. It was hypothesised that child anxiety scores would decrease following the OOW intervention. Observed trends appeared to lend tentative support for this prediction, with 67% of participants demonstrating a decrease in total anxiety score from time 1 to time 3. These trends fit with the existing literature, as support has previously been demonstrated for the use of an attachment-based intervention for treatment of childhood anxiety (Comer et al., 2012).
It was hypothesised that parent-child attachment would be enhanced following the OOW intervention. Again, the findings demonstrated tentative support for this hypothesis, as 67% of participants showed an increase in attachment score, from time 1 to time 3. Previous studies have demonstrated that maternal reflective functioning has an impact on parent-child attachment (Kelly, Slade, & Grienenberger, 2005). As the qualitative theme of ‘Parent’s emotions’ indicated enhanced maternal reflective functioning in the current study, it makes sense that attachment scores increased for the majority of participants.

Finally, it was hypothesised that child emotion regulation would increase following the OOW intervention. Observed trends did not lend support for this prediction, with only 33% of participants demonstrating an increase in emotion regulation score from time 1 to time 3, and 66% demonstrating a decrease in emotion regulation over time. This finding is in contrast to what one would expect, given previous findings on the associations between emotion regulation, anxiety, and attachment (Bender et al., 2015; Brumariu et al., 2012).

The current quantitative findings, in conjunction with the qualitative findings, provide justification for the completion of a large randomised controlled trial, in order to further examine the efficacy of the OOW intervention. It would be valuable to measure the impact of this intervention, in terms of reducing anxiety, and enhancing attachment. Existing literature has shown a relationship between emotion regulation, attachment, and anxiety (Esbjørn et al., 2012), and therefore it would be valuable to consider this variable in future studies. Although the current study did not demonstrate any trend in terms of increased emotion regulation, the small sample size may have had an impact.

5.6 Strengths and Limitations
The strengths and limitations of the current study will now be discussed. It is important to note that the current findings are based on a small sample of individuals who consented to take part in this study. These findings denote the experiences of this specific group of participants and should therefore be regarded as suggestive rather than conclusive in relation to their generalisability.

The small sample size obtained (seven parents and seven children) can be considered a limitation of the current study, particularly in terms of quantitative analysis (for which only six participants’ data could be used). As a result the study focused more on the qualitative data, while using quantitative data to merely demonstrate trends in how participants scored
over time. It must also be noted that no control or comparison group was included in the current study, and the intervention was delivered by a single team of clinicians in all cases. It must be highlighted that the central goal at this stage was to pilot feasibility rather than to demonstrate efficacy of the OOW intervention. Despite the limitations outlined, the current study is original in terms of exploring the experiences of a novel integrative intervention targeting childhood anxiety.

A strength of the current study is the way in which it encapsulates the experiences and perspectives of both parents and children who engaged with the OOW intervention. To date there have been a limited number of qualitative studies that capture the voices of children engaging in intervention for anxiety. Two studies utilised thematic analysis to explore the experiences of children who had engaged in CBT for dental anxiety (Shahnavaz, Rutley, Larsson & Dahllöf, 2015; Rodd et al., 2018). A further study explored children’s experiences of a brief exposure intervention for specific phobia (Svensson, Larsson, & Öst, 2002). The way in which the current study has depicted the children’s voices, has provided rich information in terms of how they experienced the current intervention. This information is beneficial in considering how the intervention is delivered going forward, so that it continues to engage and appeal to children.

The use of thematic analysis can be considered a further strength of the current study. Braun and Clarke (2006) maintained that thematic analysis is a valuable method for exploring the experiences of different participants, identifying similarities and differences across these varied experiences, and revealing unforeseen insights. It utilises a well-structured approach in order to condense a large data set to its key features, which ultimately assists in the production of a clear and organized final report (King, 2004).

Another strength of this study relates to the researcher being a known individual to parent participants prior to their attendance at the semi-structured interviews. This familiarity resulted in the establishment of a trusting rapport between researcher and parents. The researcher’s prior knowledge of each participant’s difficulties, allowed for a sense of genuine pleasure to be expressed upon hearing positive reports. This genuine warm regard contributed to an overall comfortable atmosphere during interviews, which appeared to contribute to the level of reflection engaged in by parents.
5.7 Critical Reflection

As the primary researcher, I am aware that my own values, biases, opinions, and experiences may have shaped the entire research process, and ultimately the final report. I believe that this is an unavoidable dilemma in research, particularly in qualitative research where analysis is largely down to individual interpretation. For the sake of transparency, I will now critically reflect on my experiences of undertaking this study.

From the very beginning of my clinical training I have been drawn to Attachment Theory. I find it to be a fascinating framework for considering how individuals develop different styles of relating to others, and how this may impact on them as they go through life. I found myself going back to this theory repeatedly when formulating in my clinical work, and it was applicable to a wide array of clients. I had previously drawn on Cohen’s (2013) work during a placement in a Child and Family service, and found it to be an extremely helpful way of guiding parents of anxious children. I had also noted during this placement that a huge percentage of referrals received by the service pertained to childhood anxiety. When the opportunity arose to evaluate the current intervention, I jumped at the chance, given my fascination in the area of attachment, and my concern about the ever-increasing number of children presenting with anxiety.

I was invited by the group facilitators to attend the first five parent sessions as I was on a research block at the time. There were pros and cons to this, which I gave great consideration to. I was concerned that my attendance at these sessions may cause participants to view me as having a direct role in the intervention, instead of being an objective researcher. I reflected on the impact this might have on how comfortable they might be in terms of reporting negative experiences about the group during interview. However there were also many positives to attending. It would give me a chance to recruit participants face-to-face at the beginning of the first session, so that they could complete the pre-intervention measures. It would also allow me to see and experience some of the group content firsthand, as opposed to merely reading through the modules. It would give me a chance to become more familiar with the parent participants prior to conducting interviews, which I felt would contribute to a more natural and relaxed interview.

Group facilitators contributed their input in terms of devising questions for the semi-structured interviews. Facilitators of the children’s group were particularly concerned about the children’s ability to express their opinions during interview. We spent a lot of
time considering different ways of phrasing questions, and alternative ways of engaging the children e.g. through art or worksheets. Focus groups had initially been considered as a way of engaging the children, as this approach may have been less intense than a one-to-one interaction. Based on their experiences of the children during the group, facilitators felt this would not be an effective way to elicit information from the children. Most of them had struggled to engage verbally in the group setting, while only a small number of children had appeared comfortable to speak out in the group. Based on these insights, a semi-structured interview was selected as the most appropriate data collection tool.

During parent interviews, I felt there was good rapport already established, as I had met with the parents during some intervention sessions. I feel that this level of rapport and familiarity contributed to the quality of data collected. At times, it was still a challenge to get real depth to participants’ answers. Some participants struggled to give specific examples of how the group had impacted on their lives, talking more in general terms about what they had learned. Despite this difficulty, I was very happy with the overall data collected. Engaging the child participants during interviews was also a challenge. This experience gave me some insight into the parents’ experiences of having an anxious child, and the frustration one can experience in trying to elicit information from them. While some children were difficult to engage, others impressed me with their ability to discuss their emotions. I was struck by how valuable their contributions were; often the value was in their simplicity.

The qualitative analysis process was lengthy and I found it to be tedious at times, while also exciting and rewarding. I feel that the final themes identified fit very well with my sense of the interviews overall. My academic supervisor also reviewed my coded transcripts, and considered the themes to be an accurate representation of the data. I found this reassuring, as I had experienced some uncertainty and self-doubt during the analysis.

5.8 Implications for Clinical Practice

In terms of implications for clinical practice, the findings of the current study suggest that it may be valuable to consider more integrative approaches for childhood anxiety. While anxiety scores remained relatively unchanged following intervention, qualitative reports indicate many improvements including a more attuned parent-child relationship,
child expression of emotions, and child tolerating anxiety provoking situations. However, it is important to note that while the current findings appear to lend support for this intervention, further research is required to evaluate its efficacy in reducing anxiety. As research on this particular intervention is still in its infancy, it would be premature to imply that clinical practice should be guided by these findings at this time. Further research will be required to establish any potential implications for clinical practice going forward, and suggestions for such enquiry will now be discussed.

5.9 Implications for Future Research

Ethical approval has been granted to carry out a quantitative study using data gathered over a five-year period. This timeframe may need to be extended to account for low uptake, as the OOW is currently only delivered on an annual basis. An increased sample size would allow for use of inferential statistics to establish if participants’ anxiety scores are significantly reduced following OOW intervention.

It is interesting to note that despite positive qualitative reports, all children continued to score within the clinical range for anxiety at both post-intervention and follow-up measurement. One hypothesis to explain this discrepancy is that the increase in child participants’ ability to vocalise their emotions, may have resulted in more reporting of anxiety that had been previously unexpressed. With this theory in mind, one might expect that a longer time period would be required to see a notable reduction in reporting of anxiety symptoms. It may be valuable to increase the time between post-intervention and follow up measures from 3 months to 6 months, in order to allow for this.

All participants reported positive experiences of the OOW intervention, and had observed some positive changes in their child and/or their own ability to manage their child’s anxiety. These positive experiences suggest it may be worthwhile to evaluate this intervention further using a randomised controlled trial on a larger sample. In terms of designing such a study, it would be valuable to examine the possible mechanisms that mediate a reduction in anxiety symptoms. Previous literature and the current findings suggest that parent-child relationship and emotion regulation may be worth exploring in this regard. In considering other potential mechanisms of change to be measured, findings from the current study suggest that it may be valuable to examine the role of parental reflective functioning.
All parent participants who volunteered to take part in this study were mothers. Only one father attended the OOW intervention, but he declined to take part in the study. From my own clinical experience, it is often mothers who attend psychology appointments with their children. Previous research has explored the differences in terms of attachment to mothers and attachment to fathers. Fathers appear to play a different role in child development compared to mothers, and tend to serve a different function in families. Mothers tend to take on the role of regulating the child’s stress, while fathers are often involved in challenging their child through play. (Bögels & Brechman-Toussaint, 2006). A longitudinal study by Grossmann et al. (2002) compared fathers’ and mothers’ specific contributions to their children’s attachment representations. Fathers’ play sensitivity and infant-mother quality of attachment predicted children’s internal working model of attachment at age 10, but not vice versa. Adolescents’ attachment representations were predicted by fathers’ play sensitivity only. These results suggest that fathers’ play sensitivity predicts the child’s long-term attachment representation, more so than early infant-father attachment security. It appears that both parents have a unique influence on their child’s psychological security. Fathers’ play sensitivity may also be linked to how a child copes with anxiety. With this in mind, it would be useful to evaluate the experiences of fathers engaging in the OOW intervention.

It may also be of interest to explore the experiences of fathers, due to the inclusion of rough and tumble play as a strategy in the OOW intervention. Rough and tumble play is thought to contribute to the development of the activation relationship. Paquette (2004) developed this construct of the activation relationship to theorise the father-child attachment. It is conceptualised as the emotional bond that supports children to explore the outside world. This relationship serves a different function in contrast to the mother-child attachment relationship, which serves the role of comforting and calming children in times of stress. Male parents tend to encourage risk-taking and exploration in their children, while simultaneously providing them with the security of knowing they are protected from potential danger. This allows children to learn courage and assertiveness in unfamiliar situations. It is possible that rough and tumble play would have a different impact on the father-child activation relationship, in contrast to the mother-child relationship. This could be explored by including fathers in future research of this intervention.
5.10 Study Conclusion

The primary aim of the current study was to explore the feasibility of a novel integrative intervention for childhood anxiety, which incorporates attachment-based and neurobiological approaches, with CBT. A comprehensive review of the literature identified theories, models and interventions relevant to childhood anxiety. Particular focus was given to the areas of Attachment Theory, CBT, and neurobiological explanations of anxiety, as these formed the major components of the OOW intervention. The constructs of emotion regulation and parent-child attachment were also focused upon in the existing literature, as they were considered possible mechanisms of the current intervention. By actively engaging with both parent and child participants it was possible to capture their experiences of engaging with the OOW intervention, and the subsequent impact of this on their day to day lives. The current study generated preliminary findings in support of the OOW intervention, however further research is required to establish the efficacy of this approach. A larger sample and a randomised controlled trial design could provide a more definitive impression of the impact of this intervention on child anxiety scores over time. A critical reflection on the research process has been outlined, as well as strengths and limitations of the current study. Potential implications for clinical practice and future research have been identified and discussed.
References


focusing on cognition: A randomised wait-list control study. *Child and Adolescent Psychiatry and Mental Health*, 5, 1–12.


Appendices

Appendix A: Parent Information Sheet and Consent Form

Study Title: ‘Examining the effectiveness of a group intervention targeting childhood anxiety’

Principal Investigator: Dr Suarla Fitzsimons, HSE West
Contact Number: 065 6863596

Co-Investigator: Amy O’Dea, University of Limerick
Contact Number: 086 4079452

Academic Supervisor: Dr Barry Coughlan, University of Limerick
Contact Number: 061 234345

Dear participant,

You are being asked to participate in a research study interested in parent’s and children’s experiences of completing a group intervention for childhood anxiety. In order to decide whether or not you want to be a part of this research study, you should understand enough about its risks and benefits to make an informed judgment. This process is known as informed consent. This information sheet gives detailed information about the research study. The Investigators will also discuss the study with you in detail. When you are sure you understand the study and what will be expected of you, you will be asked to sign the attached consent form if you wish to participate.

NATURE AND DURATION OF PROCEDURE(S):

Parent: You will be asked to attend the Child and Family Programme in the Willow Unit to complete a 30 minute interview. This interview will include questions about your experience of being part of the group intervention.

Regardless of your participation in this study, all parents attending the group are asked to complete questionnaires in order to record any improvement or deterioration their child demonstrates during this time. In participating in this research study you are asked to consent to these questionnaires also being used for research purposes. These questionnaires are completed before the group begins and will be repeated immediately following the group and again 3 months after group completion. These questionnaires look at your child’s anxiety, their ability to manage emotions and their relationship with you.

Child: Your child will be invited to attend a 30 minute focus group along with other children from the group intervention. The group will involve asking the children to talk about their experiences of the intervention group.

BENEFITS
This study may help professionals gain a better understanding of what elements of the group are really helpful to children and their families.
RISKS
There are no known risks associated with this study. You can decide to withdraw from participating in the research study at any time.

CONFIDENTIALITY/ANONYMITY
- Should you choose to participate your interview will be audio recorded. This recording will be transcribed and you will be assigned a pseudonym so that you cannot be identified by this document. This transcript will be stored on an encrypted device and will only be accessed by the co-investigator of the study.
- Your signed consent form will be stored separately from your transcribed interview so that your name is not linked to this data. Your questionnaires will also be given an identification number that cannot be linked to your name. Therefore, it will be impossible to link your answers back to you.
- The data we collect may be published in scholarly journals however your identity will be kept anonymous.

Before you begin the study it is important that you understand the following points:
- Your participation is voluntary and you may withdraw from the research at any time for any reason. Choosing not to take part in this study will have no impact on your ability to access health care services normally available to you and/or your child.
- You may omit questions that you do not want to answer
- Your data will be treated with full confidentiality and, if published, it will not be identified as yours
- Once data collection is complete you will receive a full explanation of the study

AGREEMENT TO CONSENT
The research project and the procedures associated with it have been fully explained to me. I have had the opportunity to ask questions concerning all aspects of the project and any procedures involved. I am aware that participation is voluntary and that I may withdraw my consent at any time. I am aware that my decision not to participate or to withdraw will not restrict my access to health care services normally available to me. Confidentiality of records concerning my involvement in this project will be maintained in an appropriate manner. When required by law, the records of this research may be reviewed by government agencies and sponsors of the research.

I understand that the sponsors and investigators have such insurance as is required by law in the event of injury resulting from this research.

I, the undersigned, hereby consent to participate as a subject in the above described project conducted at the Child and Family Programme in Ennis. I have received a copy of this consent form for my records. I understand that if I have any questions concerning this research, I can contact the Chief Investigator listed above. I understand that the study has been approved by the Mid West Research Ethics Committee and if I have further queries concerning my rights
in connection with the research, I can contact them at University Hospital Limerick, 061 482519.

By signing below you are agreeing that you have read and understood the Participant Information Sheet and that you agree to take part in this research study.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Tick to agree to statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have read and understand the participant information sheet</td>
<td></td>
</tr>
<tr>
<td>I agree to participate in this research</td>
<td></td>
</tr>
<tr>
<td>I agree to complete questionnaires before and after group intervention</td>
<td></td>
</tr>
<tr>
<td>I agree to allow my interview to be audio-recorded</td>
<td></td>
</tr>
<tr>
<td>I agree to my child participating in focus group if they wish to do so</td>
<td></td>
</tr>
<tr>
<td>I agree to my child’s focus group to be audio-recorded</td>
<td></td>
</tr>
<tr>
<td>I grant permission for the data collected to be used in this research only</td>
<td></td>
</tr>
<tr>
<td>I understand that my anonymised data will be stored at University of Limerick for 7 years</td>
<td></td>
</tr>
<tr>
<td>I understand that copies of completed questionnaires will be kept in my Child’s clinical file and can be accessed by the Clinical team supporting my child. This is a standard procedure associated with group attendance and is separate to the research process.</td>
<td></td>
</tr>
</tbody>
</table>

_________________  ___________________  ___________________  ___________________
Participant’s Signature  Date  Printed name of person obtaining consent  Signature of person obtaining consent
Appendix B: Child Information Sheet and Assent Form

Dear (insert name),

Thank you for coming to the ‘Opposite of Worry’ Group for the last 6 weeks. We hope that it was fun and helped you to learn lots of new things about how to manage your worries.

We would really like to learn about what made the group go well for you, the parts you enjoyed and the important things your learned there. If we find out more about these things it can help us to make the group better in future.

We would like to invite you to meet with us and some of the other children from the group to have a chat about what it was like being in the group and what you learned. We will also have some time to play together.

Anything that is said during this chat will be kept private by everyone who is there. We will be recording the chat so that we do not forget all the important stuff you have to tell us.

It is your decision if you would like to come along and join us for this chat and playtime. It is ok to decide not to come. If you do come along but change your mind along the way that is ok too!

Please sign here if you would like to take part:

__________________________________  ___________________
Child’s signature                      Date
Appendix C: Parent Interview Schedule

Interview Questions (Parents)

(These questions are the basis for a 30 minute semi-structured interview with parents; follow up questions will be asked as deemed appropriate)

1. Can you tell me about your experience of attending the OOW group?

2. Has it been beneficial to you and/or your child? If so, in what way?

3. How has the programme helped your understanding of what your child needs when she or he is feeling anxious or having strong feelings? (prompt for examples)

4. Have you noticed changes in your own approach to parenting your child as a result of participating in the OOW Group? (prompt for examples)

5. How has the programme helped you to support your child when they are anxious or having strong feelings? (prompt for examples)

6. How did what you learn in the group affect your relationship with your child?

7. What were the challenges (if any) you faced in implementing the strategies?

8. In your opinion, has your child shown any change in terms of how they manage and express their feelings/emotions?

9. Are there any changes you would like to see in how this group programme is delivered in future?
Appendix D: Child Interview Schedule

| *introduction to include purpose of interviews and use of audio recorder to capture information |
| *Invite child to show interviewer the handshake they learned at OOW group |
| *Engage child in chosen game from OOW group |

Q1. What were the things that you liked about coming to the OOW group?

Q2. What were the things that you did not like about coming to the OOW group? *(Q1+Q2 use a large sheet of paper and post-its to display the child’s likes and dislikes)*

Q3. Did you learn anything that helped you to cope better when you have a big feeling, like when you feel worried, sad or angry? Tell me how these things helped you; give examples of how you used them. *(Prompts: What kind of feelings have you been finding hard/tricky? Is there anything you have learned that has helped you with that? Have you got an example?)*

Q4. Has coming to the group changed how your parents help you with your worries?

Q5. What would make the group better the next time? *(Prompts: if you could design your own OOW group what would it be like? Where? How long? etc)*

Q6. What was the most important thing you learned in/got out of the group?
Appendix E: Demographic Questionnaire

Child’s Date of Birth ______________________
Child’s age ________________
Child’s sex  □ Male
□ Female
Child’s number of siblings ________________
Child’s position in family (e.g. eldest, youngest...)__________________

<table>
<thead>
<tr>
<th>Biological Parents’ Relationship</th>
<th>Child’s Carers</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Married</td>
<td>□ Both parents</td>
</tr>
<tr>
<td>□ Divorced</td>
<td>□ Father alone</td>
</tr>
<tr>
<td>another</td>
<td>□ Mother alone</td>
</tr>
<tr>
<td>□ Co-habiting</td>
<td>□ Father plus another</td>
</tr>
<tr>
<td></td>
<td>□ Grandparents</td>
</tr>
<tr>
<td></td>
<td>□ Other relatives</td>
</tr>
<tr>
<td></td>
<td>□ Foster parents</td>
</tr>
<tr>
<td></td>
<td>□ Adoptive parents</td>
</tr>
<tr>
<td></td>
<td>□ Children’s home</td>
</tr>
<tr>
<td></td>
<td>□ Other……………….</td>
</tr>
</tbody>
</table>

Please tick any of the following experienced by your child at present:

<table>
<thead>
<tr>
<th>Anxiety □</th>
<th>Behaviour problems □</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attention and concentration difficulties □</td>
<td>Parental separation □</td>
</tr>
<tr>
<td>Social problems □</td>
<td>Anger issues □</td>
</tr>
<tr>
<td>Low mood □</td>
<td>Toileting issues □</td>
</tr>
<tr>
<td>Phobias □</td>
<td>Sensory processing issues □</td>
</tr>
<tr>
<td>Bereavement □</td>
<td>Self-injurious and/or suicidal behaviour □</td>
</tr>
<tr>
<td>Sleep problems □</td>
<td>School refusal □</td>
</tr>
<tr>
<td>Developmental delay □</td>
<td>Poor self-esteem □</td>
</tr>
</tbody>
</table>

If you have other concerns about your child that do not belong in the above categories please describe here:
### Appendix F: Spence Children’s Anxiety Scale-Parent Version (SCAS-P)

**SPENCE CHILDREN’S ANXIETY SCALE**  
(Parent Report)

<table>
<thead>
<tr>
<th>Your Name:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Child’s Name:</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Item</th>
<th>Never</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My child worries about things</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. My child is scared of the dark</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. When my child has a problem, s/he complains of having a funny feeling in his / her stomach</td>
<td>Always</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. My child complains of feeling afraid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. My child would feel afraid of being on his/her own at home</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. My child is scared when s/he has to take a test</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. My child is afraid when s/he has to use public toilets or bathrooms</td>
<td>Always</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. My child worries about being away from us / me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. My child feels afraid that s/he will make a fool of him/herself in front of people</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. My child worries that s/he will do badly at school</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. My child worries that something awful will happen to someone in our family</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. My child complains of suddenly feeling as if s/he can’t breathe when there is no reason for this</td>
<td>Never</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. My child has to keep checking that s/he has done things right (like the switch is off, or the door is locked)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. My child is scared if s/he has to sleep on his/her own</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. My child has trouble going to school in the mornings because s/he feels nervous or afraid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. My child is scared of dogs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. My child can’t seem to get bad or silly thoughts out of his / her head</td>
<td>Always</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. When my child has a problem, s/he complains of his/her heart beating really fast</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>My child suddenly starts to tremble or shake when there is no reason for this.</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------------------------------------------------</td>
<td>-------</td>
<td>-----------</td>
<td>-------</td>
</tr>
<tr>
<td>20.</td>
<td>My child worries that something bad will happen to him/her.</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
</tr>
<tr>
<td>21.</td>
<td>My child is scared of going to the doctor or dentist.</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
</tr>
<tr>
<td>22.</td>
<td>When my child has a problem, (s)he feels shaky.</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
</tr>
<tr>
<td>23.</td>
<td>My child is scared of heights (eg. being at the top of a cliff).</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
</tr>
<tr>
<td>24.</td>
<td>My child has to think special thoughts (like numbers or words) to stop bad things from happening.</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
</tr>
<tr>
<td>25.</td>
<td>My child feels scared if (s)he has to travel in the car, or on a bus or train.</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
</tr>
<tr>
<td>26.</td>
<td>My child worries what other people think of him/her.</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
</tr>
<tr>
<td>27.</td>
<td>My child is afraid of being in crowded places (like shopping centres, the movies, buses, busy playgrounds).</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
</tr>
<tr>
<td>28.</td>
<td>All of a sudden my child feels really scared for no reason at all.</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
</tr>
<tr>
<td>29.</td>
<td>My child is scared of insects or spiders.</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
</tr>
<tr>
<td>30.</td>
<td>My child complains of suddenly becoming dizzy or faint when there is no reason for this.</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
</tr>
<tr>
<td>31.</td>
<td>My child feels afraid when (s)he has to talk in front of the class.</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
</tr>
<tr>
<td>32.</td>
<td>My child’s complains of his / her heart suddenly starting to beat too quickly for no reason.</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
</tr>
<tr>
<td>33.</td>
<td>My child worries that (s)he will suddenly get a scared feeling when there is nothing to be afraid of.</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
</tr>
<tr>
<td>34.</td>
<td>My child is afraid of being in small closed places, like tunnels or small rooms.</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
</tr>
<tr>
<td>35.</td>
<td>My child has to do some things over and over again (like washing his / her hands, cleaning or putting things in a certain order).</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
</tr>
<tr>
<td>36.</td>
<td>My child gets bothered by bad or silly thoughts or pictures in his/her head.</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
</tr>
<tr>
<td>37.</td>
<td>My child has to do certain things in just the right way to stop bad things from happening.</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
</tr>
<tr>
<td>38.</td>
<td>My child would feel scared if (s)he had to stay away from home overnight.</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
</tr>
<tr>
<td>39.</td>
<td>Is there anything else that your child is really afraid of? YES NO</td>
<td>YES</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

Please write down what it is, and fill out how often (s)he is afraid of this thing:

|   |   | Never | Sometimes | Often | Always |

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Appendix G: Parenting Relationship Questionnaire (PRQ)

Instructions:
On the pages that follow are statements that describe common feelings, thoughts, beliefs, and situations a parent may have or experience when caring for his or her child. Please read each statement, and mark the response that best describes your recent experiences (over the last several months).

Circle N if the statement never describes your beliefs about or experiences with your child.
Circle S if the statement sometimes describes your beliefs about or experiences with your child.
Circle O if the statement often describes your beliefs about or experiences with your child.
Circle A if the statement almost always describes your beliefs about or experiences with your child.

Please remember to circle your response carefully.

Your choice of the response:
Use a sharp pencil or ballpoint pen; do not use a felt-tip pen or marker. Press firmly, and be certain to circle completely the letter you choose, like this:

N  O  A

If you wish to change a response, mark an X through it, and circle your new choice, like this:

N  O  A

Before starting, be sure to complete the information in the boxes on the right-hand side of page 2.
<table>
<thead>
<tr>
<th>Number</th>
<th>Statement</th>
<th>NSOA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>My child and I play games together.</td>
<td>NSOA</td>
</tr>
<tr>
<td>2</td>
<td>I know when my child will become upset.</td>
<td>NSOA</td>
</tr>
<tr>
<td>3</td>
<td>My child is getting a good education at school.</td>
<td>NSOA</td>
</tr>
<tr>
<td>4</td>
<td>It is difficult for me to communicate clearly with my child.</td>
<td>NSOA</td>
</tr>
<tr>
<td>5</td>
<td>I enjoy spending time with my child.</td>
<td>NSOA</td>
</tr>
<tr>
<td>6</td>
<td>Children should do what parents tell them to do.</td>
<td>NSOA</td>
</tr>
<tr>
<td>7</td>
<td>My child knows the house rules.</td>
<td>NSOA</td>
</tr>
<tr>
<td>8</td>
<td>I know what my child is thinking.</td>
<td>NSOA</td>
</tr>
<tr>
<td>9</td>
<td>Our family eats together at the dinner table.</td>
<td>NSOA</td>
</tr>
<tr>
<td>10</td>
<td>My child's school meets his or her emotional needs.</td>
<td>NSOA</td>
</tr>
<tr>
<td>11</td>
<td>My child and I argue.</td>
<td>NSOA</td>
</tr>
<tr>
<td>12</td>
<td>It is important for a child to follow family rules.</td>
<td>NSOA</td>
</tr>
<tr>
<td>13</td>
<td>My child tells me about his or her day at school.</td>
<td>NSOA</td>
</tr>
<tr>
<td>14</td>
<td>I remain calm when dealing with my child's misbehavior.</td>
<td>NSOA</td>
</tr>
<tr>
<td>15</td>
<td>I find it hard to talk to my child.</td>
<td>NSOA</td>
</tr>
<tr>
<td>16</td>
<td>My child's school seems to spend its money wisely.</td>
<td>NSOA</td>
</tr>
<tr>
<td>17</td>
<td>I punish my child if he or she talks back to an adult.</td>
<td>NSOA</td>
</tr>
<tr>
<td>18</td>
<td>My child and I plan things to do together.</td>
<td>NSOA</td>
</tr>
<tr>
<td>19</td>
<td>My child tells me about activities at school.</td>
<td>NSOA</td>
</tr>
<tr>
<td>20</td>
<td>My child and I do arts and crafts together.</td>
<td>NSOA</td>
</tr>
<tr>
<td>21</td>
<td>I listen to what my child has to say.</td>
<td>NSOA</td>
</tr>
<tr>
<td>22</td>
<td>I can sense my child's moods.</td>
<td>NSOA</td>
</tr>
<tr>
<td>23</td>
<td>My child tells me about his or her problems.</td>
<td>NSOA</td>
</tr>
<tr>
<td>24</td>
<td>I allow my child to use the Internet without supervision.</td>
<td>NSOA</td>
</tr>
<tr>
<td>25</td>
<td>I teach my child how to play new games.</td>
<td>NSOA</td>
</tr>
<tr>
<td>26</td>
<td>I know when my child wants to be left alone.</td>
<td>NSOA</td>
</tr>
<tr>
<td>27</td>
<td>My child's school meets his or her educational needs.</td>
<td>NSOA</td>
</tr>
<tr>
<td>28</td>
<td>During the last year, my child has been difficult to take care of.</td>
<td>NSOA</td>
</tr>
<tr>
<td>29</td>
<td>When my child is upset, I can calm him or her.</td>
<td>NSOA</td>
</tr>
<tr>
<td>30</td>
<td>It is my responsibility as a parent to punish all of my child's misbehavior.</td>
<td>NSOA</td>
</tr>
<tr>
<td>31</td>
<td>I have the energy that I need to cope with my child.</td>
<td>NSOA</td>
</tr>
<tr>
<td>32</td>
<td>My child enjoys spending time with me.</td>
<td>NSOA</td>
</tr>
<tr>
<td>33</td>
<td>My child and I work on projects together.</td>
<td>NSOA</td>
</tr>
<tr>
<td>34</td>
<td>Teachers seem to understand my child's needs.</td>
<td>NSOA</td>
</tr>
<tr>
<td>35</td>
<td>I lose my patience with my child.</td>
<td>NSOA</td>
</tr>
<tr>
<td>36</td>
<td>I punish my child if he or she shows disrespect to an adult.</td>
<td>NSOA</td>
</tr>
<tr>
<td>37</td>
<td>My child tells me about the things that he or she is doing with friends.</td>
<td>NSOA</td>
</tr>
<tr>
<td>38</td>
<td>It is easy for me to make decisions about what my child should do.</td>
<td>NSOA</td>
</tr>
<tr>
<td>39</td>
<td>My child and I get into arguments.</td>
<td>NSOA</td>
</tr>
<tr>
<td>40</td>
<td>People at school seem to care about my child.</td>
<td>NSOA</td>
</tr>
<tr>
<td>41</td>
<td>I punish my child if he or she destroys someone else's things.</td>
<td>NSOA</td>
</tr>
<tr>
<td>42</td>
<td>I am in control of my household.</td>
<td>NSOA</td>
</tr>
<tr>
<td>43</td>
<td>My child tells me, &quot;I love you.&quot;</td>
<td>NSOA</td>
</tr>
<tr>
<td>44</td>
<td>My child and I go on outings together.</td>
<td>NSOA</td>
</tr>
<tr>
<td>45</td>
<td>My child is hard for me to handle.</td>
<td>NSOA</td>
</tr>
<tr>
<td>46</td>
<td>I know what my child is feeling.</td>
<td>NSOA</td>
</tr>
<tr>
<td>47</td>
<td>My child tells me who his or her friends are.</td>
<td>NSOA</td>
</tr>
<tr>
<td>48</td>
<td>My child's school does a good job of controlling its students.</td>
<td>NSOA</td>
</tr>
</tbody>
</table>
**Indicate how frequently each statement describes your beliefs or experiences by circling**

**N – Never**  **S – Sometimes**  **O – Often**  **A – Almost always**

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>49. My child and I take walks together.</td>
<td>N</td>
<td>S</td>
<td>O</td>
</tr>
<tr>
<td>50. I know what to say to calm down my child.</td>
<td>N</td>
<td>S</td>
<td>O</td>
</tr>
<tr>
<td>51. I am happy with the services my child's school offers.</td>
<td>N</td>
<td>S</td>
<td>O</td>
</tr>
<tr>
<td>52. My child complains about how I treat him or her.</td>
<td>N</td>
<td>S</td>
<td>O</td>
</tr>
<tr>
<td>53. I know how my child will react in most situations.</td>
<td>N</td>
<td>S</td>
<td>O</td>
</tr>
<tr>
<td>54. I punish my child so he or she learns the proper respect for others.</td>
<td>N</td>
<td>S</td>
<td>O</td>
</tr>
<tr>
<td>55. I make good parenting decisions.</td>
<td>N</td>
<td>S</td>
<td>O</td>
</tr>
<tr>
<td>56. I have confidence in my child's school principal.</td>
<td>N</td>
<td>S</td>
<td>O</td>
</tr>
<tr>
<td>57. I overreact when my child misbehaves.</td>
<td>N</td>
<td>S</td>
<td>O</td>
</tr>
<tr>
<td>58. My child's school is run well.</td>
<td>N</td>
<td>S</td>
<td>O</td>
</tr>
<tr>
<td>59. My child and I get into heated discussions.</td>
<td>N</td>
<td>S</td>
<td>O</td>
</tr>
<tr>
<td>60. I insist that my child follow the rules of the house.</td>
<td>N</td>
<td>S</td>
<td>O</td>
</tr>
<tr>
<td>61. I talk to my child's teachers.</td>
<td>N</td>
<td>S</td>
<td>O</td>
</tr>
<tr>
<td>62. My child and I agree on most things.</td>
<td>N</td>
<td>S</td>
<td>O</td>
</tr>
<tr>
<td>63. My child tests my limits.</td>
<td>N</td>
<td>S</td>
<td>O</td>
</tr>
<tr>
<td>64. The classes offered by my child's school meet his or her needs.</td>
<td>N</td>
<td>S</td>
<td>O</td>
</tr>
<tr>
<td>65. I punish my child when he or she misbehaves.</td>
<td>N</td>
<td>S</td>
<td>O</td>
</tr>
<tr>
<td>66. I am confident in my parenting ability.</td>
<td>N</td>
<td>S</td>
<td>O</td>
</tr>
<tr>
<td>67. I tell my child, &quot;I love you.”</td>
<td>N</td>
<td>S</td>
<td>O</td>
</tr>
<tr>
<td>68. My child and I do things together outdoors.</td>
<td>N</td>
<td>S</td>
<td>O</td>
</tr>
<tr>
<td>69. I lose my temper with my child.</td>
<td>N</td>
<td>S</td>
<td>O</td>
</tr>
<tr>
<td>70. When upset, my child comes to me for comfort.</td>
<td>N</td>
<td>S</td>
<td>O</td>
</tr>
<tr>
<td>71. My child tells me what he or she has learned that day.</td>
<td>N</td>
<td>S</td>
<td>O</td>
</tr>
</tbody>
</table>

Please be sure you have marked all items.
Appendix H: Emotion Regulation Checklist (ERC)

Please rate how often this child exhibits the following behaviors or emotional states.

<table>
<thead>
<tr>
<th>Never</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td>4</td>
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<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

1. Is a cheerful child.
2. Exhibits wide mood swings (for example, the child's emotional state is difficult to anticipate because s/he moves quickly from very positive to very negative emotional states).
3. Responds positively to neutral or friendly overtures by adults.
4. Transitions well from one activity to another (for example, does not become anxious, angry, distressed, or overly excited when moving from one activity to another).
5. Can recover quickly from episodes of upset or distress (for example, does not pout or remain sullen, anxious or sad after emotionally distressing events).
6. Is easily frustrated.
7. Responds positively to neutral or friendly overtures by peers.
8. Tantrums easily.
9. Is able to delay gratification.
10. Takes pleasure in the distress of others (for example, laughs when another person gets hurt or punished; enjoys teasing others).
11. Can modulate excitement in emotionally arousing situations (for example, does not get 'carried away' in high-energy play situations, or overly excited in inappropriate contexts).
12. Is whiny or clingy with teachers.
13. Is prone to disruptive outbursts of energy and exuberance.
14. Responds angrily to limit-setting by adults.
15. Can say when s/he is feeling sad, angry or mad, fearful or afraid.
16. Seems sad or listless.
17. Is overly exuberant when attempting to engage others in play.
18. Displays flat affect (for example, expression is vacant and unexpressive; child seems emotionally absent).
19. Responds negatively to neutral or friendly overtures by peers (for example, speaks in an angry tone of voice; or responds angrily and aggressively).
20. Is impulsive.
21. Is empathetic toward others; shows concern or sadness when others are upset or distressed.
22. Displays exuberance that others find intrusive or disruptive.
23. Displays appropriate negative affect (for example, anger, fear, frustration, distress) in response to hostile, aggressive or intrusive acts by peers.
24. Displays negative affect when attempting to engage others in play.
Appendix I: Examples of Reflective Memos

Meeting of Shawn 24.06.18

Discussed possible factors that may have impacted on some parents, e.g. parental SES/education level. This may have impacted on some parents' level of engagement and discussion of common factors or strategies.

All parents think about why there is no这样 
Colt, but a lack of shared understanding.

Need to be careful of assuming shared understandings between what participants have shared and what they are actually doing.

Meeting of Shawn 03.11.18

Discussed concerns and possible factors that may have impacted on some parents, e.g. parental SES/education level. This may have impacted on some parents' level of engagement and discussion of common factors or strategies.

Reflected on meeting 2 heads of curriculum/curriculum management.

Although we have learned parents' perceptions (e.g. managing attention to what could actually have achieved, such as for my fears, etc.), this is in terms of their emotional experience, still remain true to the actual data despite referring value attributed to it.
**Appendix J: Sample Interview Transcript Section with Thematic Analysis Coding**

<table>
<thead>
<tr>
<th>Data</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laura: Again like that it’s the whole of noticing my shark music...to be with him and saying ‘look’...the whole thing of recognising..‘yes I know that must be very hard’ or even saying ‘sure I’m with you..don’t be afraid..look at me’..even small things..touch his hand..and possibly things that you would’ve always done before, you know, you probably would’ve touched their hand or held their hand or hugged them or rubbed their leg or whatever and say ‘look don’t.’..but maybe again ‘don’t be worrying about it’ but now you kinda go ‘yeah well that is..or must have felt awful..I wouldn’t like if it was said to me so I can understand how you don’t like.’..small things like that d’you know..I think it’s my way of thinking you know..we tend to just kinda go ‘ahh stop sure you’re grand don’t be worrying about that kinda thing, sure look’ you know..whereas recognising his feeling..yeah..I think..yeah</td>
<td>Mother’s awareness of her shark music</td>
</tr>
<tr>
<td></td>
<td>Recognising and acknowledging child’s feelings</td>
</tr>
<tr>
<td></td>
<td>Physical touch as way of comforting child</td>
</tr>
<tr>
<td></td>
<td>Physical touch used before group</td>
</tr>
<tr>
<td></td>
<td>Tendency to dismiss worries previously</td>
</tr>
<tr>
<td></td>
<td>Mother using empathy more</td>
</tr>
<tr>
<td></td>
<td>Mother’s way of thinking is changing</td>
</tr>
<tr>
<td></td>
<td>Tendency to dismiss worries and reassure</td>
</tr>
<tr>
<td></td>
<td>Mother now aware of importance of recognising child’s feelings</td>
</tr>
<tr>
<td>Interviewer: So that’s kind of a change?</td>
<td></td>
</tr>
<tr>
<td>Laura: Yeah because as I said like he doesn’t have meltdowns..he doesn’t have..he’s a very easy going child..it’s just that he doesn’t have enough confidence to believe in himself or worries that something might happen him..you know</td>
<td>Child appears as easy going</td>
</tr>
<tr>
<td></td>
<td>Child lacking in confidence</td>
</tr>
<tr>
<td></td>
<td>Child has tendency to worry</td>
</tr>
</tbody>
</table>
Appendix K: Illustrations of Theme Development Process

Thematic Map

Parent themes

Child themes

A family affair

Parent’s Emotions

Child’s expression of feelings

Connection

Awareness of emotions

Attunement

We’re all in the same boat

Facing fears

Facing and feeling anxiety

Fun

Discomfort contemplating emotions

Coping Strategies
12th December, 2017.

Ms. Amy O’Dea,
Barnakyle,
Patrickswell,
Co. Limerick.

Re/ Protocol Title
Examining the effectiveness of a group intervention targeting childhood anxiety: does enhancing parent-child attachment and emotional regulation have a role to play?
REC Ref: 125/17.

Dear Ms. O’Dea,

Thank you for submitting the documentation as requested by the Research Ethics Committee.

I wish to advise that the Committee has now approved your study.

You should note that your study cannot commence until you also receive AON approval which will issue from the Quality and Patient Safety Department shortly.

You are obliged to inform us as soon as your study is completed or if it terminates early for any reason.

I wish you every success with your study.

Yours sincerely,

[Signature]

Pat Dillon,
Consultant Anaesthetist,
Chairperson, Research Ethics Committee.
Appendix M: Boxplots and line charts for anxiety subscales (excluding total anxiety)

*Time 1 score for John not calculable due to missing values
Participants’ Separation Anxiety scores over time

[Graph showing separation anxiety scores over time for different participants]
Participants' Physical Injury Fear scores over time

Timepoints

Physical Injury Fear score

Jane
Patrick
Tom
Sarah
John
Joe
Participants' Social Phobia scores over time

- Jane
- Patrick
- Tom
- Sarah
- John
- Joe
Participants' Obsessive Compulsive scores over time

- Jane
- Patrick
- Tom
- Sarah
- John
- Joe

Obsessive Compulsive score

Timepoints
*time 1 score for Patrick not calculable due to missing values
Appendix N: Boxplots and line charts for PRQ subscales (excluding attachment)
Participants' Parenting Confidence scores over time

- Jane
- Patrick
- Tom
- Sarah
- John
- Joe
Participants' Relational Frustration scores over time

- Jane
- Patrick
- Tom
- Sarah
- John
- Joe
Appendix O: Boxplot and line chart for emotional lability subscale of ERC