

WHAT TO DO WHEN YOU'VE TRIED IT ALL:
THE DEVELOPMENT AND PILOT EVALUATION OF A SKILLS GROUP
FOR THE PARENTS OF ANXIOUS YOUTH

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ABSTRACT

Research has identified a role for parenting behaviors in the maintenance of child and adolescent anxiety disorders (McCleod, Wood, & Weisz, 2007). This paper reviews the experimental and theoretical literature on the relationship between parenting and youth anxiety as well as the empirical support for parent involvement in child cognitive behavioral therapy (CBT). The present study describes the development and pilot evaluation of a brief cognitive-behaviorally oriented parent treatment group (CBT+PG) designed to augment individual child CBT for anxiety and presents a conceptual model on which the group is based, focusing on the relationship between parenting behaviors, parent and child distress, parental experiential avoidance, and youth anxiety. This study reports preliminary findings, including feasibility and acceptability of the program based on participant and expert feedback. It also includes case descriptions of three families who participated in the CBT+PG program and three families who received only individual child CBT. Preliminary results support the feasibility and acceptability of running this program in an outpatient setting. Parents were satisfied with the program ($M=29.2$, $SD=.24$, possible range=9-36), expert reviewers received it favorably ($M=6.4$, $SD=.26$, possible range=1-7), and it appeared to bestow some clinical benefits. This study was unique in that it assessed parenting behaviors, parental experiential avoidance, and parent psychopathology in addition to child outcomes. Discussion elaborates upon the role of these variables and implications for future research and practice involving parents in child anxiety treatment.

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What to Do When You've Tried It All:

The Development & Pilot Evaluation of a Skills Group for the Parents of Anxious Youth

Anxiety disorders are one of the most common classes of psychiatric problems in children and adolescents (Albano, Chorpita, & Barlow, 2003). Prevalence rates suggest 10% to 20% of youth suffer from anxiety symptoms (Benjamin, Costello, & Warren, 1990; Last, Perrin, Hersen, & Kazdin, 1996), and psychiatric interviews conducted with children and their parents yield a one-year prevalence rate of 15.4% for one or more anxiety disorder (Benjamin et al., 1990). Anxiety disorders also are highly comorbid with other forms of psychopathology (Ollendick & King, 1994a). When working with anxiety-disordered youth, comorbidity is the norm; estimates suggest as many as 79% of children with an anxiety disorder have at least one additional diagnosis (Kendall, Brady, & Verduin, 2001; Walkup et al., 2008). Furthermore, youth anxiety is the source of significant functional impairment as manifest by problems with interpersonal relationships and academic functioning (Ollendick & King, 1994b), including higher levels of family conflict (see Crawford & Manassis, 2001; Ginsburg, & Schlossberg, 2002), social rejection (Langley, Bergman, McCracken, & Piacentini, 2004), school refusal, and lower levels of academic achievement. When untreated, the trajectory of these disorders continues into adulthood and is marked by poor long-term outcomes (Colman, Wadsworth, Croudace, & Jones, 2007; Last, Hansen, & Franco, 1997; Reef, Diamantopoulou, van Meers, Verhulst, & van der Ende, 2009; Woodward & Fergusson, 2001). Anxious youth are at greater risk for future psychopathology such as major depression and substance abuse (Cohen, Cohen, & Brook, 1993) and are more likely to

experience educational and occupational failure (Woodward & Fergusson, 2001). In summation, youth with anxiety disorders face a host of challenges that are associated with marked distress, impact multiple life domains, and may have long-term consequences requiring professional intervention.

Youth Anxiety and the Role of Parents

Questions are often raised about the etiology of youth anxiety, which is associated with the complex interplay of factors including temperament, genetics, environment, and family. However, a significant body of theoretical and empirical research links youth anxiety with parenting practices and styles (for reviews see Ginsburg & Schlossberg, 2002; McLeod, Wood, & Weisz, 2007; Wood, Piacentini, Southam-Gerow, Chu, & Sigman, 2003). In fact, it has been suggested that parent behavior is more predictive of child anxiety status than factors including ongoing family strain and maternal psychopathology (Whaley, Pinto, & Sigman, 1999). Several parenting practices have been the focus of significant research attention, namely, over-control and restricting autonomy, modeling and reinforcing anxious behaviors, and rejection and acceptance. Moreover, extensive research has identified avoidance as the key mechanism through which anxiety is developed and maintained (Barlow, 2002; Kendall & Suveg, 2006). Given the well-established connection between anxiety and avoidance, it is posited here that each of the aforementioned parenting practices contributes to youth anxiety by encouraging avoidance of feared situations and anxiety provoking stimuli. These adult responses to child anxiety limit the child's ability to face and master fears, truncating the natural process of exposure, habituation, and new

learning. The following section reviews empirical evidence supporting the association between each type of parenting practice and youth anxiety and further discusses the ways in which each facilitates avoidance and interferes with developmentally appropriate approach and exposure.

Over-control and restricting autonomy. Comprised of behaviors including over-involvement, excessive restrictiveness, encouragement of dependence, dismissal of the child's opinions and choices, and decision-making for the child, over control and restricting autonomy have long been identified as parenting behaviors associated with youth anxiety (Ginsburg & Schlossberg, 2002; McLeod et al., 2007; Wood et al., 2003). Children who are clinically anxious are more likely to have parents who are controlling and restrictive than are children who are not anxious. In a 2007 meta-analysis (McLeod et al.), parental control, including both over-involvement and restricting autonomy, accounted for 6% of the variance in child anxiety, with a medium effect size of .25. When analyzed individually, restricting autonomy had an even stronger association with child anxiety, accounting for 18% of the variance with a large effect size of .42.

In one of the first observational studies of the interaction patterns of parents and anxious children, Krohne & Hock (1991) observed mother-daughter dyads completing a difficult puzzle task. Mothers of girls with high anxiety scores were more likely than mothers of girls with lower anxiety scores to intervene in the child's problem-solving and take control of the task. The more frequently the mother intervened in the problem-solving process, the more anxious the daughter was; however, the more clearly the mother relinquished control, the less anxious the daughter was. Subsequent studies

have documented similar interactions (Gar & Hudson, 2008; Hudson, Comer, & Kendall, 2008; Hudson, Doyle, & Gar, 2009; Hudson & Rapee, 2001; Hudson & Rapee, 2002; Moore, Whaley, & Sigman, 2004; Siqueland, Kendall, & Steinberg, 1996). Parents of anxious children have been rated by independent observers as more controlling (Siqueland et al., 1996), more intrusive during problem-solving tasks (Hudson & Rapee, 2001; Hudson & Rapee, 2002), and less granting of autonomy (Moore et al., 2004). Moreover, adolescent perceptions of maternal control are predictive of adolescent anxiety disorders (McClure, Brennan, Hammen, & LeBrocq, 2001).

These effects may be more pronounced in distressing or stressful situations (i.e., solving difficult puzzles, discussing conflictual events). Observations of parent-child interactions across high stress and low stress conditions showed elevated intrusiveness scores when anxious parent-child dyads were discussing a time the child felt anxious, but not during a discussion of a happy event. During discussions of happy events, intrusiveness ratings were not significantly different from those of a non-clinical comparison group (Hudson et al., 2008). The apparent increased prevalence of controlling and over-involved parenting observed in anxiety-provoking situations, suggests that this parenting style may emerge in response to a perceived threat or as a result of the child's anxious behavior. This position is supported by Gar and Hudson (2008) and Hudson and colleagues (2009) who observed mothers completing a puzzle task with their child, an anxious child, and a non-anxious child. All mothers, regardless of the anxiety status of their own child, were more over-involved and intrusive with

anxious children than with non-clinical children. This suggests that the child's anxious behavior may influence adult response.

Though further research is needed to clarify the directionality of the relationship between anxiety and over-control, it is clear that controlling parenting and child anxiety are linked. Wood et al. (2003) posited these parenting behaviors – intrusiveness, overinvolvement, excessive restrictiveness – contribute to youth anxiety because they prevent youth from having opportunities to develop a sense of control, mastery, and autonomy. Instead of allowing children to experience and learn from new situations, especially ones that may initially seem scary, parents intervene, permitting children to avoid the situation, thereby depriving them of the chance to habituate to distress and learn new skills. For example, the mother of an adolescent with social anxiety may contact her child's teacher to ask a question about an upcoming project, rather than encouraging the child to speak to the teacher directly. By taking control of this age-appropriate task, the mother enables the child to avoid a situation that generates anxiety (i.e., asking a teacher questions about something she does not understand), preventing her from developing the skills to handle the situation independently.

Modeling and reinforcing anxious behavior. Another pathway through which parents provide anxiety related learning experiences for their children is modeling and reinforcing anxious behavior (Fisak & Grills-Taquechel, 2007). Parental modeling of anxiety takes multiple forms including visually displaying signs of fear in the child's presence, engaging in avoidant coping strategies, and verbally communicating anxiety, either directly or in front of the child. In one of the seminal studies in this area, Muris,

Steernmen, Merchelbach, & Meesters (1996) found that mothers who “always” expressed fear in their child’s presence had more fearful children than mothers who reported they never expressed fear in front of their children. Moreover, in observed parent-child interactions, anxious mothers of anxious children catastrophized more than non-anxious mothers and were more likely to speak about problems in terms of lack of control and the lack of ability to effectively cope (Moore et al., 2004; Whaley et al., 1999). Anxious parents also have been observed to exhibit fewer adaptive coping strategies than non-anxious parents while engaging in mildly stressful tasks (i.e., preparing for an impromptu speech) with their children (Buckley & Woodruff-Borden, 2006). Parents who model poor coping strategies such as avoidance and catastrophizing may be more likely to have children who use the same ineffective tools to manage their own anxiety.

Further, it is hypothesized that parents of anxious children often support, assist in, or reward their child’s anxious or avoidant behavior (Fisak & Grills-Tauechel, 2007). A series of experimental studies found that the parents of anxious children may reinforce anxiety by supporting the child’s avoidance of ambiguous situations (Barrett, Rapee, Dadds, & Ryan, 1996; Cobham, Dadds, & Spence, 1999; Dadds, Barrett, Rapee, & Ryan, 1996). Barrett et al., (1996) presented child participants with two ambiguous situations involving potential threat and asked children to interpret each situation and give a response for handling the situation before and after family discussions. Prior to these discussions, children in the anxiety group suggested a greater number of avoidant responses than children in oppositional or non-clinical comparison groups. After family

discussions, the number of avoidant responses among anxious youth increased, suggesting that parental input may have reinforced the child's choice of a dysfunctional response pattern. A follow-up investigation (Dadds et al., 1996) determined that parents of non-clinical children were more likely to support their child's pro-social solutions whereas parents of anxious children were more likely to reinforce avoidant solutions. Specifically, parents of anxious children tended to express more agreement with and more actively listened to their children when they suggested avoidant solutions. This phenomenon has been named the FEAR effect (Family Enhancement of Avoidant Responses) and suggests that parental reinforcement may increase the likelihood that anxious children will rely upon maladaptive coping responses stressful situations.

Parental modeling and reinforcement of anxiety leads to increased child avoidance of anxiety provoking situations through at least two pathways. By behaving in avoidant ways, parents convey messages of threat. Children witness a powerful model implying they too should be afraid and should respond to that fear in a parallel manner. Additionally, parents of anxious children tend to be more supportive of their child's anxious choices than of their child's pro-social choices. For example, an anxious child might decide not to try out for the school play for fear of embarrassing herself. If her parents respond by affirming this as a positive decision, she will feel justified in her choice to avoid performing and will likely engage in similarly avoidant behavior in the future.

Rejection and acceptance. Parental rejection can be understood as consisting of two dimensions: withdrawal, representing lack of involvement, interest, or emotional

support; and aversiveness, representing hostility, criticism, punishment, and conflict (McCleod et al., 2007). A separate, but related, construct is parental acceptance, characterized by warmth and a sense of positive regard expressed by the parent to the child. Several studies have documented relationships between child anxiety and maternal rejection and acceptance, noting that mothers of children with anxiety disorders display less warmth, more criticism, and more hostility than mothers of non-clinical children (Hudson & Rapee, 2001; Moore et al., 2004; Hudson et al., 2008; Gar & Hudson, 2008). Clinical children also perceive their parents as less accepting and more critical than children without anxiety disorders (Siqueland et al., 1996).

It has been hypothesized that parental rejection stems from parental anxiety (Whaley et al., 1999), but more recent research refutes this assertion (Gar and Hudson, 2008; Moore et al. 2004). Mothers of anxious children may be more critical and display less warmth than mothers of non-anxious children, regardless of their own anxiety status. Gar and Hudson (2008) present evidence that anxious and non-anxious mothers of anxious children are more critical and less warm than anxious and non-anxious mothers of non-anxious children. They concluded that something about the behavior of anxious children may trigger a negative adult response. This position is further supported by Hudson and colleagues (2009); mothers interacted with three different children: their own child, a child from the same diagnostic group as their child (i.e. anxious or non-anxious), and a child from the opposite diagnostic group. Regardless of their own anxiety status, mothers were observed to interact more negatively with anxious children. That is, mothers of anxious children responded more negatively to

both their own anxious child and to other anxious children than they did to non-anxious children. Mothers of non-anxious children showed a similar response pattern. They responded more warmly and with more acceptance to non-anxious children than they did to children who were anxious. These results suggest that non-anxious children may elicit more support and encouragement from adults than anxious children, whose behaviors may elicit more negatively charged emotional interactions.

Rejecting or aversive parental behavior among parents of anxious children also may be influenced by contextual factors. Hudson et al. (2008) observed parent-child dyads discussing three recent real-life situations in which the child experienced anxiety, anger, or happiness. Results indicated that mothers of anxious children displayed significantly less warmth than mothers of non-anxious children, during discussions about the negative affect situations (i.e., those involving anxiety or anger). In contrast, when the family discussed a situation in which the child experienced happiness, there were no affective differences between groups. As such, there may be something specific about distressing emotional topics that causes parents of anxious children to react with negativity, rejection, and criticism.

The following vignette illustrates the way parental rejection may increase avoidance: An 8-year old boy is afraid of dogs. When his neighbors' puppy jumped on him, he cried and ran away. His father, embarrassed and irritated by his son's response, reacted harshly and criticized him. This aversive behavior had a punishing effect and reduced the behavioral manifestations of the child's anxiety. As he realized it was not okay to express anxiety or fear he avoided going outside every time the neighborhood

children played with the dog. Because any expression of fear or worry resulted in rejection from his father, he avoided situations that might trigger these emotions.

Experiential Avoidance

A connection between parenting practices and youth anxiety has been established and the relationship between these parenting practices and avoidance has been laid out, but what is the motivation for parents to respond to their anxious children with these types of reactions? Experiential avoidance has been proposed as one mechanism that explains the difference between the responses of parents to anxious and non-anxious children (Tiwari et al., 2008). A central component of Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999), experiential avoidance refers to an unwillingness or inability to accept one's own personal experiences of negative emotion. It can be conceptualized as falling on the same continuum as psychological acceptance, with high levels of experiential avoidance reflecting inflexibility and low acceptance (Greco, 2005). Experiential avoidance in the adult literature developed out of Borkovec and colleagues' research (Borkovec, Alcaine, & Behar, 2004; Borkovec & Roemer, 1995) on the role of worry in generalized anxiety disorder, which suggested worry serves a distracting function, diminishing internal distress and allowing individuals to avoid having to experience stronger negative emotions. Cheron, Ehrenreich, & Pincus (2009) adapted the concept to include the role of a parent's experiential avoidance in relation to their child's anxiety and identified parental experiential avoidance as a motivating factor for avoidance-promoting parenting behaviors. They describe parental experiential avoidance as, "the

phenomenon that occurs when a parent is faced with a situation in which their child experiences an emotionally arousing incident and the steps that parent takes to control the form or frequency of the child's experience, even when this control causes behavioral harm (p. 384)." Parental experiential avoidance reflects both a parent's unwillingness to witness their child's negative emotion as well as their inability to effectively manage their own reactions to their child's affect.

Data support the assertion that experiential avoidance limits the ability of parents of anxious children to tolerate seeing their children in distress (Tiwari et al., 2008). Turner, Beidel, Roberson-Nay, and Tervo (2003) observed parent-child interactions during a structured play task and reported that anxious parents were more distressed watching their children complete the activity than non-anxious parents. Parents of anxious children also experienced more negative cognitions and held lower expectations about their child's ability to perform difficult tasks than did parents of non-anxious children (Cobham et al., 1999). Hudson et al. (2008) found that parents of anxious children responded more intrusively and less warmly during an emotionally evocative parenting situation. By taking control, interfering in their child's activities, limiting autonomy, and reacting critically in these situations, parents may be attempting to reduce their own anxiety and discomfort.

Cheron et al. (2009) developed a tool to assess experiential avoidance in the context of parenting and found a significant relationship between parental experiential avoidance and parental control; higher levels of experiential avoidance were reported by parents who exhibited more controlling behaviors. Moreover, parental experiential

avoidance accounted for a significant portion of the variance in parent and clinician rated child anxiety symptoms, supporting the position that it plays a role in the manifestation of child anxiety symptomology. Still, little research has been conducted on the impact of parental experiential avoidance on parenting behavior; additional investigation is required to further examine this connection.

A Conceptual Model of the Influence of Parenting Behaviors on Youth Anxiety

Figure 1 presents a conceptual model explaining the relationship between parent and child distress, parental experiential avoidance, parenting behavior, and youth anxiety. When a child with a predisposition to experience anxiety encounters a potentially anxiety provoking situation, a cycle is triggered. 1) Several things may contribute to child and parent distress. The stimulus that elicits the child's anxiety may simultaneously elicit parental anxiety (Cobham et al., 1999; Whaley et al., 1999). Alternately, initial child anxiety (i.e., expressing fear, attempting to avoid, reassurance seeking) may exacerbate parent distress, in the form of anxiety or another negative emotional state (i.e., anger, embarrassment, guilt). Parent and child both experience negative emotion. 2) The parent's response in relation to the child (i.e., intrusiveness, over-involvement, anxiety reinforcement, negative affect, etc.) promotes child avoidance or reinforces the child's initial self-initiated attempts to avoid (Barrett et al., 1996; Dadds et al., 1996; Hudson et al., 2008). 3) These avoidance-fostering parent behaviors activate a cascade of child avoidance which promotes short-term decreases in both child anxiety and parent distress in an "Experiential Avoidance Loop." Parents are reinforced to continue fostering avoidance as a way to manage their child's anxiety and

their own discomfort in the moment (Tiwari et al., 2008; Cheron et al., 2009). 4) As avoidance of anxiety provoking situations becomes more ubiquitous, the child is increasingly deprived of opportunities to confront fears and is unable to develop the skills necessary to handle anxiety provoking situations. The child's anxiety is maintained and the child becomes increasingly likely to avoid similar situations in the future (Wood et al., 2003). This avoidance leads to increased interference in child and family functioning, limiting the child's ability to engage in developmentally appropriate activities from attending birthday parties to speaking with adults to separating from parents. As such, anxiety disorders are maintained and maladaptive coping responses become increasingly entrenched.

Treatment Strategies for Youth Anxiety Disorders

Individual cognitive-behavioral therapy. Individual, child-focused cognitive-behavioral therapy (CBT) has been identified as a “probably efficacious” intervention for youth anxiety disorders (Chambless et al., 1998). CBT treatment for youth anxiety is often based on the Coping Cat (Kendall & Hedtke, 2006) or one of its variants (i.e., the Coping Koala, an Australian adaptation). The Coping Cat is a 16-session program. The first half focuses on the development of coping skills including relaxation, cognitive restructuring, and problem solving, while the second half concentrates on active practice through imaginal and in vivo exposure. CBT for anxiety disordered youth has fared well in randomized clinical trials; youth who receive CBT consistently demonstrate greater alleviation of symptoms than youth in waitlist control groups (Kendall, 1994; Kendall et al., 1997; Barrett, Dadds, & Rapee, 2006). The Child-Adolescent Anxiety

Multimodal Study (CAMS), a large-scale, multisite, randomized clinical trial, also demonstrated support for the efficacy of CBT as compared to other active treatments (Walkup et al., 2008). Anxious youth received sertraline, CBT, sertraline and CBT, or a pill placebo. Post-treatment, 80.7% of children in the combination group, 59.7% of the CBT group, and 54.9% of the sertraline group were rated as very much or much improved, as compared to only 23.7% of the placebo group.

Despite this empirical support, there remains some youth for whom CBT does not yield meaningful improvement, leading researchers and treatment developers to seek ways to enhance these therapies. Given the central role parents are hypothesized to play in youth anxiety development and maintenance, a natural extension of child-focused CBT has been the inclusion of parents in the treatment process. Dating back to 1996, 12 randomized clinical trials and two multiple baseline studies have explored the benefits of increased parental involvement in child therapy (see Table 1). Yet, results remain equivocal; while some studies have found family inclusion significantly enhances child outcomes and family functioning, others have not found clinically meaningful differences between treatment modalities. The following section reviews the current literature on family involvement in child CBT for anxiety.

Family involvement in cognitive-behavioral therapy. Howard and Kendall (1996) conducted the first evaluation of a family CBT intervention for child anxiety using a multiple baseline design with six participants. Therapists conceptualized the specific role of the family in maintaining the child's anxiety and encouraged family members to look at their own experiences attempting to cope with anxiety. Post-treatment assessments

indicated that 66% of participants no longer met criteria for an anxiety disorder, providing initial support for the effectiveness of family-based CBT for child anxiety.

These positive findings were replicated by Barrett and colleagues (1996) who compared child CBT, child CBT with a family anxiety management (CBT+FAM) component, and a waitlist control group in the first randomized clinical trial of family CBT for youth anxiety. The FAM component consisted of behavior management training, parent anxiety management training, and communication and problem-solving training, delivered over 12 conjoint sessions. Both child CBT and child CBT+FAM outperformed waitlist controls, but CBT+FAM participants showed more symptom relief on self-report measures and greater improvements on clinician evaluations of psychosocial adjustment.

Given the success of individual CBT+FAM, Barrett (1998) modified the protocol for delivery in a group format. Groups have potential benefits over individual therapy because they provide opportunities for normalizing anxiety, modeling coping behavior, and reinforcing the completion of therapy related tasks. Group work also can minimize therapy costs, an important consideration in today's climate of limited mental health resources. Families were randomly assigned to one of three conditions: child only CBT, CBT+FAM, or waitlist control. Diagnostic status reports showed both active treatments significantly outperformed the waitlist, but they were not significantly different from each other. However, CBT+FAM participants showed greater improvement of internalizing and externalizing symptoms on parent and child self-reports.

Building upon this research, Cobham, Dadds, & Spence (1998) also developed a group program, but narrowed parental involvement to include only parent anxiety management (PAM). Outcomes were moderated by parent anxiety status; PAM enhanced the efficacy of child CBT for children with an anxious parent, with similar trends continuing at 6 and 12 month follow-ups, but had no added effect for children whose parents were not anxious. Thus, this approach may be beneficial when parents are also anxious, but may not be the right treatment strategy for other parents.

Group interventions have become increasingly common, given their potential to deliver treatment to a larger number of people in a more cost-effective way (Mendlowitz, et al., 1999; Shortt, Barrett, & Fox, 2001; Silverman et al., 1999; Spence, Donovan, & Brechman-Toussaint, 2000). Comparisons of group CBT with concurrent parent sessions to waitlist controls show robust results with active treatments producing and maintaining statistically significant reductions in anxiety (Shortt, et al. 2001; Silverman et al. 1999). However, while some trends suggest family involvement offers added benefits, outcomes indicating the superiority of family involvement over traditional child CBT have been equivocal. Comparing a child-only group, a parent-only group, and a combined parent-child group, reductions in child anxiety symptoms were equivalent, but children in the combined group used more active coping strategies (Mendlowitz, et al., 1999). Among children who participated in a social skills based CBT group for social phobia, there was a trend toward superior outcomes (i.e., relief from anxiety symptoms) among children whose parents participated in an adjunctive parent component, but this effect did not reach statistical significance (Spence, et al., 2000).

To more fully capture the potential benefits of family involvement, focus also has been placed on targeting the specific parenting practices that affect child anxiety. Based on the hypothesized role of intrusiveness and autonomy granting in the maintenance of anxiety disorders (see Wood, McLeod, Sigman, Hwang, & Chu, 2003), Wood, Piacentini, Southam-Gerow, Chu, & Sigman (2006) developed a dyadic CBT model based on these mechanisms. Specific components included supporting parents to allow children to learn by trial and error, promoting the acquisition of novel self-help skills, and encouraging independent behavior. Compared with child CBT, family CBT was associated with greater improvement on independent evaluator and parent ratings of anxiety symptoms, although this difference was not seen in analyses of child self-reports. In the family CBT condition, 78.9% of children met criteria for treatment response, but only 26.3% of the child CBT condition were considered treatment responders. Treatment that directly targets the mechanisms hypothesized to maintain child anxiety may provide more robust outcomes than child-focused treatments or treatments that involve the family more generally.

Despite initial research support for family CBT, other studies have posited that parental involvement does not enhance treatment outcomes (Kendall, Hudson, Gosch, Flannery-Schroeder, & Suveg, 2008; Nauta, Scholing, Emmelkamp, & Minderaa, 2001, 2003). Nauta and colleagues (2003) added a seven session cognitive parent training (CPT) program to standard child CBT, primarily focused on teaching parents to challenge negative thoughts about their anxious child. When compared, child CBT and child CBT+CPT both outperformed a waitlist control, but no measures differentiated the

active treatments from one another. The most recently published comparisons of child and family CBT for youth anxiety also have failed to clearly demonstrate the increased efficacy of parent involvement (Kendall et al., 2008; Bodden et al. 2008). In Kendall's study, family CBT only outperformed individual CBT when both parents had an anxiety disorder, pointing to parent psychopathology as a possible treatment moderator.

Conversely, Bodden et al. (2008) found individual CBT to be significantly more effective than family CBT, with 53% and 28% of children evidencing diagnostic relief, respectively. However, the structure of this family CBT paradigm was unusual; it consisted of three child sessions, two conjoint parent-child sessions, five parent sessions, and three family sessions. In sum, the effectiveness of adding family components (as currently constructed) to child CBT still has to be fully established. In a family CBT meta-analysis, Barmish and Kendall (2005) stated, "there is not sufficient evidence to conclude with confidence that adding parents as co-clients is uniformly superior" (p. 578).

Limitations of current treatment outcome literature. The current literature evaluating parent involvement in CBT for youth anxiety is limited in several important aspects. Although researchers have attempted to develop effective family CBT programs using various formats (i.e., group versus individual, conjoint parent-child sessions versus separate parent meetings) and focusing on various mechanisms (i.e., parent anxiety, transfer of control, autonomy granting and intrusiveness), it remains unclear a) whether added family involvement in CBT actually promotes enhanced outcomes and b) what treatment format is most effective.

One explanation for these inconclusive findings is that treatments may not have targeted the right mechanisms. Therapies focused on parent anxiety management were helpful when parents were anxious (Cobham et al., 1998), but did not have an effect among non-anxious parents or when parent anxiety was not considered as a treatment moderator (Nauta et al., 2001, 2003). Moreover, rather than teaching several core skills, the majority of family treatments included myriad components (i.e., psychoeducation, cognitive restructuring, behavioral management, relaxation training, problem solving, communication skills, partner support), raising the possibility that such a broad focus diluted the added effects of parental involvement. These programs tended to either a) teach skills parallel to those focused on in child treatment, or b) concentrate on more general family interventions (i.e., communication skills, family problem solving). The parenting behaviors hypothesized to be involved in the maintenance of youth anxiety were rarely addressed. An exception is Wood and colleagues' (2006) study, which directly targeted parenting-related mechanisms of change (i.e., autonomy granting and over-control) and showed definitively superior outcomes for parental involvement. Thus, parenting interventions that explicitly address the parenting behaviors most directly linked to youth anxiety likely hold the greatest potential of successfully enhancing treatment.

In this treatment outcome literature, outcomes have primarily been limited to child diagnostic status and anxiety symptoms. Variables including family functioning, parenting behaviors, and parental psychopathology have largely been neglected. Five studies measured pre-treatment parental psychopathology (Barrett et al., 1996; Bodden

et al., 2008; Cobham et al., 1998; Kendall et al., 2008; Wood et al., 2006), but only one (Kendall et al., 2008) assessed changes in parental psychopathology. ADIS-IV diagnostic interviews revealed that 38% of parents with pre-treatment anxiety disorders were diagnosis free at post-treatment. Parent anxiety has been associated with parenting behaviors hypothesized to maintain child anxiety including criticism, catastrophizing, over-control, and lowered expectations regarding their children's abilities (Cobham, Dadds, & Spence, 1999; Whaley et al., 1999). The alleviation of parent psychopathology through involvement in child treatment may serve a protective function for the child's long-term prognosis and is an important variable to more fully assess.

Similarly, only one treatment outcome study included post-treatment measurements of family functioning and parenting behavior, variables that have been implicated in the development of child anxiety and that may have an impact on the long-term maintenance of treatment gains. Bogels & Siqueland's (2006) multiple baseline assessment of family-based CBT for youth contributes significantly to the literature because outcome variables included not only child anxiety symptoms, but also parent anxiety symptoms, dysfunctional parental beliefs, parenting behaviors, and family functioning. Child outcomes were consistent with other treatment outcome studies; at post-treatment 46% of children were free of their primary anxiety disorder. Importantly, family involvement was associated with positive changes across parent anxiety, parenting behaviors, parent dysfunctional thinking, and family functioning variables. Parents reported significant improvements of their own anxiety symptoms as well as reduced dysfunctional thinking about their child's anxiety and their role as

parents. Children reported improvements in family functioning and parents reported using fewer overprotective and controlling parenting behaviors. Better understanding of the impact of family involvement in treatment on these important facets of family life is necessary to truly assess the additional benefits parent involved in CBT may be able to offer over child-focused therapy.

The Current Investigation

Despite limitations, the literature provides a strong basis for the current study by establishing an empirical foundation demonstrating partial support for increased parent involvement in CBT for youth anxiety. This investigation builds upon previous research by documenting the development and pilot implementation of a parent training group (CBT+PG) designed to augment traditional, child CBT for anxiety. Feasibility, acceptability, and a preliminary assessment of outcomes were evaluated for CBT+PG by comparing outcomes in families who received the parenting group and families who received only child CBT. Unlike previous parent treatment programs, this group targeted the primary mechanisms hypothesized to be involved in the development and maintenance of anxiety disorders: avoidance-promoting parenting behaviors. Goals of the group included 1) helping parents foster independence and autonomy in their children by encouraging exposure; 2) eliminating parenting behaviors that promote avoidance; and 3) supporting parents' abilities to tolerate negative affect triggered by witnessing their child's anxious distress through mindfulness training. Rather than focusing narrowly on child anxiety symptoms as a measure of treatment outcome, this

study evaluated outcomes more broadly, including parent psychopathology, parent experiential avoidance, and parenting behaviors.

Hypotheses

1. Parents will demonstrate high self-reported satisfaction from participating in the parent training group, and CBT+PG will be found to be feasible, as determined by group enrollment, retention, and attendance. Open-ended feedback will be solicited to provide suggestions for future revisions.
2. CBT+PG will be found to be acceptable in terms of content and structure as based upon expert reviewer evaluations and feedback from parents.
3. Both CBT only and CBT+PG will produce significant pre-post reductions in child anxiety as measured by diagnostic interviews and parent- and child-report questionnaires.
4. Parents who participate in CBT+PG will show reductions in their own self-reported psychological symptoms and decreased levels of parental experiential avoidance. Formal statistical comparisons will not made due to sample size limitations, but it is suspected that changes in the CBT+PG group will be greater than in the CBT only group.
5. Parents who participate in CBT+PG will show improvements in self-reported parenting behaviors. Formal statistical comparisons will not be made due to sample size limitations, but it is suspected changes in the CBT+PG group will be greater than in the CBT only group.

Methods

Participants

Participants were six children and adolescents and one or both of their parents. Eligible participants were families whose child met DSM-IV-TR (APA, 2000) criteria for a primary diagnosis of an anxiety disorder; exclusionary criteria included a primary diagnosis of a disorder other than an anxiety disorder or any diagnosis of intellectual disability, an autism spectrum disorder, schizophrenia, or bipolar disorder. All families who met inclusionary criteria and initiated services at the Youth Anxiety and Depression Clinic (YAD-C) during the targeted recruitment period were invited to participate. Families that initiated YAD-C services subsequent to the group recruitment period served as treatment as usual control cases. Three families participated in the group program with three families in the control condition. Four (67%) child participants were male. Five (83%) were 11-14 years old, and one (17%) was 7-10 years old. Five (83%) were Caucasian, and one (17%) was African American. Four children received a primary diagnosis of Generalized Anxiety Disorder, one Social Phobia, and one Selective Mutism. Comorbidity was high, with 86% meeting criteria for at least one additional diagnosis. The sample was upper middle class and well educated; 100% of parents had at least some college education, and 33% had post-graduate training. Annual family incomes exceeded \$80,000.

Setting and Personnel

All procedures were approved by the Rutgers University internal review board and were conducted at the YAD-C, a university-based research clinic that draws its

clients from natural referrals and community sources. Doctoral candidates in clinical or school psychology conducted structured diagnostic interviews and provided individual therapy. The parent group was administered by the study's Primary Investigator (RAM) and an advanced graduate student therapist, both masters level clinicians with several years of experience at the YAD-C. All individual therapists had extensive CBT experience and specific training in the treatment protocols. Therapists received 1.5 hours of weekly group supervision from a doctoral level clinical psychologist with over 15 years of experience. Group leaders received an additional hour a week of supervision.

Measures

Outcomes were evaluated via changes in diagnostic status and severity, child anxiety symptoms (parent and child report), and parent psychopathology, experiential avoidance, and parenting behaviors (parent report).

Structured diagnostic interviews.

Anxiety Disorders Interview Schedule for DSM-IV – Child and Parent Versions (ADIS-C/P; Silverman & Albano, 2006). Youth diagnostic status was established using the ADIS-C/P, a semi-structured clinical interview that assesses anxiety, mood, and externalizing disorders through parallel parent and child interviews. It has strong psychometric properties including good test-retest reliability and concurrent validity (Silverman, Saavedra, & Pina, 2001; Wood, Piacentini, Bergman, McCracken, & Barrios, 2002). Trained diagnosticians interviewed each youth and parent(s) before and immediately after treatment. Diagnosticians rated the severity of each diagnosis using the ADIS-C/P Clinician Severity Rating (CSR) scale, where 0=not at all, 4=some, and

8=very, very much. CSR ratings of 4 or greater are considered to be clinically meaningful. All diagnosticians were trained to sufficient inter-rater reliability ($\kappa > 0.80$ against gold standard ratings) and were supervised by a licensed clinical psychologist with more than 15 years of experience using the measure.

Child and parent report outcome measures.

State-Trait Anxiety Inventory for Children-Trait Version – Child Report (STAIC-Trait-C; Spielberger, 1973). The STAIC-Trait is a 20 item self-report measure that assesses enduring tendencies to experience anxiety and asks children to describe how often they experienced anxiety symptoms over the previous week. Symptoms are rated as occurring hardly-ever (1), sometimes (2), or often (3), for a score range of 20-60. Raw scores of 45-55 are common for clinical populations (Kendall, 1994; Kendall et al., 1997). Psychometric properties are strong; internal consistency (α ranging from .82 to .89) and test-retest (ICC ranging from .68 to .79) statistics suggest the STAIC has high reliability, and correlations with other anxiety scales suggest good validity, with coefficients over .80 (Hodges, 1990; Southam-Gerow & Chorpita, 2007). The use of the STAIC as a treatment outcome measure is well-established (Kendall, 1994; Kendall et al., 1997).

Multidimensional Anxiety Scale for Children – Child and Parent Reports (MASC-C/P; March, 1997). The MASC is a 39-item questionnaire that assesses anxiety symptoms across several domains and yields an overall trait anxiety score. Respondents rate recent anxiety symptoms on a four-point scale: never true (0), rarely true (1), sometimes true (2), or often true (3). Total score test-retest reliability is very high, ICC =

.93, and convergent and divergent validity are adequate (Baldwin & Dadds, 2007; March, Parker, Sullivan, Stallings, & Conners, 1997).

Depression Anxiety Stress Scales-21 (DASS-21; Lovibond & Lovibond, 1995). The DASS-21 is a widely used self-report measure that assesses anxiety, stress, and depression in adults. Respondents indicate the extent to which each item was applicable over the previous week using a 0-3 scale: did not apply to me (0), applied to me to some degree, or some of the time (1), applied to me a considerable degree, or a good part of the time (2), or applied to me very much, or most of the time (3). The DASS-21 distinguishes well between depression, physiological arousal, and psychological tension (Antony, Beiling, Cox, Enns, & Swinson, 1998), and has reliability scores in the acceptable to excellent ranges. It is considered a valid tool for assessing client outcomes in routine clinical practice (Ng, Trauer, Dodd, Callaly, Campbell, & Berk, 2007).

Parental Acceptance and Action Questionnaire (PAAQ; Cheron, Ehrenreich, & Pincus, 2009). The PAAQ is a 15-item self-report measure based on Hayes' Acceptance and Action Questionnaire (2004), but modified to assess experiential avoidance in the context of parenting. Responses are given on a Likert-type scale ranging from never true (1) to always true (7). The PAAQ is comprised of two factors, Unwillingness (parents' unwillingness to witness their child experience negative emotion) and Inaction (parents' inability to effectively manage their reactions to their child's affect) with higher scores indicating greater unwillingness and inaction. Psychometric data indicate moderate test-retest reliability, $r=.72$, and support the temporal stability, internal consistency, and criterion validity of the measure.

Rearing Behaviors Questionnaire (RBQ; Bogels & Van Melick, 2004; Verhoeven, Bogels, & van der Bruggen, in press). The Rearing Behaviors Questionnaire is a 28-item self-report measure designed to capture three aspects of parenting behavior: autonomy granting, over control, and rejection. The RBQ combines items from the Mother-Father-Peer Inventory (MFP; Epstein, 1983) and the Child Report of Parental Behavior Inventory (CRPBI; Schludermann & Schludermann, 1970), creating a measure that taps parenting constructs reflective of etiological models of anxiety disorders in children. Parents indicated their use of specific parenting behaviors on a 1-4 scale: not true at all (1), somewhat true (2), fairly true (3), or very true (4). Lower scores reflect greater use of positive parenting behaviors (i.e., more autonomy granting, less over control, and less rejection). Internal consistency for individual informants ranges between $\alpha = 0.35 - 0.75$ for each scale, suggesting low to moderate reliability (Bogels & Van Melick, 2004).

Feasibility and acceptability measures.

Parent Session by Session Feedback Form (PSxS). The PSxS is 3-item questionnaire given to parents at the end of each group session. Parents were asked to provide feedback about the specific topics discussed/skills presented during each meeting using a 5 point scale: unhelpful (1), neither helpful nor unhelpful (2), somewhat helpful (3), helpful (4), or very helpful (5). Group leaders left the room while parents completed these forms and deposited them in an envelope to ensure anonymity.

Parent Group Satisfaction Survey (PGSS). Based on the satisfaction scale used in the Child/Adolescent Anxiety Multimodal Study (CAMS; Walkup et al., 2008), the PGSS is a 9-item parent-report measure assessing satisfaction with the parent group component

of treatment on a 1 to 4 scale (total range = 9-36). Items address negative and positive aspects of the program, including overall quality, helpfulness, and the degree to which parents learned new skills. Additionally, the PGSS includes 5 open-ended questions allowing parents to provide qualitative feedback about the program.

Expert Feedback Form. A 20-item measure was completed by experts in the field of child anxiety, providing feedback on the acceptability of each session of the parent group using a 1 to 7 point scale, with higher scores reflecting more positive ratings. Experts were also provided with the opportunity to give open-ended feedback about the manual and its contents.

Group Leader Feedback Form. Though not considered a formal measure of acceptability, after each session, group leaders completed a 12-item feedback form. Items were rated using a 1 to 7 point scale. Group leaders evaluated the content and utility of the manual and workbook with respect to usability, meeting stated session goals, and addressing parent concerns.

Procedure

Phase I: Treatment development. The treatment development phase of this study involved creating the parenting group therapist manual and parent workbook. The development of these materials was predicated upon a comprehensive review of the child anxiety treatment literature, emphasizing studies that included parents in the treatment process. The literature review also focused on theoretical papers and experimental studies that addressed the role of parenting in the etiology and maintenance of child anxiety disorders. Existing youth anxiety treatment manuals with

parent and family components, for example, Building Confidence (Wood & McLeod, 2008) and Keys to Parenting Your Anxious Child (Manassis, 1996), were also consulted. This body of literature informed the development of an initial draft of the treatment manual and workbook, which was used during Phase II of the study. Feedback from group leaders, program therapists, and known experts in the child anxiety field was solicited and will be incorporated in future revisions of the therapist manual and parent workbook.

Phase II: Evaluation of parent treatment program (CBT+PG). Cases were referred to the YAD-C through community sources, including schools, pediatricians, and other practitioners. Parents participated in a brief phone screen at which time an intake interview was scheduled, provided the family's primary complaints seemed appropriate for treatment at the YAD-C. Families were mailed a packet of self-report measures to complete prior to the intake interview at which time consent forms were reviewed and signed. Intake interviews consisted of the ADIS-C/P and were conducted by trained diagnosticians. A week after the intake interview, all families were contacted by the YAD-C Program Director to inform them of their status, and families accepted into the program were assigned an individual therapist. Families of children meeting inclusionary criteria that initiated treatment during the study's recruitment phase were then contacted by the study's Primary Investigator (RAM) and were invited to participate in the parenting group (CBT+PG). Families of children meeting inclusionary criteria that initiated treatment immediately following the recruitment phase received individual child CBT only (CBT) and served as a non-randomly assigned active control group. This

design was necessary to accommodate issues around group scheduling and client flow at the YAD-C.

Parents in the CBT+PG condition attended five 1.5 hour weekly parent group sessions, commencing during the first 8 weeks of the child's treatment (prior to the onset of the exposure portion of the therapy). All group sessions took place at the YAD-C. In addition to self-report measures completed at intake, participants completed interim assessment packets at the conclusion of the group (post-group assessment). At termination, child diagnostic status was reassessed using the ADIS-C/P and families completed a final series of self-report measures (post-treatment assessment). Parents in the CBT+PG condition also completed feedback forms at the end of each group session and a satisfaction survey at the conclusion of the group portion of treatment.

Individual cognitive behavioral therapy. Therapists used either the Coping Cat (Kendall & Hedtke, 2006b), a 16-session, manualized CBT program for anxious youth that has been well-studied and empirically-validated (Kendall, 1994; Kendall et al., 1997), or the Cat Project (Kendall, Choudhury, Hudson, & Webb, 2002), an upward extension of the Coping Cat designed for adolescents (age 12 and up). The first half of treatment focuses on helping youth develop coping skills for handling anxious situations through use of the FEAR acronym. Specific FEAR steps help children recognize physiological responses to anxiety, identify anxious thoughts, develop a coping plan using skills including relaxation, cognitive restructuring, and problem solving, evaluate their performance, and reward their efforts. The second half of treatment focuses on practicing these skills through imaginal and in vivo exposure to feared situations.

Homework is assigned throughout treatment to facilitate the practice and generalization of skills and youth can earn rewards for the completion of their homework and their active participation in session. Sessions 4 and 9 are parent sessions which provide an opportunity for the child's individual therapist to inform parents about treatment goals and progress, provide psychoeducation, collect additional information, and answer questions.

Parent treatment group (CBT+PG). Parents participated in What to Do When You've Tried it All (Merson & Chu, 2011), an adjunctive, five session treatment program, designed to help parents become better able to proactively respond to their child's anxious behavior (see Figure 2 for a summary of session content). Treatment specifically targeted parenting behaviors associated with increased child avoidance. To assist parents in recognizing their use of these behaviors a "Parent Traps" mnemonic was introduced (see Figure 3). Parents also were taught mindfulness skills to manage their own distress in relation to parenting an anxious child as well as strategies to increase child approach behaviors including fostering child independence and autonomy, contingency management, and modeling brave behavior. Parents were encouraged to support one another and build a peer network among group participants.

Treatment Integrity and Adherence

Treatment fidelity checklists detailed the targeted tasks for each session and concordance between targeted tasks and therapist behaviors. At the end of each session, group leaders jointly completed a treatment fidelity checklist, rating the extent to which they completed each of the session's objectives. Ratings were made using a 0-4

point scale, where 0=did not address this topic at all, 1=addressed this topic minimally, 2=addressed this topic in some detail, but not to the extent outlined in the manual, 3=addressed this topic as outlined in manual, and 4=addressed this topic in more depth than outlined in manual. Explanations for why any objective not completed as outlined were documented. Eighty-eight percent of tasks received ratings of 2, 3, or 4, with 12% receiving ratings of 2, 61% receiving ratings of 3, and 15% receiving ratings of 4. Only one item received a 0 rating, the optional module on giving effective praise, which was not administered due to time constraints. Three additional topics were “addressed minimally” also due to time constraints. Parents spent more time than anticipated asking questions and sharing their experiences completing homework assignments and trying to implement skills at home. Group leaders felt it important to respond to these questions to facilitate the mastery and continued use of already introduced skills.

Treatment Feasibility and Acceptability

Primary goals of this study included demonstrating the feasibility and acceptability of augmenting child-focused CBT for anxiety disorders with a parent treatment component as described here within. Feasibility of implementing the parent group was determined by success in recruitment, enrollment, and retention of parents in the CBT+PG condition. Participants were classified as dropouts if they missed more than three treatment sessions or requested termination. Treatment acceptability to parents was established by satisfaction ratings from the PSxS and the PGSS, including perceived benefits from treatment, likelihood to recommend the program to others, and overall satisfaction.

Feedback from known experts in the field of youth anxiety also provided information about the feasibility (time, format) and acceptability (content, format) of the therapists' manual and parent workbook from the perspective of objective reviewers. Acceptability scales (Expert Feedback Form) allowed for open-ended comments and dimensional ratings the manual and workbook. Impressions regarding the usability, content, and format of the treatment program also were collected from group leaders via the Group Leader Feedback Form. Though not a formal measure of acceptability, this information provided an additional perspective about refining future iterations of the program.

Plan of Analysis

Given this pilot study's small sample size, it is inappropriate to compute power calculations or obtain effect size estimates. However, a reliable change index (RCI) was calculated for each participant to provide initial data on individual pre-post treatment change. RCI was calculated according to Jacobson and Truax (1991): $RCI = \frac{X_1 - X_2}{S_{diff}}$, where x_1 = pre-treatment score, x_2 = post-treatment score, and $S_{diff} = \sqrt{2(SE)^2}$, the standard error of difference between the two scores. $SE = s_1\sqrt{1 - r_{xx}}$, where s_1 = the standard deviation of the normal population and r_{xx} = the test-retest reliability of the measure. An RCI greater than or equal to 1.96 represents statistically significant change when $\alpha=.05$. The RCI for each participant provides a preliminary indication of the clinical efficacy of the parenting program. The percentage of successful cases is compared across CBT+PG and CBT only conditions.

Results

Feasibility and Acceptability

Recruitment, attendance, and attrition. The parenting group was held over 5 weekly 90 minute sessions, as planned. Six of nine families expressed interest in the group. Three declined participation due to concerns about fit of group to their needs (Figure 4). Notably, the three families who refused the group invitation also dropped out of individual therapy prematurely. Of the six families interested in the group, scheduling limitations prevented three from participating.

Of the three families (six parents) who started the program, participant retention was 100% and attendance was excellent; at least one parent from each family attended 100% of sessions. Child 1's mother and father both attended 100% of sessions, Child 2's mother attended 100% of sessions and his father attended 80%, and Child 3's mother attended 100% of sessions and his father attended 40% (absences were expected due to unpredictable work circumstances).

Participant satisfaction. Assessing parent satisfaction was a primary study aim. PSxS ratings completed after each session indicated parents found group content and activities helpful ($M=3.95$, $SD=.51$, possible range=1-5). Mean ratings ranged from 2.8 to 4.67 for each group component (see Table 2). All components were rated as "somewhat helpful" or higher, except for the third mindfulness practice exercise, whose score of 2.8 fell just below the "somewhat helpful" designation. Participants rated specific behaviorally-oriented techniques such as active ignoring, encouraging independence, and modeling using the FEAR plan most highly ($M=4.22$, $SD=.26$). Psychoeducational

activities received mixed ratings ($M=4.04$, $SD=.46$). Although participants still viewed them as helpful overall, mindfulness components received the lowest helpfulness scores ($M=3.34$, $SD=.46$).

Parent satisfaction also was assessed through the PGSS, an end of group questionnaire. Parents were highly satisfied with the group ($M=29.2$, $SD=.24$, possible range=9-36). They reported they would refer the program to a friend, would come back to the program if they were to seek help again, and that they believed the skills learned would help them more effectively respond to their anxious children (see Table 3). Participants indicated that meeting other parents helped them feel less isolated and alone in their experiences, but wished the group had provided more opportunities for open-ended discussion and support between participants. Detailed qualitative PGSS feedback is provided in Appendix A.

Expert feedback. Six experts in child anxiety and parent interventions were invited to review the group manual and workbook; four accepted. Reviewers were provided with a copy of the materials and asked to rate each session based on the quality of content and feasibility of implementation. Experts rated the program favorably ($M=6.4$, $SD=.26$, possible range=1-7). Mean ratings for individual sessions ranged from 6.12-6.62, and mean ratings for each area of evaluation (i.e., feasibility to implement, understandability of content, etc.) ranged from 6.05-6.65 (see Table 4). Reviewers also provided qualitative feedback through which several themes emerged. The inclusion of parental modeling was well-received and was identified as an important concept not explicitly addressed by many other parenting programs. However, several

reviewers felt session four contained too much content (tangible rewards, active ignoring, and effective praise). It was recommended to split this session and focus more on creating well-developed behavior rewards plans. The inclusion of mindfulness was viewed favorably, but questions were raised about the ability of the therapist with average CBT training to effectively implement these skills. Qualitative feedback from expert reviewers can be found in its entirety in Appendix B.

Group leader feedback. Data regarding the content and structure of the group also were collected from the group leaders – therapists who would be potential end-users of the program. Because the group was run by the study’s PI with a second therapist, this data cannot be interpreted as a formal assessment of acceptability and feasibility, but it does provides important and relevant feedback about the administration of the program as well as suggestions for program refinement. Using the Group Leader Feedback Form, group leaders reported that the manual was easily understood, contained an adequate amount of information, and addressed the “right” elements (see Table 5). Importantly, group leaders felt the manual provided adequate flexibility to meet program goals and individual participant needs. However, sessions three and four felt rushed. Group leaders also recommended adding the following elements: an expanded explanation of mindfulness, more specific instructions about when to use “empathize and encourage,” and a discussion of disincentives for anxious oppositionality. Additional feedback from group leaders can be found in Appendix C.

Case Examples and Individual Results

CBT+PG participants.

Child 1. The first youth was a 14-year-old, African-American female who lived with both her parents. Both parents graduated from 4 year colleges and earned a family income of \$80,000-\$100,000. Child 1's mother was referred to the YAD-C by her pediatrician. Initial concerns included excessive reassurance seeking, perfectionism, fear of germs, and worry about negative peer evaluation. At intake, Child 1 received diagnoses of GAD (CSR=6), OCD (CSR=5), and SOP (CSR=4) as well as subclinical diagnoses of minor depressive disorder (CSR=3) and specific phobia (CSR=2). Overall functioning was in the "markedly ill" range (CGI-S=5). She had no history of prior therapy or psychiatric medication use.

Parent functioning measures indicated maternal DASS scores in the normal range, but paternal Depression and Stress subscales were mildly elevated. Mother and father PAAQ Inaction and Total scores were elevated (more than one standard deviation above the mean)ⁱ, suggesting they were experiencing greater experiential avoidance than most parents of anxious children, particularly with respect to their ability to engage in proactive parenting while experiencing unwanted internal events. RBQ measures of parenting behavior indicated high mother and father rejection (more than one standard deviation above the mean) and low father autonomy granting (more than one standard deviation below the mean)ⁱⁱ.

Child 1's treatment goals focused on building comfort socializing with peers, decreasing compulsive behaviors (i.e., use of hand sanitizer, repetitive dish washing,

reassurance seeking), and reducing worry about making mistakes. In response to Child 1's anxiety, her mother regularly fell into Parent Traps A and B – “agreeing with your child's anxious assessment of a situation; modeling and reinforcing anxiety” and “butting in; over-involvement, overprotection, and intrusiveness.” At school, Child 1's anxiety was often highest in the cafeteria, so her mother took her out to lunch several days a week. On other days, she encouraged her daughter to go to the library during lunch. This behavior reinforced the child's anxiety and limited opportunities for age appropriate independence (i.e., eating lunch with peers). Child 1's father most frequently fell into Parent Trap C – “criticizing or coldness.” He had difficulty tolerating his daughter's reassurance seeking and was quick to show his frustration, leading to many father-daughter fights. These fights allowed for a temporary change of focus from the anxiety provoking stimuli, contributing to the cycle of avoidance and arousal while also straining the parent-child relationship. Through participation in the CBT+PG group, Child 1's mother was able to more fully understand her role in the bidirectional anxious-avoidance cycle, and felt a tremendous sense of relief, both to learn that other parents were struggling with similar issues and that her daughters problems were not “her fault.” She found encouraging independence and tangible rewards to be particularly useful interventions. Child 1's father reported that although difficult at first, active ignoring and mindfulness helped him cope with his own anger and frustration triggered by his daughter's compulsive behaviors.

At post-treatment, Child 1 no longer met criteria for any diagnoses. Based on child report, she demonstrated statistically reliable changeⁱⁱⁱ in anxiety symptoms (see

Table 6). Mother DASS Depression scores showed a statistically reliable^{iv} increase from pre-treatment to post-group followed by a statistically reliable decrease (back to pre-treatment, normative levels) at post-treatment. Post-group, all father DASS scores were within normal limits, although these changes were not statistically reliable (see Table 7). Mother and father PAAQ scores showed reductions to the average level post-group; however post-treatment, mother scores returned to pre-treatment levels (see Table 8). Post-group measures of parenting behavior showed no changes in mother or father rejection (remained elevated). Mother autonomy granting dropped as did father over control. At post-treatment, mother autonomy granting and rejection were average, though over control was high (see Table 9). Paternal post-treatment data was lost to follow-up.

Child 2. The second youth was a 13-year-old, Caucasian male who lived with his parents. Mother and father both graduated from 4 year colleges, held professional jobs, and earned a combined income of over \$150,000 a year. The family was referred to the YAD-C by the child's guidance counselor. At intake, he had missed approximately 25 days of school over the previous 4 months due to anxiety, primarily regarding negative social evaluation. This fear had intensified so much that the child rarely left the house. Child 2 was diagnosed with SOP (CSR=7) and School Refusal (CSR=6), with overall functioning in the "severely ill" range (CGI-S=6). Prior to attending the YAD-C, he had received outpatient therapy and psychiatric intervention; at intake, he was taking 50 mg of Zoloft daily.

DASS scores indicated mildly elevated mother Stress and moderately elevated father Stress. Mother PAAQ Unwillingness and Total scores were elevated, but father scores were average as compared to the parents of other anxiety disordered youth. On the RBQ, all mother scores were in the average range. Father rejection and autonomy granting scores were elevated.

Treatment goals for Child 2 included helping him feel less anxious attending school, interacting with peers, and spending time outside of the house. When Child 2's school refusal first emerged, his mother often fell into Parent Trap A. She frequently allowed him to stay home from school or picked him up early, reinforcing school-related anxiety. As his school refusal became more entrenched, any attempt to get him to attend school resulted in an escalation of anxiety and oppositionality. Paternal reactions fell into Parent Trap C, leading to anger and hostility in the father-son relationship. Child 2's parents reported finding the "empathize and encourage" activities and role plays particularly helpful, because they provided the family a script to use in challenging situations at home. While Child 2's mother reported she struggled with mindfulness, Child 2's father indicated it helped him "take a step back" before interacting with his son.

At termination, Child 2 no longer met criteria for SOP, but retained his School Refusal diagnosis (CSR=4). Based upon parent report, he demonstrated significantly reliable change in anxiety symptoms (see Table 6). At intake, Child 2 was quite resistant to treatment and completed his entire intake packet by circling all "0s" or "1s" down almost every page. He admitted to his individual therapist that he had not completed

the forms accurately, but refused to re-do them. Thus, his pre-treatment STAIC and MASC scores are not reported. His post-treatment scores are believed to be accurate assessments of his functioning, but change in symptoms could not be calculated. Post-group, mother DASS Stress scores remained mildly elevated and Depression scores showed a significantly reliable increase to the mildly elevated range, but at post-treatment, scores showed a significantly reliable decrease. Father reports of Stress also demonstrated a significantly reliable decrease. All father DASS scales were in the normal range (see Table 7). Mother and father post-group PAAQ scores were average, but at post-treatment, mother PAAQ Inaction and Total scores increased to more than one standard deviation above the mean (see Table 8). On the RBQ, father rejection remained elevated. Mother scores showed an increase in autonomy granting (see Table 9). Father data for Child 2 was lost to follow-up at post-treatment.

Child 3. Child 3 was a 7-year-old Caucasian male. He lived with his parents, twin brother, and younger sister. Both parents completed post-graduate education and earned a combined family income of over \$150,000 a year. Child 3's parents contacted the YAD-C after participating in a selective mutism webinar delivered by the Program Director. They reported the child would not speak above a whisper in public and relied heavily upon non-verbal communication. He experienced anxiety in social situations, particularly those that involved an evaluative component (i.e., athletic activities) or the unknown (i.e., going to unfamiliar places, meeting new people). During the intake interview, he answered questions using a white board and markers, but did not speak verbally. Child 3 was diagnosed with selective mutism (CSR=7), SOP (CSR=6), SAD

(CSR=4), and specific phobias of bees, darkness, blood, and vomiting (CSR=4). His overall functioning was in the “severely ill” range (CGI-S=6). He had an IEP which included a behavior plan to reinforce speech in the classroom, and received speech, occupational therapy, and psychiatric services (3 mg Zoloft, daily).

At intake, mother DASS Stress scores were mildly elevated. Father DASS scores were in the normal range. Mother and father PAAQ Unwillingness scores were elevated, but Total PAAQ scores were average. On the RBQ, mother and father rejection was more than one standard deviation below the mean and mother autonomy granting was elevated.

Primary treatment goals for Child 3 included increasing his comfort speaking in front of people he did not know well and decreasing his anxiety interacting with peers. Child 3’s parents frequently used Parent Trap B behaviors. Embarrassed by the child’s refusal to speak in public and pained to witness his discomfort, they were quick to speak for him, often not even giving him an opportunity to speak for himself. While eliminating Child 3’s anxiety in the short-term, taking over this task ultimately limited the child’s autonomy and perpetuated his fear of speaking in the long-run. Child 3’s mother indicated that sharing with other parents was a highlight of the group. She also found the discussion of modeling particularly helpful as it allowed her to use the same language at home that her child was using in individual therapy.

Post-group and post-treatment data was only available from Child 3’s mother (see Tables 7, 8, and 9). Across time points, low RBQ rejection was coupled with high autonomy granting. Over control was more than one standard deviation below the

mean, suggesting little use of this parenting behavior. DASS and PAAQ scores generally remained low, but at post-treatment there was a statistically reliable increase in the DASS Stress scale. However, this assessment coincided with the child's hospitalization for kidney failure. Due to this hospitalization, a post-treatment diagnostic interview was not conducted, although mother and child completed post-treatment questionnaires. Based on these measures, Child 3 demonstrated statistically reliable change in anxiety symptoms according to parent and child report (see Table 6).

Treatment as usual control cases.

Child 4. Child 4 was a 12-year-old Caucasian male. His parents separated shortly after the commencement of treatment, but retained joint custody. His mother completed post-graduate education while his father attended college, but did not graduate. Combined, the family income was \$100,000-\$150,000. At intake, Child 4 was diagnosed with GAD (CSR=6), specific phobia of blood (CSR=5), MDD (CSR=4) and subclinical attention deficit problems (CSR=3). Overall functioning was in the "markedly ill" range (CGI-S=5). Intake data was only collected from Child 4's father, who did not endorse any psychopathology on the DASS, but reported elevated PAAQ Unwillingness scores and high rejection on the RBQ. At post-treatment assessment, Child 4 retained his diagnoses of SP (CSR=4) and ADHD (CSR=4), but no longer met criteria for GAD or MDD. By child report, he showed statistically reliable reductions in anxiety symptoms (see Table 6). No changes in paternal DASS or PAAQ scores were noted (see Tables 7 and 8), but RBQ rejection was in the normal range and RBQ autonomy-granting increased to more than one standard deviation above the mean (see Table 9).

Child 5. Child 5 was a 12 year-old Caucasian female who lived with both parents and two younger siblings. Her mother completed college and her father obtained post-graduate education. The combined family income was over \$150,000 a year. Child 5 received pre-treatment diagnoses of GAD (CSR=6), SAD (CSR=4), and subclinical specific phobia (CSR=3); overall functioning was in the “markedly ill” range (CGI-S=5). Intake data was only available from Child 5’s mother. Her DASS scores were in the normal range, but her PAAQ Unwillingness score was elevated. RBQ rejection was high, but other RBQ scales were average. Post-treatment, Child 5 no longer met criteria for her diagnoses at intake, but was experiencing symptoms severe enough to warrant a new diagnosis of Minor Depressive Disorder (CSR=4). By child report, anxiety symptom measures showed a statistically reliable worsening of symptoms. Mother reported anxiety symptoms showed no changes (see Table 6). Maternal DASS Stress levels demonstrated a statistically reliable increase in stress (see Table 7). Elevations were present in PAAQ Inaction and Total scores (see Table 8), but RBQ scores were average (see Table 9).

Child 6. Child 6 was a 12-year-old Caucasian male who lived with both parents. His mother completed post-graduate education and his father had a college degree. Combined family income was between \$100,000-\$150,000. At intake, Child 6 was diagnosed with GAD (CSR=4) and subclinical SOP (CSR=2); overall functioning was in the “moderately ill” range (CGI-S=4). Pre-treatment DASS scores were average, but PAAQ Unwillingness and Total scores were elevated. On the RBQ, rejection was high and over-control was low. At post-treatment, Child 6 no longer met criteria for any diagnoses and

demonstrated statistically reliable change in anxiety symptoms by parent and child report (see Table 6). All DASS and PAAQ scores were within normal limits (see Tables 7 and 8). RBQ over-control scores continued to be low and a reduction in rejection was demonstrated so that scores were more than one standard deviation below the mean (see Table 9).

Parenting variables outcome trends. Among CBT+PG participants, parent psychological symptoms, represented by mean DASS Total scores, showed no change from pre- to post-treatment ($M=18$, $M=18$). However, a visual inspection of scores shows a post-group increase ($M=26.67$), indicating more intense symptoms were reported at this time point. Mid-treatment DASS data is unavailable for control families, but pre- and post-treatment scores showed minimal group level changes ($M=14$, $M=10.67$) (see Figure 5). From pre-treatment to post-group, a visual inspection of CBT+PG mean PAAQ Total scores shows a drop, ($M=59.67$, $M=51.6$), suggesting decreases in experiential avoidance; however, from post-group to post-treatment, scores showed a 13 point increase ($M=64$). Among control families, pre- and post-treatment PAAQ scores showed minimal group level changes ($M=61$, $M=57$) (see Figure 6). Across both groups, a visual inspection of RBQ scores shows a downward trend over time (CBT+PG: $M=5.29$, $M=5.01$, $M=4.59$; CBT only: $M=5.57$, $M=4.85$) (see Figure 7), which indicates the greater use of positive parenting behaviors at post-treatment.

Discussion

Researchers have long considered the benefits of including parents in treatment for youth anxiety, yet the results of published clinical trials have proven equivocal

(Barmish & Kendall, 2005; Kendall et al., 2008; Wood et al., 2006). The current study presents a promising adjunctive group treatment for the parents of anxious youth receiving individual cognitive behavioral therapy. Unlike the majority of previous parent treatment programs, it explicitly targets specific parenting behaviors which the literature has identified as mechanisms involved in the maintenance of child anxiety (Fisak & Grills-Taquechel, 2007; Ginsburg & Schlossberg, 2002; Wood et al., 2003). Through this five session group program, parents were taught strategies for encouraging age-appropriate child autonomy and independence, reinforcing brave behavior, and modeling effective coping strategies. Recently, parental experiential avoidance has been introduced into the child anxiety literature (Tiwari et al., 2008), and data support a relationship between high parental experiential avoidance and child anxiety symptoms (Cheron et al., 2009). As a means of reducing experiential avoidance and helping parents better manage their personal emotional responses triggered by their anxious children, parents were trained in basic mindfulness skills, which were practiced every session.

This novel program, *What to Do When You've Tried it All*, appeared feasible and acceptable to this small group of families. Based on only a brief description of the program, 67% (6/9) of invited parents were interested in participation, with 50% of those interested electing to participate. One hundred percent of participants completed treatment and attendance was excellent. Previous clinical trials report non-completion rates ranging from 5% to 27% (Barrett, 1998; Silverman, et al., 1999; Shortt et al., 2001; Wood et al., 2006). Notably, all the families who initially refused the group invitation also dropped out of individual therapy prematurely. This attrition suggests these

families may have experienced a lack of commitment to therapy in general or a mismatch between families' goals and the overall treatment model of the YAD-C, rather than a specific disinterest in or negative evaluation of the parent group. Reasons for non-participation among interested families were largely logistical. Two families indicated they could only attend the group if it were held on a specific day or if it coincided with their child's individual therapy sessions. A third family initially agreed to participate, but withdrew several days before the start of the study, informing the PI that their schedule was too full and they could not make any additional commitments. Among the six families interested in the group, there were trends for greater initial anxiety symptom severity in the children of participants (pre-treatment CGI-S scores of 5, 6, and 6 for participants versus 4, 4, and 5 for non-participants). Thus, parents who perceived their children to be experiencing more distress may have been more likely to view group participation as important and accordingly, may have been more willing to make accommodations to attend.

Parent satisfaction with the program was generally good. While norms are not available for the PGSS, mean satisfaction was 29.2, above the midpoint of the potential total range (9-36). This rating is comparable to treatment satisfaction ratings from other parent group programs (Shortt et al., 2001). Parents also reported finding specific group components helpful. Among these ratings, an interesting pattern emerged. Participants rated behaviorally-oriented techniques (i.e., active ignoring, encouraging independence, and modeling using the FEAR plan) most highly. These strategies may have best fit with the participants' conceptualizations of their children's problems. Additionally, these

components tended to be the most active, fostering increased engagement and group discussion. Notably, there is overlap between these skills and the skills included in other successful combined parent-child treatments (Wood et al., 2006). Parents had mixed responses to psychoeducational content. Some participants commented that this material was repetitive and they had heard it already from their child's individual therapist, which highlights the need for communication among therapists when running an adjunctive treatment. In general, parents appreciated new psychoeducational content and reported particular interest in the results of several research studies presented in the manual. Though ratings were largely in the helpful range, mindfulness training received the lowest helpfulness ratings, relative to other components. This reaction may suggest that parents felt uneasy focusing on their own emotional experiences or discomfort with the relatively abstract nature of mindfulness as a skill. Practicing mindfulness also may have seemed less directly connected to their child's anxiety.

Program acceptability and feasibility also were evaluated by experts in the field of child anxiety. Again, normative data is not available for this rating scale, but reviewers perceived the program positively. Quantitative and qualitative feedback suggests the program contained the "right" elements, which is important given suggestions that some other parent programs may have targeted the wrong mechanisms (i.e., parent anxiety management, family communication, problem solving) leading to null findings (Bodden et al., 2008; Cobham et al., 1998; Nauta et al., 2003). The manual and workbook were described as user-friendly and easily understood, important

consideration for future program development and dissemination. In general, reviewers believed that a therapist with average CBT training would be able to appropriately apply the skills and techniques of the program. Some reviewers noted the mindfulness activities might be difficult for therapists unskilled in these techniques to implement. Yet, despite these cautions, the inclusion of mindfulness was viewed favorably overall. Mindfulness-based parenting interventions are becoming increasingly common and empirical support for these treatments is growing (Duncan, Coatsworth, & Greenberg, 2009; Harnett & Dawe, 2012).

After administering the program, group leaders also provided feedback about the usability of the manual and workbook and made suggestions for future revisions. Like the expert reviewers, group leaders felt the program content reflected the “right elements” and that the strategies presented matched group goals and the overall orientation of the program. Reviews also indicated the treatment protocol allowed for appropriate flexibility, even when faced with the diverse needs of parents whose children had three distinct diagnostic profiles (GAD/OCD/SOP, school refusal/SOP, and selective mutism/SOP/SAD). Proponents of manual-based therapies encourage “flexibility within fidelity” (Kendall & Beidas, 2007; Kendall, Chu, Gifford, Hayes, & Nauta, 1998), which emphasizes the ability of a treatment to be delivered in a way that meets the individualized needs of each client to maximize treatment outcomes. This early report suggests the manual was capable of such flexibility.

From a feasibility and acceptability standpoint, program developers also were interested in finding the right treatment dose. Previously studied parent programs

ranged in length from 4 to 24 hours of parent contact, with a median length of 10 hours (see Table 1). Despite conventional wisdom that more time equates to better treatment, no clear association between treatment length and outcomes emerges. Understanding the multiple demands for parents' time and attention as well as the logistical challenges presented with scheduling, childcare, and transportation, effort was taken to create a program that both effectively and efficiently delivered content. In general, parents thought five 90 minute sessions (7.5 hours total) was an appropriate program length; their comments included "I felt the length of the program was adequate, maybe add one more," "about right," and "definitely enough sessions." However, both expert reviewers and group leaders noted that some sessions seemed rushed and recommended including at least one additional session. Parents may have felt more comfortable with a shorter program because at the time the group ended, their children were only halfway through individual therapy. Therefore, if any questions or problems arose, parents were still connected with a source of professional support.

Results are too preliminary to make inferences about the program's overall efficacy, but early data are promising. None of the children in the CBT+PG group deteriorated, as compared to one child in the CBT only group whose symptoms worsened. Across both groups, all children experienced diagnostic relief of their primary diagnosis, but children in the CBT only group retained more clinical and subclinical diagnoses post-treatment than did children in the CBT+PG group. Based upon reports by either child or parent, 100% of children in the CBT+PG group and 67% of children in the CBT only group showed significantly reliable change in anxiety symptom levels.

Given the potential influence of parent variables as treatment mediators and moderators, we were eager to assess changes in parent functioning. Despite research that shows anxiety disorders aggregate in families (Beidel & Turner, 1997; Last, Hersen, Kazdin, Orvaschel, & Perrin, 1991; Turner, Beidel, & Epstein, 1991) very few parent anxiety symptoms were reported in this sample. In fact, at no assessment point were any DASS Anxiety scores even mildly elevated. Instead, most parent emotional distress was experienced in the form of stress. While the Anxiety scale emphasizes the acute fear response (i.e., I experienced breathing difficulty, I experienced trembling, I felt close to panic), the Stress scale measures persistent arousal and ongoing tension (i.e., I found it hard to wind down, I tended to over-react to situations, I found it difficult to relax) which may have a greater impact on day to day functioning and parenting. Among the participants for whom DASS data from all time points is available (pre-treatment, post-group, and post-treatment), an interesting pattern emerged: Total scores increased upon the conclusion of the group, but returned to pre-treatment levels by the termination of therapy. The group ending roughly coincided with the transition to the exposure stage of child treatment. The increase in DASS scores may have been a result of parents questioning their ability to implement newly learned parenting strategies independently, particularly as their children were beginning a more challenging phase of treatment. The timing of the current iteration of this group was intentionally planned to co-occur with the first phase of child treatment, so parents would have acquired new skills in preparation for exposure. However, it may be that the group should span the

two phases of treatment or that booster sessions should be scheduled during the latter half to provide parents with additional support as child treatment demands intensify.

Pre- and post-treatment DASS scores also showed minimal group level differences among control families. Across conditions, treatment produced few changes in parent psychopathology symptoms. Few previous studies have assessed changes in parent psychopathology as an outcome of participation in child/family treatment, but Kendall et al. (2008) found among parents with a diagnosed anxiety disorder, 38% were diagnosis-free at post-treatment. The minimal changes in DASS scores observed in this sample may have been because pre-treatment parent symptoms were mostly in the non-clinical or mildly elevated ranges (Lovibond & Lovibond, 1995).

The conceptual rationale upon which this program was developed is that specific parenting behaviors contribute to the child anxiety-avoidance cycle. As suggested by the literature, these behaviors fall into three categories: over-control and restricting autonomy, rejection, and modeling and reinforcing anxious behavior (Bogels & van Melick, 2004; McLeod et al., 2007; Wood et al., 2003). Group interventions were explicitly designed to address these mechanisms, and this study is unique in that it provides one of the few assessments of change in parenting behaviors as a result of this type of intervention. Previous studies of parent involvement in child CBT for anxiety have measured aspects of family relationships including perceptions of family functioning and parental conflict (Howard & Kendall, 1996; Manassis et al., 2002), but only one study looked at parenting behaviors (Bogels & Siqueland, 2006). In this sample, post-treatment reductions in over-protection, psychological control, and rejection were

reported. Stemming from this study, Verhoeven et al. (in press) created the Rearing Behaviors Questionnaire (RBQ), which was used in the present study. Psychometric data is limited, but the RBQ provided the best means of measuring specific behaviors of interest, with scales assessing rejection, autonomy granting, and over control. A visual inspection of RBQ scores shows a downward trend, signifying increased use of positive parenting behaviors across time. Though the direction of this trend is encouraging, the small sample size limits statistical inferences, and given the nascent state of the measure, results should be interpreted cautiously. Similar patterns were observed for both the CBT+PG and CBT only groups. At this time, it remains unclear whether participation in this parent program led to any changes in self-reported parenting behavior above and beyond that experienced by parents in the control group.

Parental experiential avoidance reflects a parent's unwillingness to witness their child experience negative emotion as well as their inability to effectively manage their own reactions to their child's affect (Tiwari et al., 2008). It has been associated with high levels of controlling parenting behaviors, automaticity, and inflexibility (Cheron et al., 2009; Duncan et al., 2009). The present investigation is based on a conceptual model that identifies parental experiential avoidance as a barrier to effectively parenting anxious children. Treatment sought to lower experiential avoidance through the practice of mindfulness, defined as "the awareness that emerges through paying attention on purpose, in the present moment, and non-judgmentally to the unfolding of experience moment by moment" (Kabat-Zinn, 1994, p. 4). It was believed that mindful parenting would facilitate the participants' ability to implement new parenting

strategies, particularly those that increased child exposure to feared situations. The Parental Acceptance and Action Questionnaire (PAAQ; Cheron et al., 2009) was used to assess changes in experiential avoidance. Interpretations that can be drawn from the PAAQ are limited due to minimal available psychometric data, including a lack of non-clinical norms. However, norms based on a comparable population (parents of children with anxiety disorders), allow for some comparisons. In general, parents in this sample, across both groups, reported high levels of experiential avoidance (more than one standard deviation above published clinical means). For most parents, pre- and post-group PAAQ Total scores remained relatively constant, which initially suggests few changes in experiential avoidance. However, an interesting pattern emerged among mothers in the CBT+PG condition who completed assessments across three time points. A visual inspection of the data shows a drop in mean scores from pre-treatment to post-group, followed by an increase in scores from post-group to post-treatment. A possible explanation for this trend is that upon the completion of group parents did not continue to regularly use mindfulness skills. At post-group, parents had been practicing mindfulness weekly during group sessions and were encouraged by group leaders to complete additional practice at home. However, it is possible that at post-treatment, several months after the end of group, mindfulness practice did not continue. If this explanation is accurate, it may speak to the importance of booster sessions subsequent to group ending, particularly since mindfulness is a less intuitive skill, with which parents may have been less comfortable practicing independently.

The inclusion of mindfulness warrants further discussion and raises several questions. Could we have presented the rationale for mindfulness differently to increase parent buy-in? Could the skills themselves have been presented differently to enhance their accessibility to parents? Making the link between mindfulness and parenting more explicit seems important. A simple initial step may be “re-branding.” By presenting mindfulness activities as “mindful parenting,” the message is conveyed that mindfulness is an approach to parenting rather than a separate skill that can be helpful in parenting. It also may have been beneficial to spend additional time encouraging parents to talk about their emotional reactions to the anxiety of their children. By further increasing comfort with these emotions and becoming more cognizant of their impact, parents may have been more willing to accept mindfulness as a strategy for helping their child. However, to increase the potency of this discussion, it may be better placed later in the program. During the second session, parents still may have been “feeling out” the group setting and less open to addressing more personal content. A third possibility for increasing buy-in may be sharing research data supporting the connection between parental experiential avoidance, child anxiety, and mindfulness. Understanding that there is a documented link between these constructs may have provided increased motivation for out of session mindfulness practice, even in the face of uncertainty or discomfort. The group of parents who participated in the current trial reacted positively to research findings related to parenting and anxiety; however, it is possible that future participants with more diverse sociodemographic and educational backgrounds may not relate as strongly to this academic rationale.

It also is possible that our six in-session mindfulness exercises were insufficiently powerful to activate a more meaningful shift in parenting experience and behavior. Thus, the group may have benefitted from additional mindfulness practice. However, it is unclear whether a brief intervention with myriad goals could provide sufficient formal mindfulness practice and whether such a focus even would be acceptable to parents. What might be more effective is to think about how to translate mindfulness practice into the use of mindfulness “in the moment.” Given the short nature of this program, one suggestion is to provide a cognitive link to mediate the mindfulness process. Participants may have benefited from exploring their myths about emotions as related to parenting and using a challenge to these myths as a “catchphrase” to reorient themselves to a mindful stance at challenging parenting moments. Similarly to empathize and encourage and active ignoring, mindfulness, particularly with the use of a cognitive component, could have been practiced more actively in session through role plays and demonstrations. For example, the group leaders, acting as parent and child, could have played out a scenario in which the parent used mindfulness, verbalizing their internal state to illustrate the process. It also may have been helpful to encourage parents to identify more specific trigger situations in which mindfulness could be used, to prepare them for approaching these situations in their daily lives.

There are a number of limitations to the current study. Most notable is the small sample size, which limited the ability to draw statistically driven conclusions regarding treatment efficacy and effect size. While the inclusion of a treatment-as-usual control group provided a broader framework for understanding outcomes and visually assessing

changes in scores, no group level data analyses were able to be conducted. Although this study was successful in recruiting fathers as well as mothers, post-treatment father data was lost to follow-up, which also limits the ability to draw conclusions about treatment efficacy. A potential threat to validity is the lack of random selection and assignment of participants; participants were given a choice regarding group participation and initial analysis suggests that families who opted to participate may have been experiencing greater distress with respect to both child and parent functioning. In essence, this was a quasi-experimental design, in which some pre-existing differences existed between groups. Validity threats also may have arisen from the use of instrumentation whose psychometric properties have not been well-documented. Parental experiential avoidance and mindfulness are concepts that are enjoying a widening spotlight in experimental and clinical literature, but tools for their measurement, especially with respect to the parenting role are limited. The PAAQ is a newly published measure, and while it has not been used with a non-clinical group, among measures of mindfulness/experiential avoidance it is unique in that it specifically captures experiential avoidance as it relates to parenting. Similarly, and surprisingly, research is scant with respect to measures capable of assessing the use of specific parenting behaviors. Ideally, an observational assessment would have been used to make these ratings, but such procedures are time consuming and costly. Moreover, while self-reports are subject to bias, so are observational assessment systems in which the participants know their actions are being watched and rated. However, despite the limitations of these experimental measures, the study's other outcomes measures

(ADIS-C/P, DASS, MASC, and STAIC) have been well-supported by the literature as reliable and valid tools for assessing child anxiety and parent psychological symptoms.

In conclusion, the provision of a structured group intervention for parents of anxious children was well-received and initial outcomes are promising. Hypotheses 1 and 2 were supported; the program was feasibly implemented as an adjunctive treatment in a clinical setting and participants reported high levels of satisfaction. Experts in the field who provided independent reviews of the program and group leaders found the treatment to be acceptable. Hypothesis 3 also was supported. In this small sample, all children in the CBT+PG group showed reductions in anxiety symptoms based upon child, parent, and/or independent evaluator report. Conversely, one child in the CBT only condition showed a worsening of symptoms. Hypothesis 4 was not supported. DASS scores showed minimal pre-treatment to post-treatment changes across both groups, and mothers in the CBT+PG group actually reported a spike in psychological symptoms mid-treatment. In the CBT+PG group, despite an initial decline, PAAQ scores rose at post-treatment assessment meaning parents were experiencing greater unwillingness and inaction. Hypothesis 5 was partially supported; trends across both groups indicated improvements in self-reported parenting behaviors; however the significance of these changes cannot be evaluated.

Overall, early results suggest that families of children experiencing significant anxiety may benefit from this group, What to Do When You've Tried it All. Future development will include revisions to the manual and workbook based on solicited feedback, focusing on 1) more clearly describing the rationale for mindfulness, how

parents can use mindfulness “in the moment,” and increased mindfulness practice; 2) adding an additional session to focus more on developing strong behavior reward plans and fully reviewing active ignoring and effective praise; and 3) creating additional opportunities for parents to connect and share their stories. Future studies must incorporate randomized designs, larger sample sizes, and more diversity among participants to further elucidate findings.

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Table 1
Family-Based Treatment Studies for Youth Anxiety Disorders

Study	N	Age	Primary Diagnoses	Treatment Format	Treatment Conditions	Hours of Parent Contact
Howard & Kendall (1996)	6	9-13	OAD SAD	Individual	Conjoint CBT	15
Barrett et al. (1996)	79	7-14	OAD SAD SOP	Individual	Child CBT Child CBT + Conjoint CBT Waitlist Control	8
Barrett et al. (1998)	60	7-14	OAD SAD SOP	Group	Child CBT Child CBT + Parent CBT Waitlist Control	24
Cobham et al. (1998)	67	7-14	GAD/OAD SAD SOP SP AG	Group	Child CBT (w/ Anx Parents) Child CBT (w/ Non-Anx Parents) Child CBT + Parent CBT (w/ Anx Parents) Child CBT + Parent CBT (w/ Non-Anx Parents)	4
Mendlowitz et al. (1999)	62	7-12	Anxiety Symptoms	Group	Child CBT Parent CBT Child CBT + Parent CBT Waitlist Control	12
Silverman et al. (1999)	56	6-16	GAD/OAD SOP	Group	Child CBT + Parent CBT + Conjoint CBT Waitlist Control	14
Shortt et al. (2001)	71	6-10	GAD SAD SOP	Group	Child CBT Child CBT + Parent CBT Waitlist Control	6
Spence et al. (2000)	50	7-14	SOP	Group	Child CBT Child CBT + Parent CBT Waitlist Control	6
Nauta et al. (2003)	79	7-18	GAD SAD SOP PD	Individual	Child CBT Child CBT + Parent CBT Waitlist Control	7
Bogels & Siqueland (2006)	17	8-17	GAD SAD SOP SP AD NOS	Individual	Conjoint CBT	12
Wood et al. (2006)	40	9-13	GAD SAD SOP	Individual	Child CBT Conjoint CBT	9-12
Kendall et al. (2008)	161	7-14	GAD SAD SOP	Individual	Child CBT Conjoint CBT Family Education, Support, and Attention	16
Bodden et al. (2008)	128	8-18	GAD SAD SOP SP PD	Individual	Child CBT Conjoint CBT	9

Note. GAD = Generalized Anxiety Disorder, OAD = Overanxious Disorder, SAD = Separation Anxiety Disorder, SOP = Social Phobia, SP = Specific Phobia, PD = Panic Disorder

Table 2
Mean Parent Satisfaction Ratings of Sessions and Treatment Components

Session	n	M (SD)
Session 1	4	3.92 (.51)
Session 2	5	4.08 (.25)
Session 3	6	3.87 (.61)
Session 4	5	3.6 (.71)
Session 5	6	4.17 (.43)
Component	n	M (SD)
Modeling using the FEAR Plan ^a	3	4.67 (.58)
Role of Parents in Child Anxiety Discussion ^b	6	4.5 (.55)
Encouraging Independence ^a	5	4.4 (.55)
Active Ignoring ^a	3	4.33 (.58)
Parental Emotional Responses to Child Anxiety Discussion ^b	5	4.25 (.5)
Common Patterns of Anxiety Take Home Review ^b	5	4.2 (1.3)
Tangible Rewards ^a	5	4.17 (.98)
Habituation Curve ^b	6	4 (.89)
Empathize and Encourage ^a	5	4 (1.22)
Tangible Rewards Take Home Review ^a	3	4 (1)
Empathize and Encourage Take Home Review and Discussion ^a	6	4 (1.1)
Introduction to Mindfulness ^c	5	3.8 (.84)
Mindfulness Practice 2 ^c	6	3.67 (.58)
Common Patterns of Child Anxiety Discussion ^b	4	3.25 (.96)
Mindfulness Take Home Review and Mindfulness Practice 1 ^c	5	3.2 (1.91)
Mindfulness Practice 3 ^c	3	2.8 (1.3)

^a Behaviorally-oriented parenting strategies

^b Psychoeducational components

^c Mindfulness activities

Table 3
Mean Parent Group Satisfaction Survey (PGSS) Ratings

PGSS Item	M (SD)
1. How would you rate the overall quality of the program?	3.2 (.45)
2. Did you learn the kinds of skills you expected to learn?	3.2 (.45)
3. How much has this program met your needs regarding parenting your anxious child?	2.8 (.45)
4. If a friend were in need of similar help, would you recommend this program to him/her?	3.4 (.55)
5. How satisfied are you with the amount of support received in the group?	3.4 (.55)
6. To what extent do you feel you were able to connect with other parents experiencing similar stressors?	2 (1)
7. Have the skills you learned in this program helped you to more effectively respond to your anxious child?	3.2 (.45)
8. In an overall, how satisfied are you with the help you have received?	3.4 (.55)
9. If you were to seek help again, would you come back to our program?	3.6 (.55)
Total	29.2 (.24)

Note: Ratings were made on a 4 point Likert-scale with high ratings reflecting a higher degree of satisfaction.

Table 4
Mean Expert Feedback Form Ratings

Session	M (SD)
Session 1 – Know Your Child	6.44 (.50)
Session 2 – Know Yourself	6.13 (3.11)
Session 3 – Empathize and Encourage	6.63 (1.0)
Session 4 – Reward the Good and Ignore the Bad	6.37 (1.91)
Session 5 – Be a Good Role Model	6.44 (1.50)
Area of Evaluation	M (SD)
Content: How easy was it to understand the content of the manual and workbook for this session?	6.65 (.49)
Content: Are the techniques and lessons described in this session the right techniques/lessons to meet the session objectives?	6.55 (.76)
Usability: Would the therapist with the average CBT training be able to appropriately apply these techniques?	6.05 (1.15)
Content: To what extent were important elements missing from this session?	6.35 (.93)

Note: Ratings were made on a 7 point Likert-scale with higher ratings reflecting more favorable impressions.

Table 5
Mean Therapist Feedback Form Ratings

Therapist Feedback Form Item – Group A	M (SD)
How easy was it to understand the content of the manual and workbook?	6.7 (.42)
How helpful do you think the strategies/activities were for this session?	6 (.94)
How well did today's session fit with the program overall?	6.9 (.32)
How useful was the workbook for today's session?	5.9 (1.4)
How capable did you feel in leading this group meeting?	5.9 (.57)
Did you feel the group was able to master the information presented in the session?	5.2 (.92)
Therapist Feedback Form Item – Group B	M (SD)
Were there any unnecessary elements included in this session?	1.4 (.70)
Were there important elements missing from this session?	2 (.97)
Did you feel rushed to accomplish all of the goals of today's session?	3.1 (1.91)
Therapist Feedback Form Item – Group C	M (SD)
How much information did the manual include for this group meeting?	4.6 (.70)
How much did the manual allow for flexibility in today's meeting?	4 (0)

Note: Items in Group A were rated on a 1-7 point Likert scale with higher ratings indicating more favorable responses. Items in Group B were rated on a 1-7 point Likert scale with lower ratings indicating more favorable responses. Items in Group C were rated on a 1-7 Likert scale with a 4 indicating the most favorable response (i.e., "the right amount").

Table 6
Diagnosis, Impairment, and Symptom Severity at Pre- and Post-Treatment

ID	Diagnoses	Pre-Tx CSR ^a	Post-Tx CSR ^a	Pre-Tx CGI-S	Post-Tx CGI-S	Pre-Treatment			Post-Treatment		
						MASC-C	STAIC-C	MASC-P	MASC-C	STAIC-C	MASC-P
1	GAD	6	--	5	1	56	48	51	27*	33*	45
	OCD	5	--								
	SOP	4	(3)								
	Minor Dep	(3)	--								
	SP	(2)	--								
2	SOP	7	(2)	6	3	52	18	26	20*
	SR	6	4								
3	SM	7	...	6	...	54	46	57	33*	29*	36*
	SOP	6	...								
	SAD	4	...								
	SP	4	...								
4	GAD	6	--	5	3	17	41	50	0*	20*	40
	SP	5	4								
	MDD	4	--								
	ADHD	(3)	4								
	SOP	--	(2)								
5	GAD	6	(3)	5	4	26	24	62	56**	24	54
	SAD	4	--								
	SP	(3)	--								
	Minor Dep	--	4								
6	GAD	4	--	4	1	39	36	52	5*	20*	40*
	SOP	(2)	--								

Note: CSR=ADIS-IV Clinician Severity Rating; CGI-S=Clinical Global Impression-Severity Rating; MASC-C/P=Multidimensional Anxiety Scale for Children Child/Parent raw total scores; STAIC-C = State Trait Anxiety Inventory for Children-Child raw total scores

GAD=Generalized Anxiety Disorder; OCD=Obsessive-Compulsive Disorder; SOP=Social Phobia; SP=Specific Phobia; SR=School Refusal; SM=Selective Mutism; SAD=Separation Anxiety Disorder; MDD=Major Depressive Disorder; ADHD=Attention Deficit Hyperactivity Disorder

^aCSR ≥ 4 is threshold for clinical diagnosis; parentheses denote subclinical diagnosis

-- denotes diagnosis not present at time of assessment; ... denotes missing data

* RCI p<.05, indicates clinically significant reduction in scores; ** RCI p<.05, indicates clinically significant increase in scores

Table 7
Parent Self-Report of Emotional Distress Pre-Treatment, Post-Group, and Post-Treatment

ID	Respondent	Condition	Pre-Treatment			Post-Group			Post-Treatment		
			DASS			DASS			DASS		
			Depression	Anxiety	Stress	Depression	Anxiety	Stress	Depression	Anxiety	Stress
1	1	A	0	0	14	16	0	16	0 ^b	2	14
1	2	A	14	4	16	6	2	6 ^a	--	--	--
2	1	A	6	0	16	18	2	18	2 ^b	4	6 ^{bc}
2	2	A	8	6	24	10	0	10 ^a	--	--	--
3	1	A	0	0	18	6	0	6 ^a	2	0	24
3	2	A	0	0	4	--	--	--	--	--	--
4	2	B	4	0	10	--	--	--	0	2	2
5	1	B	6	2	0	--	--	--	10	0	16
6	1	B	6	2	12	--	--	--	0	0	2 ^c

Notes: DASS=Depression, Anxiety, and Stress Scales; Respondent 1=Mother, Respondent 2=Father;
Condition A=CBT+PG, Condition B=CBT only

^a pre-treatment to post-group RCI $p < .05$; ^b post-group to post-treatment RCI $p < .05$; ^c pre-treatment to post-treatment RCI $p < .05$

Table 8
Parent Self-Report of Experiential Avoidance Pre-Treatment, Post-Group, and Post-Treatment

ID	Respondent	Condition	Pre-Treatment			Post-Group			Post-Treatment		
			Unwill	PAAQ Inaction	Total	Unwill	PAAQ Inaction	Total	Unwill	PAAQ Inaction	Total
1	1	A	27	36	63 ^a	26	28	54	25	40 ^a	65 ^a
1	2	A	25	40 ^a	65 ^a	25	28	53	--	--	--
2	1	A	33 ^a	31	64 ^a	27	24	51	29	44 ^a	73 ^a
2	2	A	28	22	50	30	31	61	--	--	--
3	1	A	33	19	52	31	19	50	25	29	54
3	2	A	34	22	56	--	--	--	--	--	--
4	2	B	39 ^a	21	60 ^a	--	--	--	22	37	59
5	1	B	37 ^a	25	62 ^a	--	--	--	26	39 ^a	65 ^a
6	1	B	37 ^a	34	62 ^a	--	--	--	15	32	47

Notes: PAAQ=Parental Acceptance and Action Questionnaire; Respondent 1=Mother, Respondent 2=Father;

Condition A=CBT+PG, Condition B=CBT only

^a Denotes a score that is more than 1 standard deviation above clinical mean (as reported in Cheron et al., 2009)

Table 9

Parent Self-Report of Parenting Behaviors Pre-Treatment, Post-Group, and Post-Treatment

ID	Respondent	Condition	Pre-Treatment			Post-Group			Post-Treatment		
			Rejection	RBQ Autonomy [*]	Control	Rejection	RBQ Autonomy [*]	Control	Rejection	RBQ Autonomy [*]	Control
1	1	A	2 ^b	2.29	1.71	2 ^b	2.57 ^b	2	1.67	2.14	2.29 ^b
1	2	A	2.78 ^b	3.14 ^b	1.71	2.33 ^b	2.17	1.29 ^a	--	--	--
2	1	A	1.44	1.71	2	1.33	1.57 ^a	1.71	1.11	1 ^a	1.71
2	2	A	2.33 ^b	1.43 ^a	1.43	2.44 ^b	2.29	1.57	--	--	--
3	1	A	1 ^a	1.86	1.86	1 ^a	1.57 ^a	1.27 ^a	1 ^a	1.43 ^a	1.43 ^a
3	2	A	1 ^a	1.57 ^a	1.57	--	--	--	--	--	--
4	2	B	2.11	1.57	2	--	--	--	1.33	1.29 ^a	1.86
5	1	B	2.11	1.86	1.57	--	--	--	1.56	1.86	1.71
6	1	B	2.22	2.14	1.14	--	--	--	1.11 ^a	2.57	1.27 ^a

Notes: Respondent 1=Mother, Respondent 2=Father; RBQ=Rearing Behaviors Questionnaire^{*} Autonomy scale is reverse scored; across scales, higher scores represent greater use of negative parenting behaviors^a Denotes a score that is more than 1 standard deviation below the mean; ^b denotes a score that is more than 1 standard deviation above the mean (as reported in Verhoeven et al., in press)

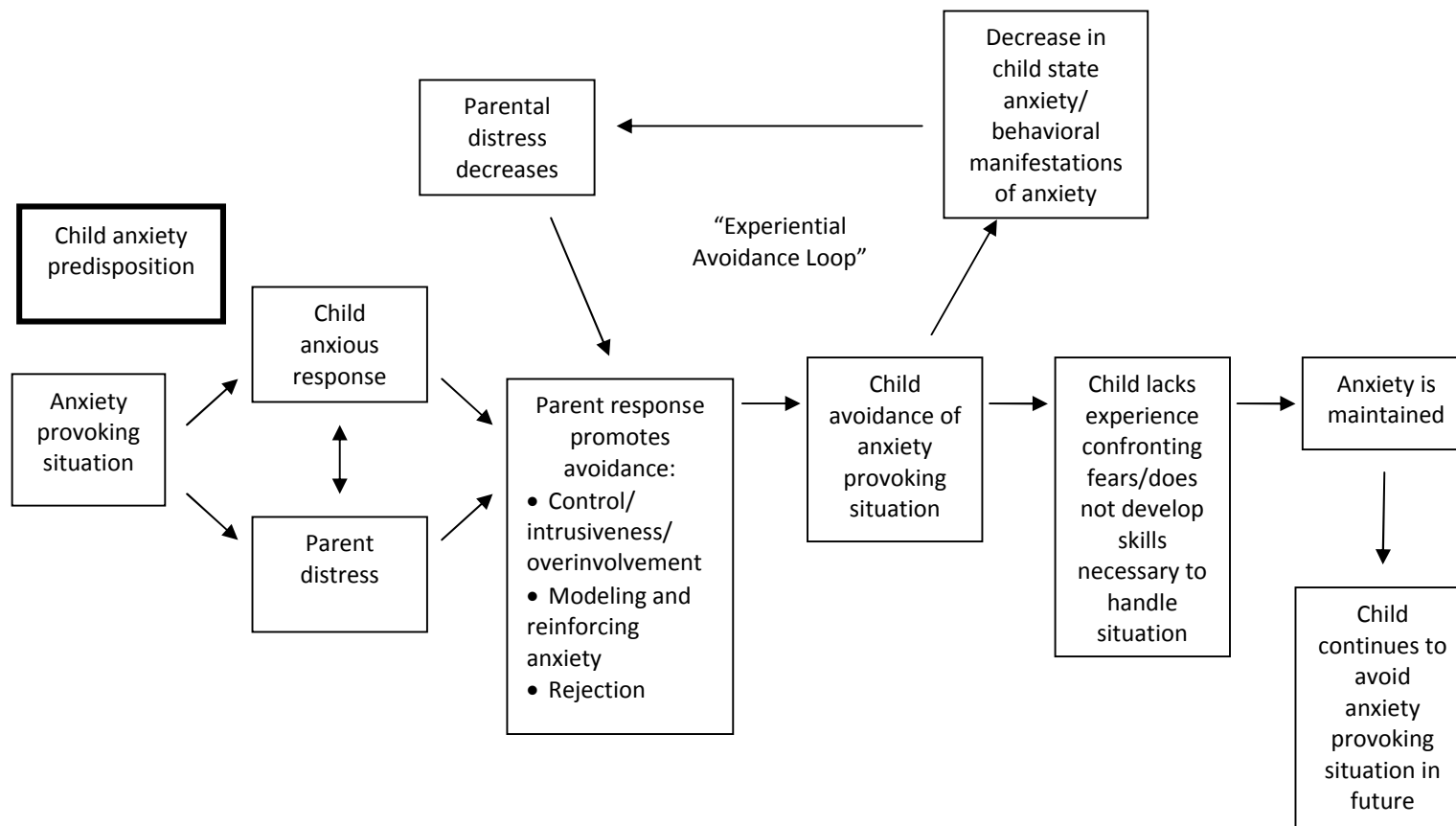


Figure 1. A model of the influence of parenting behaviors on avoidance and youth anxiety.

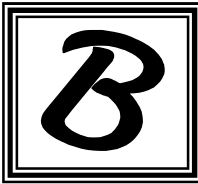
Session 1 – Orientation and Psychoeducation “Know Your Child”	
Content	Rationale
<ul style="list-style-type: none"> • Welcome and introductions • Overview of program including goals and rationale • Psychoeducation about anxiety <ul style="list-style-type: none"> ○ Transactional relationship between parenting and youth anxiety ○ Habituation curve ○ Common patterns of anxiety • Common patterns of anxiety • Assign homework 	<ul style="list-style-type: none"> • Orientation to the program; builds rapport and increases parental commitment to treatment • Normalizes anxiety and destigmatizes parents • Increases awareness of impact of family/parenting on anxiety • Introduces processes (avoidance) that maintain anxiety
Session 2 – Parent Distress Tolerance and Mindfulness “Know Yourself”	
Content	Rationale
<ul style="list-style-type: none"> • Review agenda • Review homework • Emotional responses to child anxiety • Mindfulness practice • Assign homework 	<ul style="list-style-type: none"> • Helps generalize skills, provides models for other group members • Allows parent to acknowledge and accept own negative feelings regarding child’s behavior • Allows parents to better tolerate own distress regarding child’s distress
Session 3 – Encouraging Independence and Appropriate Coping “Empathize and Encourage”	
Content	Rationale
<ul style="list-style-type: none"> • Review agenda • Brief mindfulness exercise • Review homework • Encouraging independent behavior • Assign homework 	<ul style="list-style-type: none"> • Promotes autonomy and independence • Decreases intrusiveness • Encourages child mastery and build self-confidence • Makes children feel more mature, competent, and confident
Session 4 – Contingency Management “Reward the Good and Ignore the Bad”	
Content	Rationale
<ul style="list-style-type: none"> • Review agenda • Brief mindfulness exercise • Review homework • Contingency management skills <ul style="list-style-type: none"> ○ Active ignoring ○ Effective praise ○ Tangible rewards • Assign homework 	<ul style="list-style-type: none"> • Facilitates generalization of skills • Creates new learning history – extinguishes maladaptive behavior (i.e. tantruming, excessive whining related to anxiety) • Enhances success of exposure exercises
Session 5 – Modeling Brave Behavior “Be a Good Role Model”	
Content	Rationale
<ul style="list-style-type: none"> • Review agenda • Brief mindfulness exercise • Review homework • Being a good role model • Review of program and goodbye 	<ul style="list-style-type: none"> • Models effective coping behavior • Facilitates transfer of control from therapist to parent to child

Figure 2. Summary of CBT+PG session content.

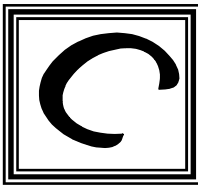
The “Parent Traps”



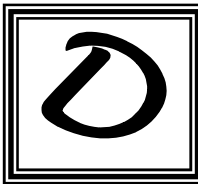
Agreeing with your child’s anxious assessment of a situation; modeling and reinforcing anxious behavior



Butting in; overinvolvement, overprotection, and intrusiveness; limiting opportunities for independence



Criticizing or coldness; showing frustration or anger; behaving less warmly when your child is anxious



Doh! Good, honest attempts that go horribly wrong!

Figure 3. Mnemonic to help parents recognize behaviors that foster avoidance; from the What to Do When You’ve Tried it All Parent Workbook (Merson & Chu, 2011).

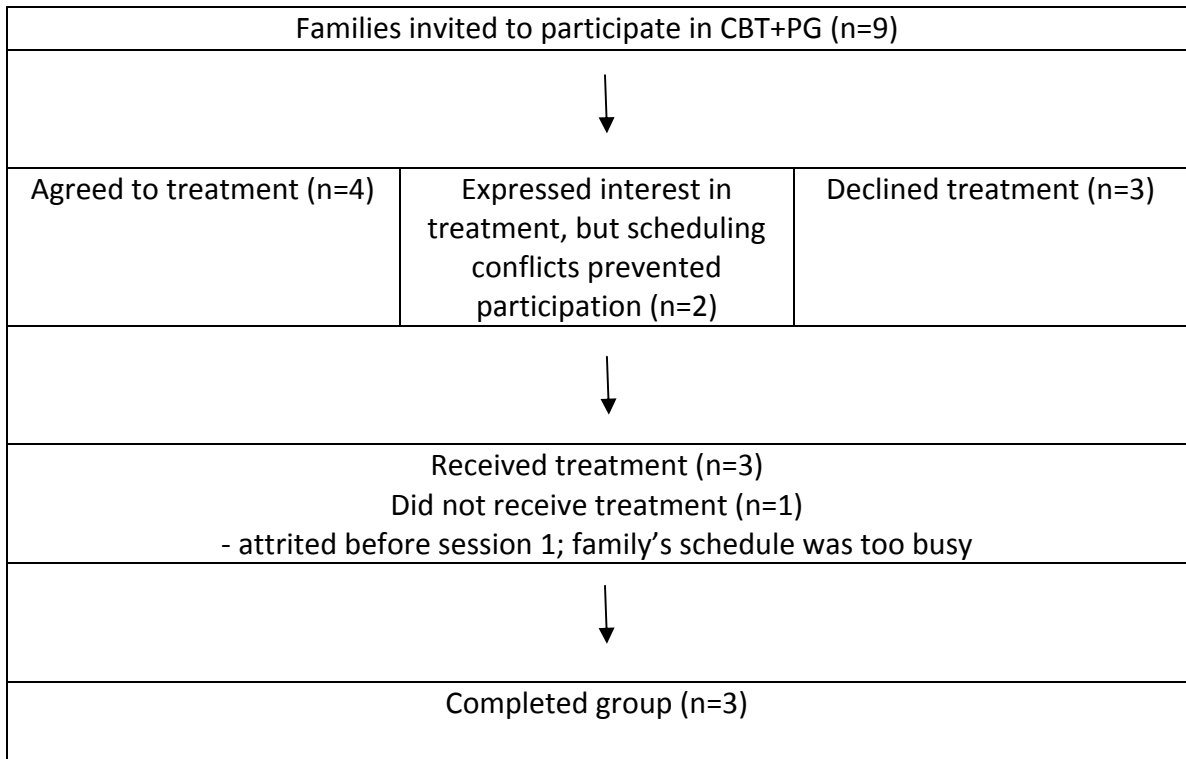


Figure 4. Flow of participants through CBT+PG pilot trial.

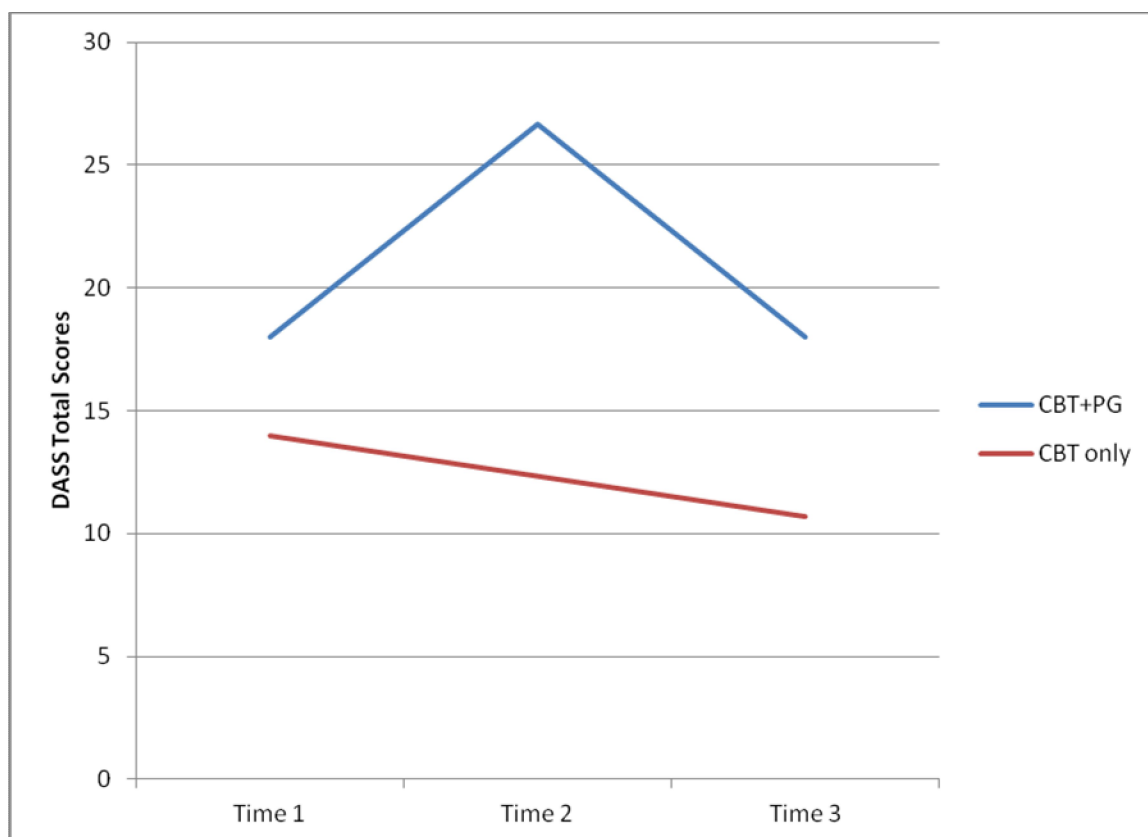


Figure 5. Mean DASS Total scores at pre-treatment, post-group, and post-treatment.

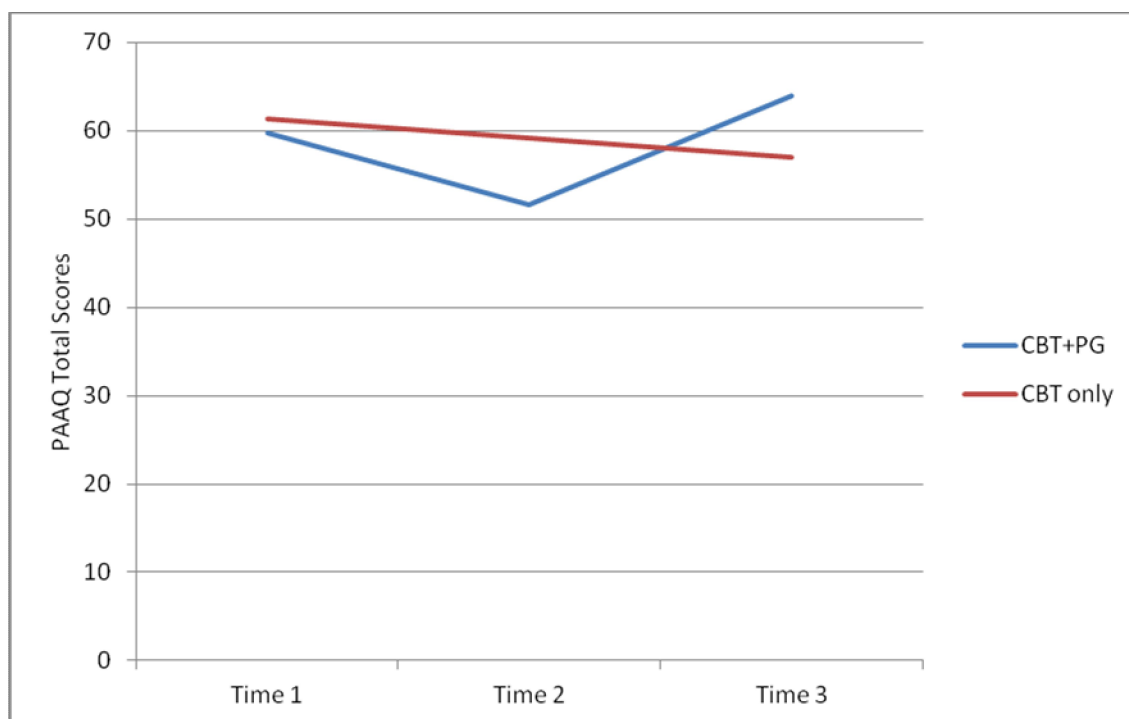


Figure 6. Mean PAAQ Total scores at pre-treatment, post-group, and post-treatment.

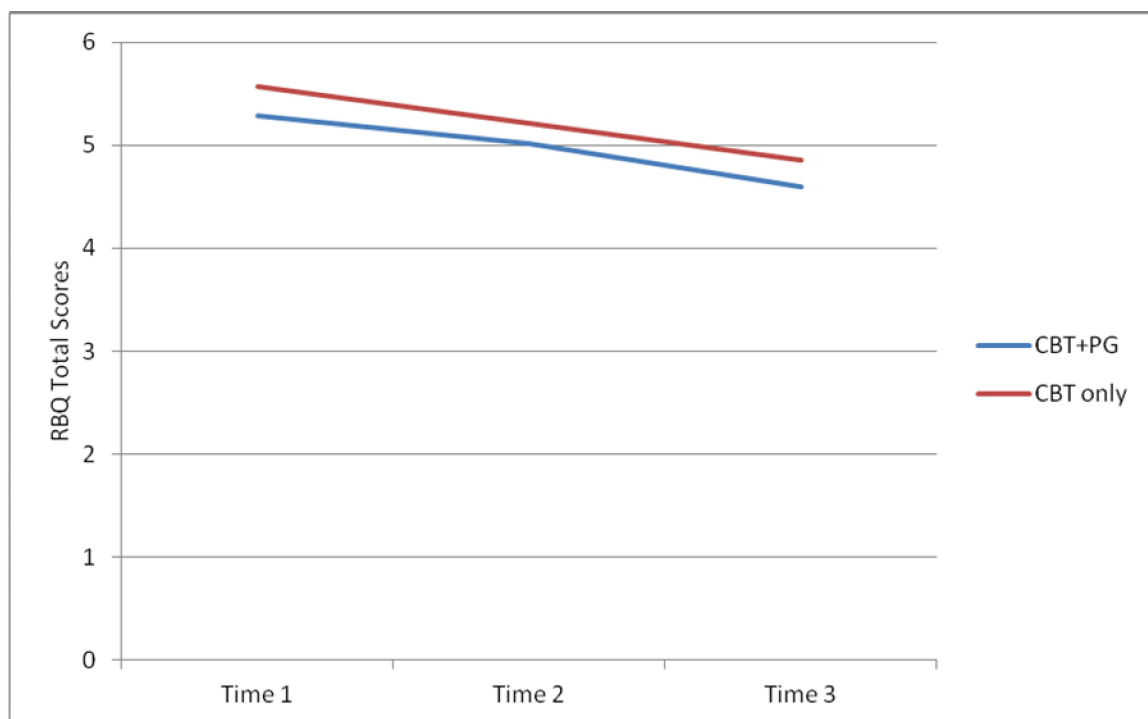


Figure 7. Mean RBQ Total scores at pre-treatment, post-group, and post-treatment.

Appendix A

Qualitative Feedback from the Parent Group Satisfaction Survey (PGSS)

1. What were the strengths of this program? What did you like most about it?
 - Group situation with other parents; not feeling isolated and alone in your experiences; tools to attempt to change the situation
 - Program was informative with research based studies; I liked the small personal touches (i.e., using examples tailored to my child's situation) and presentations
 - Rachel and Laura are very knowledgeable and covered key points very well
 - Relaxation techniques. Hearing other parents struggle with similar issues. Techniques to encourage child to overcome anxiety.
 - Hearing about current research and strategies related to kids with anxiety - using language similar to what my child is learning
2. What were the weaknesses of the program? Is there anything you did not like about it?
 - Starting too late in the process; parent and child program beginning together would have been more helpful
 - There were times when I felt the instructors were reading too much from a script
 - I really wanted a better dialogue between parents; I wish we had an opportunity to talk and share experiences informally. This may have facilitated a more relaxed sharing dialogue.
 - A lot of what was discussed in the individual counseling was covered here too (redundant).
 - I was under the impression that the group was going to be a "support" group versus the parent "training" it turned out to be.
3. What changes would you suggest to improve the program?
 - More sessions, a little rushed.
 - If the instructors were less dependent on the script; however I understand they are students
 - Starting promptly at 6pm even if people are late. Incorporate a parent who has previous experience with a child with anxiety. Try to get parents to discuss and share more freely. Include reading suggestions or web site list.
 - Have more interaction between the parents - discussion of what bothers them, issues they are having, etc.
 - Grouping similarly involved families - since our group consisted of families of adolescents they had differing needs than a family of a younger child
4. How did you feel about the length of the program? Were there enough sessions? Too many?
 - More sessions

- I felt the length of the program was adequate, maybe one more session
 - The length was good. 5-6 sessions are good.
 - About right
 - Definitely enough sessions. I don't think we needed a whole session devoted to mindfulness.
5. Are there any other comments or feedback you'd like to share with the group leaders?
- Thank you for delivering the program in a non-judgmental and encouraging way; it was very helpful and productive
 - I felt both the group leaders were adequately prepared to respond to issues and concerns expressed by participants
 - Excellent 1st time. I think you should continue this program. I think many parents would like to connect and share experiences.
 - They both did an excellent job. It was also nice having our child's counselor facilitate this group.
 - Do in a webinar format; traveling was an added dimension that was difficult to incorporate into our family's schedule.

Appendix B
Qualitative Feedback from the Expert Feedback Form

Session One

1. Are the techniques and lessons described in this session the right techniques/lessons to meet the session objectives?
 - Perhaps discuss other factors that lead to anxiety. I think parents spend a lot of time trying to “make sense” of their child’s anxiety (BF)
2. Would the therapist with average CBT training be able to appropriately apply these techniques?
3. To what extent were important elements missing from this session?
 - As mentioned below, perhaps add a discussion of other etiological factors. (BF)
 - Perhaps a discussion of parental withdrawal behavior when children are anxious. This would fit nicely in the “C” parent trap under low warmth. See Woodruff-Borden, J., Morrow, C., Bourland, S., & Cambron, S. (2002). The behavior of anxious parents: Examining mechanisms of transmission of anxiety from parent to child. *Journal of Clinical Child and Adolescent Psychology*, 31(3), 364-374. (DC)
4. Please include additional comments, if any, about this session.
 - Good intro, reasonable amount of content (JW)
 - I wonder if the discussion of “traditional model” is necessary. In particular, I wonder how many parents attribute this model to their child’s anxiety before intervention. Consequently, you are debunking a model that may not have been perceived by many parents in the first place. (BF)
 - I like that you used a mnemonic (i.e., ABCD). I would, however, be curious to see how well parents remember it. For example, it may not be easy to remember modeling and reinforcement from “A”. How often do you use the mnemonic throughout the program, if not, could it be eliminated? Also, does the program necessarily flow from this mnemonic?
 - I like the habituation curve diagrams and the common patterns of child anxiety.
 - When discussing the role of parenting, I think it important to emphasize that clinicians are not blaming the parent. You mention this in the therapist manual, but maybe this can also be included in the parent manual. Perhaps a brief mention of some the other variables related to anxiety, including temperament, heritability, and stress (this is included in some other manuals that I have seen).
 - Therapist Manual- I wonder if specific reference to the Hudson study adds much over just saying something like “researchers consistently find that parents of anxious children...”

- I like the vignette.
- It might be helpful to include a contrast to “riding out” anxiety to parents. In other words, kids who avoid 1) never learn their anxiety will pass without avoidance 2) never disprove their fears, 3) learn they can’t face their fears directly. The references to the workbook appear one page off in this section. The “Habituation Curve” and the “Key Points” worksheets are VERY good! (DC)

Session Two

1. How easy was it to understand the content of the manual and workbook for this session?
2. Are the techniques and lessons described in this session the right techniques/lessons to meet the session objectives?
3. Would the therapist with average CBT training be able to appropriately apply these techniques?
 - To a certain degree, this session may assume some therapist orientation to mindfulness- not all CBT practitioners have this. Ideally, they would at least try these strategies themselves. (BF)
 - I think you are always going to run into the fact that mindfulness is a very tricky thing for the average-trained CBT therapist to understand. This session is prepared very well though! (DC)
 - The mindfulness techniques might be more difficult for newer therapist unskilled in these techniques. The manual does explain it clearly however. (JH)
4. To what extent were important elements missing from this session?
 - Perhaps more discussion on the relevance to anxiety management (BF)
 - I think it may be beneficial to add in a line or two in the second script encouraging parents to be mindful not only of the emotions they experience in the situation, but the urges they have to react to those emotions. Then, helping the parents notice those urges to react without actually reacting would be important to really drive home the objectives of the session. (DC)
5. Please include additional comments, if any, about this session.
 - This is interesting as an addition to the typical parent training curriculum. There is some controversy in the lit on whether parent anxiety management helps or not, but it probably can’t hurt! (JW)
 - I have mindful parenting in my prevention program. I think it is great that you included, and I did not know anybody else was doing this in relation to child anxiety. I think it is a great strategy to help parents manage negative emotion, which may help them be able to successfully implement the behavioral strategies discussed in these programs. Similar to your program, I actually use

the term “autopilot” in my program, and I use mindful breathing and leaves on a stream as my two main exercises. (BF)

- To me the research is unclear regarding the “dose” (how many sessions and how much practice) of mindfulness are necessary for significant benefit. However, one point to consider is that you are introducing this somewhat abstract concept along with 3 techniques in a single session. It looks like you refer back to the techniques in other sessions, but I wonder if introduction of the topic and 3 techniques is too much to assimilate.
- Other point, I would make an effort to tie the mindfulness back into other critical parenting tasks including exposure (parent mindfulness during exposure), overprotection, ignoring, etc. when discussed later in treatment. I think the manual does this in some places, but I wonder if there is enough of an emphasis (e.g., it may be very important for parent modeling).
- Once concept that may be worth adding is “riding the wave of distress’ as a concept to use to help parents understand their negative emotions and to prevent caving in to them. For example, during exposure or when experiencing the urge to overprotect, they can visualize a wave- negative mood is temporary. Parents can also use this concept to understand and resist rescuing their child when they experience anxiety. I remember reading this in a parenting book on ACT therapy for anxious kids, and parents I have worked with really seem to like this concept. Can send you the reference if you like.
- Therapist Manual- as discussed above, perhaps more discussion on how mindfulness is relevant to child anxiety. I like the CD idea.
- If you do decide to distribute this more broadly, be careful with the faces on the “Common Emotional Responses to Child Anxiety” worksheet. Those are copyrighted by Creative Therapy Associates, Inc. (DC)
- There is some discrepancy about the title “soothe” or “know” yourself. (JH)

Session Three

1. How easy was it to understand the content of the manual and workbook for this session?
2. Are the techniques and lessons described in this session the right techniques/lessons to meet the session objectives?
3. Would the therapist with average CBT training be able to appropriately apply these techniques?
4. To what extent were important elements missing from this session?
5. Please include additional comments, if any, about this session.

- Not a critique, but this draws pretty heavily on the Wood/McLeod Encouraging Independence module, so it would probably be desirable to reference the 2008 manual on the relevant materials for this session. I also wonder if the list of self-help tasks blends a bit into anxiety tasks at the end [e.g., making a phone call to a friend]. Our intention was to focus on self-care tasks that the child could start doing more independently that wouldn't immediately trigger their anxiety in the early sessions, or maybe just a bit (JW)
- “Tasks with which children sometimes struggle”— this page is great. (BF)
 - I like the concept of empathize and encourage. I also like that you focus on encouraging independence. This seems like a more positive spin than decreasing overprotection.
 - I am not sure if you are indirectly covering overprotection; however, I wonder if encouraging independence would lead parents to decrease in overprotection. I am not completely sure that they are on the opposite ends of the same continuum.
 - Therapist manual- no comments.
- I think this is a well written, to-the-point session! Minor correction...in the manual, and on page 21 of the workbook, choice 2 has a typo. It should read call me at work if you need to. (DC)

Session Four

1. How easy was it to understand the content of the manual and workbook for this session?
2. Are the techniques and lessons described in this session the right techniques/lessons to meet the session objectives?
3. Would the therapist with average CBT training be able to appropriately apply these techniques?
4. To what extent were important elements missing from this session?
 - More detailed description of how to create and implement a rewards plan. (DC)
5. Please include additional comments, if any, about this session.
 - It seems that using daily privileges as an incentive might be emphasized as a reasonable option more explicitly in the materials. Sometimes this is necessary to motivate a highly avoidant child (JW)
 - Includes tangible rewards, ignoring, and praise—I wonder if this may be too much content for a parent to comprehend, retain, and practice in a single session. (BF)
 - Also, as part of the parent manual, I wonder if you can provide a brief section regarding why praise, rewards, and ignoring are important to child anxiety (e.g., a way to reward brave behavior and way to decrease

stress in the parent-child relationship by effectively decreasing the child's disruptive behaviors).

- Perhaps praise should go before tangible rewards.
- Therapist Manual- you mention mindfulness with ignoring. This is great. However, it is only briefly mentioned. You may want elaborate more in the manual (e.g., parents can focus on noticing thoughts and emotions without responding to them)—see my riding the wave comment above.
- I thought this session was excellent in terms of the content discussed. However, there seems to be way too much material to cover in one session. I am sure you have wrestled with this, and seem to have attempted to address this by making the praise section optional, but it still seems like a crowded section, especially with the rewards lesson included. I think one of the reasons families say rewards don't work is because not enough planning goes into them. I am worried that if rewards are covered so quickly, families won't have as much success. (DC)
- I disliked the distinction between good and bad and equating anxious behavior with "bad." (JH)

Session Five

1. How easy was it to understand the content of the manual and workbook for this session?
2. Are the techniques and lessons described in this session the right techniques/lessons to meet the session objectives?
 - Since the agenda for this session is focused on how to model the coping strategy for children, I think this session could benefit from providing more explicit guidance for parents in how to respond to common questions children have for their parents...like a Child FAQs section along with the role play to prepare parents for the questions their children might have about managing anxiety. (DC)
3. Would the therapist with average CBT training be able to appropriately apply these techniques?
4. To what extent were important elements missing from this session?
5. Please include additional comments, if any, about this session.
 - Good idea. Some parents will be prickly about this, of course. (JW)
 - I like that you include modeling in your program—your discussion of modeling seems more comprehensive than other manuals. Focusing on the modeling positive coping behavior is great, as parents and children can practice using the same skill. I do wonder if you can add something here (this is a brief session) about decreasing the modeling of anxiety, including the concept that parents can experience stress and anxiety without modeling stress and anxiety. (BF)

- I am not sure if modeling can be easily be decreased, but mindfulness may help parents notice their emotions and anxious behavior when interacting with the child (mindfulness may lead to increased self-awareness). One possibility to discuss this is to use the concept of “fake it until you make it” in that parents can practice maintaining a neutral expression (e.g., when encouraging independence or during exposure). I also think parents can ask for feedback from trusted friends or family.
- A well done session! I think accounting for modeled behavior is an important piece that is often overlooked in treatment. Great job! (DC)
- The discussion of gradual exposure to feared situations for the parent seemed to be missing. This is mentioned with regards to breaking down the child’s tasks into smaller manageable steps. (JH)

GENERAL COMMENTS

DC

- You did a great job putting this together, and I think it would be a great program for parents. There are some points here and there that I commented on, but overall, I think the material is well described and appropriately grounded in the literature.

BF

- Overall, this is a great manual, and I appreciate the opportunity to review it. In most cases my comments above are not intended to indicate problems with manual, they are more or less intended as discussion points-- things to consider. Many of issues I have been struggling with when making my own parent manual.
- This manual is very aesthetically pleasing—great use of diagrams, font, charts, etc.
- I wonder if 5 sessions is enough. You have 16 to 20 sessions with the child, could you add a few sessions.
- I imagine it may be a challenge to measure the additive effect of a parent-based intervention such as this, if some of the child sessions also include the parents. For example, would exposure be discussed with the parent regardless of the presence of your parent intervention? This may be important to try to control for this in your methodology.
- A comment based on personal preference and speculation regarding how some parents may react, but I am not sure I am wondering about the header, which reads “what to do when you’ve tried it all.” Again, not sure how parents will read this, but I wonder, if that this statement implies that we as clinicians believe that the parents are desperate.

- Throughout, I would be careful about the use of psychology lingo and vocabulary that may not be understood by somebody of limited education and of low SES. Parents will have plenty to comprehend and assimilate. When it can be avoided, perhaps psychologists can avoid the need to introduce terms or vocabulary that parents may not have been familiar with. Also, avoiding lingo may make the treatment seem more accessible and less intimidating. Examples include: mutually influence, autonomy, habituation, traditional model (the use of model).

JH

- This is a lovely, user-friendly manual. It is not blaming and very engaging for parents.

Reviewers

- BF – Brian Fisak, Ph.D. – Assistant Professor, University of North Florida
- DC – Dan Cheron, Ph.D. – Staff Clinician in Clinical Care, Judge Baker Children's Center
- JH – Jennifer Hudson, Ph.D. – Associate Professor and Research Fellow, Macquarie University
- JW – Jeff Wood – Associate Professor, University of California Los Angeles

Appendix C
Qualitative Data from the Group Leader Feedback Form

Session 1

Were there any unnecessary elements included in this session?

- Maybe anxiety statistics
- Habituation curve may have been repetitive for some parents who received same information from their individual therapists

Were there important elements missing from this session?

- More orientation to program as a whole; outline of what is to come

Did you feel rushed to accomplish all of the goals of today's session?

- Yes, but session started late due to late parents and need to review consent forms
- Felt short on time because we had to do consents and forms

Other comments

- Parents were able to readily identify with the parent traps and seemed comforted to know that it's not their fault that they have fallen into anxious patterns with their kids. They actually seemed to appreciate the little exert from the Hudson study about parents of non-anxious kids interacting with anxious kids.

Session 2

How helpful do you think the strategies/activities were for this meeting?

- Since mindfulness was a "new and different" concept to most parents, having 3 exercises seemed to help provide a good sized dose to get parents to at least give it a chance

Were there important elements missing from this session?

- A better/more clear description of when to do mindfulness practice and how to use it in the moment
- Not so much that an entire element was missing/not addressed, but in the section describing reasons mindfulness is helpful, manual described people operating on autopilot. However, parents brought up that they actually feel they over-think everything with their child; would be good to address this as another possible way parents may feel/reason mindfulness is helpful (i.e. to slow down and experience the moment).

How useful was the workbook for the today's session?

- Not much really done with the workbook in this session.

Do you feel the group was able to master the information presented in this session?

- Some confusion about what mindfulness is and how to use it
- I just think that mindfulness is difficult to master in general and not necessarily that the things in the manual/exercises need to be changed

Other comments:

- Parents seemed to have some lingering questions about when to use mindfulness, so maybe a page in the workbook listing some examples of when this could be most useful or having parents try to generate ideas of when this mindset would be most helpful could be added.
- Also maybe it could be made clearer that we do not expect them always to go through an entire mindfulness exercise when difficult situations arise.

Session 3

Were there important elements missing from this session?

- Better description of independence (i.e., things you just do for child to prevent them from having to struggle)
- More elaborate EE role play; parental involvement in EE role play
- Could have some more info on how the EE statements are intended to be applied (i.e., when child is seeking reassurance versus when parents need child to do something).

Other comments:

- More role plays, active practice
- Good idea to break into groups (moms and dads) - do more of this

Session 4

Were there unnecessary elements included in this session?

- Some things were repetitive
- Tangible rewards - some parents had already done in individual therapy

Were there important elements missing from this session?

- Disincentives/loss of rewards/consequences

Did you feel rushed to accomplish all of the goals of today's session?

- More time - tangible rewards could have been own session...also parents benefit from extended discussion of homework and review of previous session's content

Session 5

Were there important elements missing from this session?

- Even though we didn't get to have them do it in session, I think that having the parents think about applying the FEAR plan to their own anxiety could have been very helpful
- Maybe some suggestions for having a review of the tools/discussion or a wrap-up/review exercise would be useful

Did you feel rushed to accomplish all of the goals of today's session?

- Would have had plenty of time for all of session 5 content, but had to "make up" some content from session 4
- Had to cover active ignoring from Session 4, so some content was rushed

How much did the manual allow for flexibility in today's meeting?

- Left room for questions to be asked/addressed.

Other comments:

- If we had not had to cover material from session 4, I think there was a nice balance between new content and leaving adequate time for review/questions about both the lesson and the program overall.

Endnotes

ⁱ PAAQ clinical means and standard deviations used as comparison data are as follows: Inaction M=25.2 and 25.7, SD=6.2 and 6.8, for mothers and fathers, respectively; Unwillingness M=28.6 and 29.1, SD=6.3 and 5.3, for mothers and fathers, respectively; Total M=53.8 and 54.9, SD=9.0 and 9.3, for mothers and fathers, respectively (Cheron et al., 2008).

ⁱⁱ RBQ normative means and standard deviations used as comparison data are as follows: For elementary school aged children – Autonomy-granting M=2.79 and 2.80, SD=.41 and .43, for mothers and fathers, respectively; Over-control M=1.93 and 1.81, SD=.41 and .38, for mothers and fathers, respectively; Rejection M=1.42 and 1.45, SD=.3 and .31, for mothers and fathers, respectively. For adolescents - Autonomy-granting M=3.02 and 3.02, SD=.47 and .43, for mothers and fathers, respectively; Over-control M=1.76 and 1.72, SD=.42 and .38, for mothers and fathers, respectively; Rejection M=1.36 and 1.40, SD=.33 and .28, for mothers and fathers, respectively (Verhoeven et al., in press).

ⁱⁱⁱ RCI, representing reliable change beyond measurement error, was calculated according to Jacobson and Traux (1991): $RCI = (x_1 - x_2) / S_{diff}$, where x_1 =pre-treatment score, x_2 =post-treatment score, and $S_{diff} = \sqrt{2(SE)^2}$, the standard error of difference between two scores. $SE = s_1 \sqrt{1 - r_{xx}}$, where s_1 =standard deviation of normal population and r_{xx} =test-retest reliability of the measure. An $RCI \geq 1.96$ represents a reliable change at $\alpha=.05$. Normative data used to measure RCI in these cases were as follows: MASC-C: $s_1=14.35$ and 14.44 for boys and girls, respectively, $r_{xx}=.93$ (March et al., 1997); MASC=P: $s_1=13.48$ and 14.77 for boys and girls, respectively, $r_{xx}=.7$ (Baldwin & Dadds, 2007); STAIC-C: $s_1=7.3$ and 7.9 for boys and girls, respectively, $r_{xx}=.65$ and $.71$ for boys and girls, respectively (Spielberger, 1973)

^{iv} Normative data used to measure RCI in these cases were as follows: DASS Depression: $s_1=7.43$, $r_{xx}=.713$; DASS Anxiety: $s_1=5.39$, $r_{xx}=.785$; DASS Stress: $s_1=8.04$, $r_{xx}=.813$ (Brown et al., 1997; Crawford & Henry, 2005).