A Systematic Review Examining the Efficacy of Group Delivered Mentalization-Based Parenting Interventions and an Empirical Study Developing a Brief Parenting Group Intervention to Improve Children's Understanding of Emotions

Thesis submitted in partial fulfilment of the requirement for

the degree of:

Doctorate of Clinical Psychology (DClinPsy)

South Wales Doctoral Programme in Clinical Psychology

Cardiff University

Sarah Lavender

Supervised by: Dr Chris Hobson and Dr Cerith Waters

25/05/21

Contents

Acknowledgements

Thank you to all the participants who have taken part. Your wisdom and knowledge has shaped this project and would not have been possible without you. I will be forever grateful. Thank you to my supervisors, Chris and Cerith, whose guidance, support and enthusiasm have seen me through this process. I look forward to continuing working with you on this project.

I also want to thank my wonderful Cohort, you're a really special group of people. West Wales girls I definitely could not have done it without you! My amazing friends (CBs and Dawns especially) thank you for always being so supportive and the perfect distraction when needed over these last 3 years.

Thank you to my amazing family. Mum, Dad and Ellen thank you for being my biggest inspiration and cheerleaders. All your support (and sometimes lack of sympathy) has got me through. Thank you for reminding me "There is a crack, a crack in everything, that's how the light gets in". Grandma, I really wish you could still be with us, I know you would be proud.

And finally, thank you to Joel. Thank you for the endless love, patience and always knowing how to make me laugh. Your unwavering belief in me has been the best motivation.

Preface

Emotional and behavioural problems in early-to-middle childhood can have a significant impact on a child's longer-term wellbeing, health and educational outcomes. Group delivered parenting interventions have been identified as one way of supporting children to both resolve early emerging difficulties and prevent escalation of behavioural and emotional problems into later childhood, adolescence and early adulthood.

The systematic review examined the evidence for group delivered mentalization-based parenting interventions. The aim of these interventions is to increase mentalization, the ability to understand and interpret one's own and others mental states. The literature search identified ten relevant studies that were examined for programme content, methodological quality and outcomes. There was no clear evidence of core programme content for mentalization-based parenting interventions. Eight out of the ten included studies reported improvements in parent's ability to mentalize, which was operationalised as parental reflective functioning in each of these studies. There was some limited evidence for improvements on other intervention outcomes for parents and children. This may be due to the lack of high quality studies and the absence of longer-term follow-up of the parents who took part in interventions. There is a need for future research to conduct high quality studies with greater diversity in participating parents to better understand the value of group delivered mentalization-based parenting interventions.

The empirical paper describes the systematic development of a parenting intervention aimed at improving children's understanding of emotions using a two round Delphi Survey method. In the first round, an initial outline of the intervention was developed and experts were interviewed about their views about the proposed

outline intervention. Experts included: Academics and clinicians with expertise in child and adolescent mental health; parents of children identified as experiencing early emerging behavioural and emotional problems; and child and family practitioners who routinely work with children and their parents in early to middle childhood. Following the interviews, the data was analysed using Thematic Analysis (Braun & Clark, 2006) and themes generated. These themes were then used in the second round to create a survey that was sent to all the experts who rated how important it would be to include or consider the different items in the intervention. All of the items received at least moderate consensus to be included. This research has informed the development of a new intervention for parents to improve their child's understanding of emotions. Future research will investigate the feasibility and acceptability of this intervention.

The efficacy of group delivered mentalization-based parenting interventions: a systematic review of the literature

Sarah Lavender

Manuscript prepared in line with referencing guidance for the journal Parenting: Science and Practice (Appendix A).

Word count: 8265

Abstract

Mentalization refers to the capacity to understand and interpret one's own and others mental states. There is good evidence for individualised treatments aimed at increasing this capacity including mentalization-based treatments with children and adolescents. However, as yet there has been no focused synthesis of the literature concerning specifically group delivered mentalization-based parenting interventions. Such groups may be an effective intervention for parents of children with emotional and/or behavioural difficulties. The current study aims to systematically review the literature in relation to group delivered mentalization-based parenting interventions. Three databases were searched to identify N=515 studies that were screened and reported according to PRISMA guidelines. Inclusion criteria were met by N=10 studies and assessments of methodological quality were conducted. Interventions varied in terms of content, but often included psychoeducation, experiential group exercises and homework tasks. The length and setting of interventions did not appear to influence outcomes. Significant improvements in parental reflective functioning were found in eight of the ten studies. There was mixed evidence for the efficacy of the interventions in terms of other parental and child outcomes such as parental stress and mental health difficulties, and child emotional and behavioural problems. This may be due to the lack of high quality studies and the absence of longer-term follow-ups. There is a need for future research to conduct high quality studies with greater diversity in participating parents. Long-term follow-up studies of group delivered mentalization-based parenting interventions are needed to better understand their impact on parental and child outcomes over time.

Keywords: Mentalization, Parents, Systematic Review, Group interventions

Introduction

  Mentalization (or reflective functioning) is a concept that has developed through an integration of psychoanalysis, developmental psychology and cognitive neuroscience. It refers to the capacity to understand and interpret one's own and others' mental states such as thoughts, feelings and needs (Fonagy, Steele, Steele, Moran, & Higgitt, 1991). Mentalizing encompasses the principle that one can never fully know about the inner world of another person, but that a curious and non-judgemental stance allows understanding (Fonagy & Target, 1997). Mentalizing is an ability that is primarily developed by the infant being treated by their primary caregiver(s) like an individual, with his or her own needs and desires. Mentalization theory suggests that the capacity to mentalize allows important social and cognitive capabilities to develop, including affect regulation and attention control. Disturbance of relationships with primary caregivers can therefore lead to disruptions in mentalizing abilities, which consequently leaves the child vulnerable to difficulties in social relationships (Fonagy & Target, 2006).

  Despite mentalizing being an ability that develops within the infant and caregiver relationship, the most established evidence base for mentalization-based psychological interventions is in the area of adult personality disorder; specifically, Mentalization Based Treatment (MBT) for Borderline Personality Disorder (Fonagy & Bateman, 2008) and Antisocial Personality Disorder (Bateman, O'Connell, Lorenzini, Gardner, & Fonagy, 2016). The evidence for adapting MBT to focus on parents and children is in its infancy (Midgley & Vrouva, 2012; Byrne, Murphy, & Connon, 2020). There are a number of mentalization-based parenting interventions that have been developed. Mothering from the Inside Out is a 12-session programme for mothers with a child between 0 and 3 years old. The programme is for mothers

with mental health problems and substance misuse difficulties (Suchman et al.; 2016; Suchman et al., 2017). Minding the Baby is another mentalization based parenting intervention gaining an evidence base (Ordway et al., 2014; Slade et al., 2020; Sadler et al., 2013). These programmes often combine individual and group based elements. Additionally, programmes for foster carers and adoptive parents have been developed (Midgley et al., 2019; Midgley, Alayza, Lawrence, & Bellew, 2018) and a number that are solely delivered in a group-based format rather than individually (Bammens, Adkins, & Badger, 2015; Adkins, Luyten, & Fonagy, 2018; Midgley et al., 2019; Adkins et al, 2021). Whilst the evidence base for the efficacy of mentalization based parenting programmes is emerging, it lacks synthesis and cohesion.

One core aim of mentalization-based interventions with parents is to increase parental "Reflective Functioning". Reflective Functioning (RF), often considered as synonymous with mentalization, was operationalised by Fonagy et al. (1991) in the coding of the Adult Attachment Interview (AAI; George, Kaplan & Main, 1985). The "Reflective Function Scale" on the AAI is an observational measure of an adult's capacity to reflect on the mental states and intentions of others (mainly their parents or key attachment figures) whilst recalling childhood experiences. There is evidence of significant correlations between the ability of the parents to reflect upon their own history in the AAI and attachment security with their own child (Camoirano, 2017; Fonagy et al., 1991). The Reflective Functioning Scale was applied to the Parent Development Interview (PDI, Aber et al., 1985) to create the PDI-RF (Slade et al., 2004). Parental Reflective Functioning (PRF) is a parent's ability to be aware of their own mental states and how this influences their behaviour, while also being open and curious to understanding their child's mental states and behaviours (Fonagy et al., 1991). More recently the Parental Reflective Functioning Questionnaire (PRFQ) has

been developed as a brief, multidimensional assessment of PRF (Luyten, Mayes, Nijssens, & Fonagy, 2017). These measures have been developed and validated in western countries, and therefore it is important to consider their applicability in other countries and cultures.

Research into associations between PRF and parenting quality or offspring outcomes provides theoretical support for parenting interventions that have a core aim of increasing PRF. For example, PRF has been linked to more sensitive caregiving, positive parenting skills and parental satisfaction (Borelli, West, Decoste, & Suchman, 2012; Rostad & Whitaker, 2016). It also appears to be a key factor in the development of a secure attachment between child and caregiver, and therefore impacts a child's ability to develop a sense of self (Fonagy & Target, 1998; Ensink, Normandin, Plamondon, Berthelot, & Fonagy, 2016). High PRF is associated with better offspring social and cognitive developmental outcomes (Ensink, Begin, Normandin, & Fonagy, 2017; Laranjo, Bernier, Meins, & Carlson, 2010), whereas, low PRF is associated with offspring emotional and behavioural difficulties (Camoirano, 2017; Ensink, Begin, Normandin, Godbout, & Fonagy, 2017). In a narrative review of the literature, Camoirano (2017) reported evidence that PRF has a strong influence on quality of caregiving, attachment security, emotion regulation and child's RF ability. Again, this research has predominantly been conducted in western cultures therefore limiting the validity of these findings across cultures.

PRF is a mental activity that can be effortful and therefore is likely to decrease in conditions of stress (e.g. due to interpersonal conflict, financial strain and loss; Fonagy & Target, 1997). Being a parent is an inherently stressful role, and therefore PRF is likely to fluctuate. PRF might allow parents to respond to difficult behaviour whilst also considering the emotional wellbeing of the child (Cooper & Redfern,

2015). Parenting stress has been found to negatively affect the ability to mentalize (Nolte et al., 2013), as well as mediate the association between maternal history of maltreatment and parental sensitivity (Pereira et al., 2012). A higher baseline PRF can lead to a greater likelihood of remaining emotionally regulated during times of difficulty (Fonagy, Gergely, & Jurist, 2018), and has been related to lower levels of perceived parenting stress (McMahon & Meins, 2012). Therefore, interventions aimed at increasing PRF are theorised to have a multitude of beneficial effects for parent and child, especially those who are living in conditions of stress.

In spite of the potential benefit of parenting interventions, that have a core aim of increasing PRF, there is not currently a systematic review that draws together the evidence of group delivered mentalization-based parenting interventions. There are however two previous relevant reviews that have looked at mentalization-based interventions with children and families. Barlow, Sleed and Midgley (2021) found a non-significant improvement in PRF following mentalization-informed interventions (individual and group formats) with parents with children aged 0-36 months old. Byrne and colleagues (2020) conducted a systematic review of mentalization-based interventions aimed at parents, children and/or adolescents and concluded that there was tentative support. Although these reviews alone do not deliver clear conclusions about the efficacy of mentalization-based parenting groups, they offer some provisional support for mentalization-based interventions for parents, children and adolescents. Neither of the reviews focus on the parenting group literature specifically, and therefore do not summarise the content and method of delivery involved in current group delivered mentalization-based parenting interventions.

Therefore, a systematic review that focused purely on group delivered mentalization-based parenting interventions would be a useful addition to the

literature in that it would provide information about the current content and design of group work in this area, and also synthesise the evidence about the efficacy of such groups. Group delivered parenting interventions have long been identified as a means of improving children's emotional and behavioural outcomes in a cost-effective manner, whilst also normalising experiences and creating opportunities for parental peer support (Furlong et al., 2012). The original MBT protocol for individuals with Borderline Personality Disorder involved both individual and group sessions. A main mechanism of change targeted in MBT are intersubjective transactions, and therefore the group element of mentalization-based interventions is important (Karterud, 2015). A group format allows for many of these transactions with a range of different people other than just between parent and therapist.

This systematic review goes beyond the scope of previous reviews by focusing solely on group delivered mentalization-based parenting interventions for parents with children aged 0 to 18 years old. The specific aims were to: (1) Consider the nature of the mentalization-based parenting groups currently described in the literature, in terms of similarities and differences in the group content and delivery, and target populations; (2) Describe and examine the quality of the quantitative research on mentalization-based parenting group interventions; (3) Synthesise the evidence for the efficacy of mentalization-based parenting groups in terms of improvement in PRF and other relevant outcomes for the parent, child and parent-child interactions.

Method

The review follows the guidance outlined in the Preferred Reporting Items for Systematic Reviews and Meta-analysis (PRISMA) group (Moher, Liberati, Tetzlaff,

& Altman, 2010, 2010) and was registered on the International prospective register of systematic reviews (PROSPERO, 2021, CRD42021210062).

Search Strategy

Following initial searches, search terms were refined and were used on three electronic databases; PsycINFO, MEDLINE and Web of Science. The terms used were 'MBT' or 'mentalization' or 'mentalization-informed' combined with 'parenting' or 'parent' or 'parents' or 'adoptive' or 'expectant' or 'foster' or 'surrogate' or 'fathers' or 'mothers' or 'carer' or 'caregivers' or 'care giver'. Searches were conducted for papers published for the entire time periods for which the databases are available and up until April 2021.

Inclusion and exclusion criteria

Due to the limited number of published studies in the field, no specific control group was specified, therefore a mixture of experimental and quasi-experimental studies were included. All studies included were: peer-reviewed published journal articles; studies that evaluated the outcomes of a parenting intervention ("parenting intervention" for the purpose of this review included those aimed at biological and/or non-biological parents/carers); delivered in a group format; had been developed based on mentalization theory therefore aiming to improve parents ability to mentalize; and aimed at parents with children aged less than 18 years. Only studies that used at least one validated standardised outcome measure related to the parent's ability to mentalize or parental reflective functioning were included. In addition, only studies available in English were included and book chapters and single case designs were excluded.

Study selection

Figure 1 outlines the process of study selection. Searches of the relevant databases obtained 661 records with a further 3 records identified through reference lists of identified papers. 515 records remained after duplicates were removed, and the author screened titles and abstracts. 457 records were excluded, leaving 58 records that were screened following review of the full text.

Figure 1

PRISMA flowchart of included studies.

Identification

Records identified through database searching
(n = 661)

Additional records identified through other sources
(n = 3)

Screening

Records after duplicates removed
(n = 515)

Titles and abstracts screened for eligibility
(n = 515)

Records excluded
(n=457)

Eligibility

Full-text articles assessed for eligibility
(n =58)

Full-text articles excluded (n=48), with one or more of the following reasons:

Full text not available in English (n=13)

Single case design or case series (n=5)

Article only described intervention (n=11)

Aimed at parents of children aged over 18 (n=1)

Full paper unavailable (n=2)

Included

Studies included in narrative synthesis
(n=10)

Data Extraction

The researcher extracted data from the selected papers with 30% of data cross checked by an independent rater. Data extracted included: title; authors; year; study location; sample size and effect size; attrition rate; study design; measures; intervention characteristics (duration, timing, frequency, group size, mode of delivery, description of intervention, control group); participant demographic information (e.g. age, gender, type of parent); outcome measures (primary and secondary outcomes), data analysis (type of analysis used) and intervention effects (results).

Quality Assessment

Study quality was assessed using The Evaluation of Public Health Practice Projects (EPHPP; Ciliska, Miccouci and Dobbins, 1998) quality assessment which is a standardised evaluation tool that been used widely to assess health interventions (See Appendix B). The tool assesses six methodological dimensions: selection bias; study design; confounders; blinding; and withdrawals and dropouts. The tool gives guidance to assign each aspect a rating of strong, moderate or weak. The ratings from these aspects are combined to calculate a global rating of strong (no weak ratings), moderate (one weak rating) or weak (two or more weak ratings). The tool assesses two further methodological dimensions including intervention integrity and statistical analysis quality; these are not included in the global rating.

Results

The main findings and details of the 10 studies that met the inclusion criteria are presented in Table 1. Three of these studies examined the efficacy of Family Minds a Mentalization-based psychoeducation program for foster parents. Three

studies investigated the efficacy of New Beginnings a group Psychotherapy program for mothers in prison or experiencing homelessness. The remaining papers investigated the efficacy of: a Reflective Fostering Programme, a group based program to support Foster Carers; a mentalization based group intervention for parents with a child with a diagnosis of Autism Spectrum Disorder; Nurture and Play, a Mentalization-based perinatal group; and a group delivered mentalization-based parenting intervention with video feedback. The majority of these studies took place in English speaking countries with four carried out in the United States of America and three in the United Kingdom. The remaining three studies took place in Finland, South Africa and Chile.

Table 1

Sample characteristics, intervention, outcome measures and findings from included studies.

Authors	Sample characteristics	Design	Sample size, % female (parents), Age range and/or mean age of parents/child (years/ months)	Intervention	Outcome Measures	Results
Adkins, Luyten and Fonagy (2018)	USA Foster parents **Ethnicity**: 61% Caucasian, 18% Black, 15% Hispanic **Education**: 84% at least some form of college education	NRCT	**N** = 102 (54 intervention, 48 control) **Female** = 63% **Age range of parents** = 24-71 **Age range of children** = 2-216	Family Minds - Mentalizing psycho-education program	FMSS PRFQ PSI-SF	Significant increase on PRFQ (*d*=.74) in the intervention group compared to control group. Significant increases in all FMSS subscale scores (*d*=1.31) in the intervention group compared to control group. Non-significant trend of improvement on PSI (d=.5) in the intervention group compared to control group.
Adkins, Reisz, Hasdemir and Fonagy (2021)	USA Foster parents **Ethnicity**: 72% Caucasian, 11% Black, 11% Hispanic, 7% Multi-ethnic **Education**: 89% at least some college education	RCT	**N** = 89 (49 intervention, 40 control) **Female** = 60% **Age range of parents** = 22-76 **Age range of children** = 1–210	Family Minds - Mentalizing psycho-education program	PRFQ RF-FMSS PSI-SF SDQ	Significant increase in reflective functioning (d=.85) in the intervention group compared to control group. Post-test differences between groups were significant for the PSI-SF subscale Child Dysfunctional Interaction (d=.58). No significant change on SDQ.
Bain (2014)	South Africa Mothers living in a homeless shelter **Ethnicity**: Not reported **Education**: 31% completed school, 18% some form of tertiary education	RCT	**N** = 22 (16 intervention, 6 control) **Female** = 100% **Age range of parents** = 18-43 **Age range of children** = 0-30	New Beginnings	PDI K10 GMDS EA Scales	Significant improvement in speech development in intervention group compared to control group. No significant effects of the programme on infant's level of responsiveness and maternal RF.

Authors	Sample characteristics	Design	Sample size, % female (parents), Age range and/or mean age of parents/child (years/ months)	Intervention	Outcome Measures	Results
Bammens, Adkins and Badger (2015)	USA Foster/ adoptive parents **Ethnicity**: Not reported **Education**: Not reported	NRCT	**N** = 31 (18 intervention, 13 control) **Female** = 61% **Mean age of parents** = 44 (Intervention), 42 (Control) **Mean age of children** = 70 (Intervention), 65 (Control)	Family Minds programme	FMSS	Significant increase in RF on FMSS in intervention group compared to control group.
Baradon, Fonagy, Bland, Lenard and Sleed (2008)	UK Mothers in prison **Ethnicity**: 53% Black African, 27% White British, 20% Asian **Education**: Not reported	Observational (No control)	**N** = 27 **Female** = 100% **Age range of parents** = 19-40 **Age range of children** = 0-10	New Beginnings	PDI	Significant increase in mean overall level of RF from pre- to post-intervention.
Enav et al. (2019)	USA Parents with a child with ASD **Ethnicity**: 51% Caucasian, 31% Asian, 5% Hispanic, 11% Other, 2% Missing **Education**: Not reported	NRCT	**N** = 64 (36 intervention, 28 control) **Female** = 81% **Age range of parents** = 31-64 **Age range of children** = 36-216	Group for parents of children with ASD (Unnamed)	PDI ITE ERQ CBCL PSOC	Significant improvement on parental RF (d=.79) in intervention group compared to control group. Significant increase in ITE (d=.41) in intervention group compared to control group. Significant reductions in CBCL (d=.13–.33) in intervention group compared to control group. Significant increase in PSOC (d=.37) in intervention group compared to control group. No significant change on ERQ in either group.

Authors	Sample characteristics	Design	Sample size, % female (parents), Age range and/or mean age of parents/child (years/ months)	Intervention	Outcome Measures	Results
Midgley et al. (2019)	UK Foster parents **Ethnicity**: 96% White, 4% Other **Education**: 43% school level education, 14% ALevel or equivalent, 14% Vocational training, 18% University degree, 11% Postgraduate degree	Observ-ational (No control)	**N** = 28 **Female** = 86% **Mean age of parents** = 52 **Mean age of children** = 106	Reflective Fostering Group	PRFQ PSI-SF RFQ BP-SES SDQ BAC-C ERC	Significant reduction on PSI-SF (d=.56) from pre- to post-intervention. Significant reduction on SDQ (d=0.3) from pre- to post-intervention. Significant reduction on BAC-C (d=0.29) from pre- to post-intervention. No significant reduction on PRFQ, RFQ and Brief Parental Self-efficacy scale. No significant reduction on ERC.
Salo et al. (2019)	Finland Pregnant women with depressive symptoms **Ethnicity**: Not reported **Education**: 60% low education (primary and high or trade school), 40% high education (university and doctoral degrees)	RCT	**N** = 45 (24 intervention, 21 control) **Female** = 100% **Age range or mean age of parents** = Not reported **Age range or mean age of children** = At recruitment between 22 and 31 gestational weeks	Mentalization-based perinatal group intervention, Nurture and Play (NaP)	EPDS MIM EA Scales PI PDI Narratives coded for reflective functioning	Maternal availability ($\eta2 = 0.24$) and maternal sensitivity ($\eta2 = 0.18$) significantly improved in intervention group compared to control group. Significant increase in RF ($\eta2 = 0.4$) in intervention group compared to control group. Mother's depressive symptoms significantly reduced ($\eta2 = 0.11$) in intervention group compared to control group. No change on maternal hostility.
Sieverson et al. (2021)	Chile Mothers of preschool children	NRCT	**N** = 50 (22 intervention, 28 control) **Female** = 100%	Preventative mentalization-based intervention with video feedback	EMSCQ PICCOLO	Less parental stress in the intervention group compared to control group. Higher number of references to mental states and more references to cognitions and emotions

Authors	Sample characteristics	Design	Sample size, % female (parents), Age range and/or mean age of parents/child (years/ months)	Intervention	Outcome Measures	Results
	Ethnicity: Not reported		**Mean age of parents** = 30		PSI-SF	in intervention group compared to control group.
	Education: 8% Primary complete/ incomplete, 14% Secondary incomplete, 42% Secondary complete, 22% University incomplete, 10% University complete		**Mean age of children** = 45		ASQ-SE	
Sleed, Baradon and Fonagy (2013)	UK	RCT	**N** = 163 (88 intervention, 75 control)	New Beginnings	PDI	Significant increase in PRF in intervention group compared to control group.
	Mothers in prisons		**Female** = 100%		CES-D	
	Ethnicity: 54% White, 32% Black, 6% Asian, 7% Mixed, 1% Other		**Age range of parents** = 18-42		MORS	No significant difference on maternal depression or self-reported representations of their babies over time.
	Education: 39% no qualifications, 26% Basic, 23% Further, 5% Higher, 7% Missing		**Age range of children** = 0-23		CIB	

Key: NRCT (Non-Randomised Control Trial); RCT (Randomised Control Trial); FMSS (Five-minute Speech Sample); PRFQ (Parental Reflective Functioning Questionnaire); PSI-SF (Parenting Stress Inventory – Short form); RF-FMSS (Reflective Functioning Five-Minute Speech Sample); SDQ (Strengths and Difficulties Questionnaire); PDI (The Parental Development Interview); K10 (Kessler Psychological Distress Scale); GMDS (Griffiths Scales of Mental Development); EA Scales (Emotional Availability Scales); ITE (Implicit Theories of Emotion scale); ASD (Autism Spectrum Disorder); ERQ (Emotional Regulation Questionnaire); CBCL (The Child Behaviour Checklist); PSOC (Parenting Sense of Competency Scale); RFQ (Reflective Functioning Questionnaire); BP-SES (Brief Parental Self-Efficacy Scale); BAC-C (Brief Assessment Checklist for Children); ERC (Emotion Regulation Checklist); EPDS (Edinburg Postnatal Depression Scale); MIM (Marschak Interaction Method); PI (The Pregnancy Interview); EMSCQ (The Evaluation of the Mentalization of the Significant Caregivers Questionnaire); PICCOLO (Parenting Interactions With Children: Checklist of Observations Linked to Outcomes); ASQ-SE (The Ages and Stages Questionnaire–Social-Emotional); CES-D (The Center for Epidemiologic Studies Depression Scale); MORS (The Mother's Object Relations Scales); CIB (Coding Interactive Behavior).

Intervention characteristics

In the ten studies that met inclusion criteria, six different group delivered mentalization-based parenting interventions were evaluated. The characteristics of these interventions are described below.

Size and length of group

Table 2 shows the different group interventions in relation to the number of sessions, length of sessions, length of intervention and the number of parents attending each group. The number of sessions varied from 3 to 12 and the mean number of sessions was 8.8. Sessions lasted between 1.5 and 3 hours, and the number of parents per session varied between 6 and 20. The number of hours per intervention ranged from 9 to 30 with an average of 13.95. In two of the interventions, infants are present throughout the intervention sessions.

Table 2

Interventions in included papers

Intervention	Number of sessions	Length of sessions	Length of intervention	Number of parents per group	Child present
Family Minds	3	3 hours	4-6 weeks	Between 10 and 20	No
New Beginnings	8	2 hours	4 weeks	6- 16	Yes
	12	1.5 hours			
Mentalization-informed group for parents of children with ASD	4	1.5 hours	4 weeks	8-10	No
Reflective Fostering Programme	10	3 hours	10 weeks	6-10	No
Nurture & Play	11	1.5 hours	Information not provided	Information not provided	Yes
Mentalization-based group parenting intervention with video feedback	5	2 hours	5 weeks	Information not provided	No

Settings

The ten studies were conducted across a variety of settings. In the three studies that evaluated the Family Minds intervention, the group's participants were recruited through Child Protection Services (the state authority for foster children in the USA) and child placing agencies in Texas. Similarly, the Reflective Fostering Programme (Midgley et al., 2019) was also delivered to foster parents who were referred by their social workers from two local authorities in the UK. There were three papers that evaluated the New Beginnings programme, and all took place in settings where there would be a high risk of child protection concerns; two in Mother and Baby Units (MBU) in UK prisons (Baradon et al., 2008; Sleed et al., 2013) and one across two homeless shelters in South Africa (Bain, 2014). The other four studies were conducted in what could be described as more general community based settings such as local clinics, schools and kindergartens (Enav et al., 2019; Salo et al., 2019; Sieverson et al., 2021).

Facilitators

There was variation across studies in terms of the facilitators of the interventions. In the papers evaluating the Family Minds intervention where facilitator information was provided, all facilitators had training in mentalization-based interventions, but varied in terms of being academic researchers or individuals with experience of working in social care settings (Adkins et al., 2018; Adkins et al., 2021). Midgley and colleagues (2019) was the only paper stating that the programme was designed to be delivered by social care professionals as opposed to mental health specialists.

In the papers evaluating the New Beginnings intervention in UK prisons facilitators had psychodynamic training and therapeutic experience. In the other study evaluating New

Beginnings (Bain, 2014) four Psychologists with a minimum of 8 years clinical practice and experience working with parent-infant dyads facilitated the intervention. They had not previously run parent-infant groups but received regular supervision from the program developer. Similarly, Sieverson et al. (2021) reported that two psychologists with clinical experience and/or postgraduate qualifications facilitated the intervention. In the remaining studies, Enav et al. (2019) stated that "trained clinicians" facilitated the intervention and Salo et al. (2019) did not provide details of facilitators.

Content

Family Minds is designed as a mentalizing psychoeducation program for foster carers whom are likely to be caring for children who have experienced varying degrees of developmental trauma. The programme includes information on trauma, attachment, behaviour, emotions, sensitive and reflective parenting and education on the importance of mentalizing. Although described as a psychoeducational programme, the intervention involves experiential group exercises that progress from general mentalizing activities to more specific tasks involving mentalizing the child. Parents are also encouraged to examine their own responses and reactions to their children. The intervention involves at-home parent and child activities designed to build mentalizing skills.

The New Beginnings program is a psychotherapy group for mother-infant dyads. It is described as a learning and experience-based program originally developed to address early attachments between mothers and babies in prison. It is designed to work directly with the infant's attachment needs through mirroring emotional states, verbalising experiences and creating opportunities for intersubjectivity and connectedness between parent and infant. In

addition, the programme aims to address intergenerational patterns of difficult attachments. It covers subjects including pregnancy, family tree of the infant, perception of the baby, experiences of motherhood, and mother's representation of her own childhood. Mothers are encouraged to notice the infant throughout, and understand their communications. Handouts and worksheets are used, and homework tasks set following each session.

Enav et al. (2019) evaluated a mentalization-based group for parents of children with Autism Spectrum Disorder (ASD). The sessions involved information about emotions, emotion regulation, mentalization strategies and content relevant to the challenges of parenting a child with ASD. The intervention involved a PowerPoint presentation with information, discussion and practice of strategies. Handouts and homework tasks were also given. Homework tasks involved parents sharing and discussing with the group an emotionally intense experience with their child in a structured format.

The Reflective Fostering Programme (Midgley et al., 2019) was developed by the Anna Freud National Centre for Children and Families (AFNCCF). It builds on the Reflective Parenting model (Cooper & Redfern, 2016) and promotes reflective functioning in relation to the self and child while considering ways of managing emotions and stress. It also aims to provide foster parents with practical strategies to help them to build supportive relationships with their foster children.

The Nurture and Play intervention (Salo et al., 2019) involves four pregnancy sessions before the child is born and seven sessions following the birth of the baby. The intervention involves theraplay activities to promote physical touch and joint attention such as singing, playing instruments, rhythmic movements and baby massage. In addition, in each session a topic

is chosen for mothers to reflect on such as pregnancy, childhood history or experience of being a mother. Mentalizing techniques to enhance understanding of mother and infant interactions are used such as the pausing technique, active and explicit acknowledging of feelings, and how to stop non-mentalizing. Cognitive and affective regulation techniques are also incorporated to improve mothers' depressive mood. Homework diaries are also given to encourage thinking and feeling towards the child as well as coping with emotions.

The mentalization-based group parenting intervention with video feedback (Sieverson et al., 2021) is a five session, mothers only group delivered in a non-clinical setting. It is the only paper evaluating an intervention that was developed in a non-western country. The first two sessions involve psychoeducation about mentalization and communication, the third and fourth are described as video feedback sessions called 'Recognising us' and 'Difficult moments' and the fourth session a psychoeducation session called 'Keep the mind in mind'. It is unclear from the paper what the content of videos shown to mothers was, but it appears likely it was a pre-recorded video of a parent and child not a recording of a group participant. The aim of the intervention is to understand and promote mentalization, identify different levels of perception (internal and external), reflect and improve communication of ones own mental states, improve perception of other's thoughts and feelings, and practice responses to promote mentalization.

Participants

Across the ten studies there was a total of 629 participants. Of the parents who participated, approximately 17% were male and 83% female, and parents ranged in age from 18 to 76 years old. In five studies, only females participated. The age of the child or children that parents were caring for ranged from in utero to 18 years old, with the mean age of the child

below 10 years in all 10 studies. The predominant ethnicity in studies was White, with the exception of Baradon and colleagues (2008) paper evaluating the New Beginnings intervention in UK prisons, where the highest reported ethnicity was Black. Other reported ethnicities included Asian, Hispanic and mixed ethnicity (See Table 1 for further details).

There was variation in terms of level of education across the studies. From the information reported it appears that the majority of foster parents who received the Family Minds intervention in the USA had at least some form of university education. However, information regarding the education level of participants was not reported in one study where Family Minds was evaluated (Bammens et al., 2015). In contrast participants who took part in the New Beginnings intervention tended to have a lower level of education, with only 18% having some level of tertiary education in one study, and 5% having a university education in the other. In the other studies, the proportion of university-level educated participants ranged from 22% to 40%.

Quality Assessment

Table 3 provides an overview of the quality ratings given to the included studies using the Effective Public Health Practice Project (EPHPP; Ciliska, Miccouci and Dobbins, 1998) quality assessment tool. An independent assessor, a postgraduate doctoral student, reviewed 30% of included papers and was blinded to quality assessment ratings given by the first author. Global ratings of study quality made by the second reviewer matched those made by the first author in all instances (100% agreement). Discrepancies on individual dimensions of the tool were discussed and resolved.

One study had an overall quality rating of strong, six were moderate and three were weak. All were retained for further analysis due to the limited number of published studies and in

order to provide a comprehensive overview of the available evidence. In four studies participants self-selected to take part and were therefore rated weak in terms of selection bias. In five studies participants were recruited through a clinic or agency so were rated moderately and in only one study were participants selected from a pool of target population participants. All studies were rated as strong or moderate in design, this will be examined in more detail below. Seven studies controlled for potential confounding factors. Three studies did not provide a description of this and were therefore given a weak quality rating for this dimension. Only one of the included studies described adequate blinding of participants and assessors. In three of the studies blinding of participants did not occur as participants self-selected whether to take part in the intervention or control condition. These studies were therefore rated weak. In the remaining six studies blinding was not described and therefore in line with the quality assessment tool, these studies received a moderate rating. All studies appeared to use appropriate statistical methods to analyse the data and were therefore rated strongly. There was variation in terms of withdrawals and dropouts that will be discussed in more detail below.

In terms of treatment adherence, eight out of the ten studies reported the number of participants receiving the intended treatment dose, being 80-100% in five of the studies (Adkins et al., 2018; Bammens et al., 2015; Midgley et al., 2019; Salo et al., 2019; Sleed et al., 2013) and 60-79% in three studies (Enav et al., 2019; Bain, 2014; Adkins et al., 2021). Bammens et al. (2015) was the only paper that included a fidelity assessment. Finally, no study reported that power calculations had been conducted to determine the required sample size, but in one paper it was acknowledged that the high dropouts led to the study being underpowered (Adkins et al., 2021).

Table 3

Quality ratings for the included studies using the Effective Public Health Practice Project (EPHPP) quality assessment tool.

Study	Global Rating	Selection Bias	Study Design	Confounders	Blinding	Data Collection	Withdrawals & Dropouts
Adkins et al. (2018)	Weak	Weak	Moderate	Strong	Weak	Strong	Strong
Adkins et al. (2021)	Weak	Weak	Strong	Strong	Strong	Strong	Weak
Bain (2014)	Moderate	Moderate	Strong	Weak	Moderate	Strong	Strong
Bammens et al. (2015)	Weak	Weak	Moderate	Weak	Weak	Strong	Strong
Baradon et al. (2008)	Moderate	Moderate	Moderate	Weak	Moderate	Strong	Moderate
Enav et al. (2019)	Moderate	Weak	Moderate	Strong	Moderate	Strong	Strong
Midgley et al. (2019)	Moderate	Moderate	Moderate	Strong	Weak	Strong	Strong
Salo et al. (2019)	Strong	Moderate	Strong	Strong	Moderate	Strong	Strong
Sieverson et al. (2021)	Moderate	Moderate	Moderate	Strong	Moderate	Strong	Weak
Sleed et al. (2013)	Moderate	Strong	Strong	Strong	Moderate	Strong	Weak

Study design

Four of the reviewed studies used Randomised Control Trial designs (Adkins et al., 2021; Bain, 2014; Salo et al., 2019; Sleed et al., 2013). Only one used an active control group (Adkins et al., 2021) whereas the other three used 'treatment as usual' or 'waiting list controls'. Four studies (Adkins et al., 2018; Bammens et al., 2015; Enav et al., 2019; Sieverson et al., 2021) were designed as Non-Randomised Control Trials with two using an active control group

(Adkins et al., 2018; Bammens et al., 2015). The remaining two papers used an observational design taking measures pre and post intervention (Baradon et al., 2008; Midgley et al., 2019).

In terms of attrition and drop out, four studies (Adkins et al., 2018; Bammens et al., 2015; Enav et al., 2019; and Salo et al., 2019) had attrition rates between 0 and 20%. Three had an attrition rate between 21% and 40%; Bain (2014), Baradon et al. (2008) and Midgley et al. (2019). Three studies had attrition rates of over 40% (Adkins et al., 2019; Sieverson et al., 2021; Sleed et al., 2013). Studies varied in their explanations for drop out, but it appeared for many that it was difficult to reach all participants to conduct assessment following the initial intervention phase. It is noteworthy that studies evaluating the New Beginnings programme in prisons often lost participants due to movement of participants between or out of prisons. Factors weighing against drop out were the inclusion of highly motivated participants (e.g. in one of the Family Minds studies with low attrition, participants could choose whether to take part in the control or intervention group).

Outcomes

Across the studies a total of 25 different outcome measures were used. There tended to be some similarities across measures used to assess Parental Reflective Functioning (PRF) but less so in measures of other parental and child outcomes.

Reflective Functioning outcomes

All studies included a measure of PRF or mentalizing capacity. The most commonly used measure of PRF was the Parental Development Interview (PDI; Aber et al., 1985) coded for RF (Slade et al., 2004). This was used in five of the 10 studies reviewed. In four of these studies, significant increases in Reflective Functioning were found following the intervention and/ or

32

compared to control groups. The only non-significant result was Bain's (2014) study. In contrast, other studies of the New Beginnings intervention reported significant improvements in PRF following the interventions (Baradon et al., 2008; Sleed et al., 2013). Enav et al. (2019) found significant improvement in PRF following their mentalization-based parenting group for parents with a child with ASD. All of these papers were rated as moderate in quality. Salo et al. (2019), in the only paper given a strong quality rating, also found significant improvements in PRF following the Nurture and Play intervention compared to controls, with a large effect size.

The Parental Reflective Functioning Questionnaire (PRFQ; Luyten et al.; 2017) was used in three studies. In two of the studies evaluating the Family Minds programme for foster carers significant differences in PRF were found between the intervention and control groups with large effect sizes (Adkins et al., 2018; Adkins et al., 2021). Adkins et al. (2018) found that the increase was clearest on the 'Certainty in Mental States' and the 'Interest & Curiosity' in Mental States subscales. Midgley at al. (2019) found no significant change in PRF on the PRFQ pre and post the Reflective Fostering Programme intervention. It is noteworthy that the two studies that did find a significant improvement were rated as low in quality whereas the study with non-significant findings was rated moderately.

All of the studies assessing the Family Minds intervention used the Five Minute Speech Sample (FMSS; Gottschalk and Gleser 1969) coded for Reflective Functioning to measure PRF. In the papers by Adkins et al. (2018) and Adkins et al (2021) this was in addition to the PRFQ. In both papers, significant increases in PRF scores were found for the intervention groups. In the paper by Bammens et al. (2015) the FMSS was the only measure used, with significant increases in PRF reported following group delivered mentalization based therapy. These three papers were rated weak in terms of quality therefore findings should be interpreted with caution.

The final measure used to assess PRF or mentalizing capacity, was the evaluation of the Mentalization of the Significant Caregivers Questionnaire (Farkas et al., 2017). This was used by Sieverson et al. (2021) in a study that received a moderate quality rating. They found higher number of references to mental states in the intervention group compared to the control group, therefore suggesting higher PRF. This measure has been validated but less widely used to assess mentalizing.

In summary, out of the 10 studies included in the review, eight found that the interventions led to a significant increase in PRF, of which one was rated strong in quality, four moderate and three weak. Two studies found a non-significant improvement on comparisons between pre and post outcome measures or compared to control groups and were rated moderate in quality.

Parental outcomes

Of the 10 studies that met the inclusion criteria, eight included measures related to parental outcomes (not including PRF). The most commonly used measure was the Parenting Stress Inventory-Short Form (PSI-SF; Abidin, 1995) that was used in four studies. In two studies rated as moderate in quality, significant reductions in parenting stress were observed. One of these studies was uncontrolled (Midgley et al., 2019) and the other included a control group (Sieverson et al., 2021). In contrast, Adkins and colleagues (2018) did not observe significant reductions in parenting stress in their study and Adkins and colleagues (2021) only found a significant improvement on one of the PSI-SF subscales (Child Dysfunctional Interaction). These two papers were rated as weak in quality. Therefore, there is mixed evidence for reduced parenting stress following group delivered mentalization-based parenting interventions.

In three studies, parental anxiety and/or depression was assessed. In one study that used the Edinburgh Postnatal Depression Scale (EPDS; Murray & Cox, 1990) significant reductions in depressive symptoms were observed in intervention group compared to the control group (Salo et al. 2019). In contrast, Bain (2014) used the Kessler-10 (Kessler et al., 2002) to assess maternal anxiety and depression and did not find significant improvements in maternal depression and anxiety at post-treatment. Similarly, Sleed, Baradon and Fonagy (2013) did not find a significant improvement in parental depressive symptoms using The Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977) to assess parental depression. In summary, these findings, from strong and moderate quality papers, found minimal evidence for consistent improvements in parental anxiety and depression following group delivered mentalization-based parenting interventions.

Three studies measured parental emotion understanding and regulation. The Implicit Theories of Emotion (ITE; Tamir et al., 2007) scale was used by Enav and colleagues (2019) who reported a significant increase in ITE scores in the intervention group compared to the control group, however no significant improvements in emotion regulation (Emotional Regulation Questionnaire, ERQ; Gross & John, 2003). Midgley and colleagues (2019) used the Emotion Regulation Checklist (ERC; Shields & Cicchetti, 1997) and found no significant reduction between pre and post intervention scores. Therefore, findings from these two moderate quality rated papers provide no evidence for improvements in parental emotional regulation, and limited evidence for improvements in parental emotional understanding following participation in group delivered mentalization-based parenting interventions.

Finally, two studies assessed parental sense of competency and self-efficacy. Enav and colleagues (2019) used the Parenting Sense of Competency Scale (Gibaud- Wallston &

Wandersmann, 1978). In this study, parents in the intervention group reported an increased sense of competency compared to the waitlist control group at the post-treatment assessment (Enav et al., 2019). In contrast, Midgley and colleagues (2019) used the Brief Parental Self-Efficacy Scale (Woolgar, Unpublished) and found no significant change in participants' scores pre and post intervention. Therefore, in these studies of moderate quality, there is mixed evidence regarding the impact of interventions on these parental outcomes.

Parent-Child Interaction outcomes

Three of the included papers included measures of parent-child interactions. The Emotional Availability Scales (EA; Biringen et al., 1998), which measure parents' perceptions of the quality of interactions between parent and child, was used in two studies. Both studies reported significant improvements in parent rated emotional availability following participating in a mentalization based parenting intervention (Bain, 2014; Salo et al., 2019). The Mother's Object Relations Scale (MORS; Milford & Oates, 2009) is a screening tool used to identify potential problems in early mother-infant relationships. Sleed and colleagues (2013) used this measure and found no significant differences between control and intervention groups at post-treatment. In addition, Sleed and colleagues (2013) used the Coding Interactive Behaviour scales (CIB; Feldman, 1998) to analyse observed parent-child interactions. This study found mentalization-based treatment produced significant increases in dyadic attunement and parent positive engagement compared to the control group. In summary, for the studies that measured parent-child interaction outcomes, most reported improvements in the quality of the parent-child relationship following engagement in group delivered mentalization-based parenting interventions.

Child outcomes

Four out of the ten studies directly measured outcomes for the child. In two studies, the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997) was used. Adkins and colleagues (2021) found no significant difference on the SDQ total and subscale scores at post-treatment. In contrast, Midgley and colleagues (2019) found a significant reduction on the "Emotional Problems" SDQ subscale following engagement in a mentalization based parenting programme. Similarly, the Child Behaviour Checklist (CBCL; Achenbach & Edelbrock, 1983) was used by Enav and colleagues (2019) and they found significant reductions in parent-rated child difficult behaviour at post-treatment. It is of note that significant findings were found in two papers of moderate quality and no significant findings in the study with a lower quality rating.

When evaluating the New Beginnings Programme, Bain (2014) used the Griffiths Scale of Mental Development (Luiz et al., 2006) to examine the impact of the intervention on the child. In this study, significant improvements in speech development were observed in children whose mothers had been in the intervention group compared to controls. In keeping, the Brief Assessment Checklist for Children (BAC-C; Tarren-Sweeney, 2013) was used in an evaluation of the Reflective Fostering Programme (Midgley et al., 2019). In this study, foster parents reported significant improvements on the "Emotion Regulation" subscale of this measure. In summary, the majority of studies reporting on child outcomes found some level of improvement in child functioning following the intervention and importantly in studies rated as moderate in quality. However, the outcome measurements used across the included studies were variable and inconsistent, limiting the conclusions that can be drawn from the data.

Discussion

This review considered the available evidence for group delivered mentalization-based parenting interventions. The aims were to provide a summary of the components of the different interventions, assess the quality of the evidence, and examine the efficacy of interventions in terms of improving Parental Reflective Functioning (PRF) and outcomes for the parent, child and parent-child relationship. The systematic literature search identified 10 relevant studies that examined six different interventions across a variety of populations.

The core components of the group delivered mentalization-based parenting interventions

In terms of the components of the mentalization-based parenting interventions, there were both similarities and differences in the way in which the interventions had been designed. The majority of interventions had been developed in western countries with the exception of the intervention described by Sieverson et al. that was conducted in Chile. Therefore, it is unclear if these core components of mentalization-based parenting interventions would apply across different countries and cultures.

It appeared that all interventions involved psychoeducation, although it was not always clear in what format this was provided. Many of the interventions also gave information and allowed space for group discussion on topics relevant to the particular client group (e.g. developmental trauma in groups aimed at foster and adoptive carers; infant development in interventions designed for the perinatal period; and Autism Spectrum Disorder (ASD) for parents with a child with this diagnosis). In addition, the majority of the interventions also appeared to include an experiential element whereby parents practiced techniques or engaged in exercises to encourage mentalizing/ reflective functioning during intervention sessions. In eight of the ten

papers, tasks to be completed at home were included as part of the intervention. These tasks tended to be reflective in nature or involved encouraging parents to engage in an activity with their child.

Reported specific techniques derived from more established mentalization-based treatments in adults included 'Projective Picture Exercise' and 'stopping non-mentalizing' (Allen, Fonagy & Bateman, 2008). In addition, techniques such as 'pausing technique' and 'focusing on the here and now' derived from individually delivered mentalization based treatments for families were also used (e.g., MBT-F; Midgley & Vrouva, 2012). However, these techniques were not consistently reported across interventions. In at least one study, techniques derived from other therapeutic modalities were also included, such as cognitive and affective regulation techniques (Salo et al., 2019). Overall, there were similarities between the groups in terms of content and understandable adaptations depending on the target population. The analysis shows that the group delivered mentalization-based parenting interventions included in this review did not have a clear core battery of techniques. As such, the literature might benefit from guidelines being developed for what should constitute the key components of group delivered mentalization-based parenting interventions.

There was variation in terms of the length of the interventions ranging from 9 to 30 hours. The variation in length did not appear to have an impact on effectiveness. For example, the intervention longest in duration, the Reflective Fostering Programme (Midgley et al., 2019), did not lead to a significant change in PRF, whereas the shortest programme, Family Minds (Adkins et al., 2018; Adkins et al., 2021; Bammens et al., 2015), found significant improvements in PRF across all three studies. Across eight of the 10 studies included in the review, the facilitators had training in mentalization-based interventions although typically, the extent of this

training was not clear. In the study by Midgley and colleagues (2019) it was stated that the intervention was designed to be delivered by facilitators without training in mental health. In this study no significant changes in reflective functioning were found. Therefore, it could be that training in mental health, specifically in mentalization-based approaches, may be an important factor that impacts on intervention effectiveness. Further, only one of the studies included an assessment of facilitator fidelity to the model, which would be an important factor to incorporate into future evaluations of group delivered mentalization-based parenting interventions.

Variability in sample characteristics and target populations

In nine of the ten studies, interventions were targeted at what could arguably be described as specific clinical populations (e.g. foster/ adoptive parents, mothers experiencing perinatal mental health difficulties, mothers in prison, mothers experiencing homelessness or parents with a child with a diagnosis of ASD). Sieverson and colleagues (2021) described the only intervention delivered to a non-clinical population and found increased PRF and decreased parental stress at post-treatment. The use of group delivered mentalization-based parenting interventions for clinical populations is understandable given the association between poorer PRF and adverse outcomes in clinical populations (Camoirano, 2017). However, this review demonstrates that there is a lack of evidence for the efficacy of group delivered mentalization-based parenting interventions in both nonclinical populations, and other more generic populations where mentalization based treatments are of theoretical relevance (e.g. parents of children with emotional or behavioural difficulties).

There was variation across studies in terms of participant characteristics. The number of mothers participating in all intervention studies was much greater than fathers (83% compared to

17%). Therefore, this limits the generalisability of findings to fathers. Of the studies that reported parents' ethnicity, 60% were white and only one study took place in a non-westernised country, which again limits the generalisability of findings across race and cultures. In addition, it is important to understand this generalisability given the white western influences that are likely to have shaped the development of these interventions. Education level of parents was also reported in six of the included studies, and on average 41% had a college or university education. This therefore limits the generalisability of findings to parents with lower educational experience.

Quality of evidence for group delivered mentalization-based parenting groups

The majority of studies included in the review received a moderate quality rating and were conducted using a mixture of randomised and non-randomised controlled designs and uncontrolled pre and post designs. A number of the studies that used a randomised controlled design did not use an active control group, instead using a treatment as usual or waiting list control group. In two studies where an active control group was used, participants self-selected their treatment. Thus, for the majority of studies, it is not clear whether it was the mentalization-based content of the intervention, or other variables (e.g. non-specific therapeutic factors such as peer support and validation) that gave rise to improved outcomes. Further, only two studies conducted a longer-term follow-up (6-12 months) making it difficult to understand long term impacts on PRF. In addition, it may be that effects on parent, child and parent-child relationship outcomes manifest after improvements in PRF are embedded.

The effectiveness of group delivered mentalization based parenting interventions

All studies used PRF as a primary outcome measure, with eight of the 10 studies reporting significant improvements in PRF following engagement in a group delivered

mentalization-based parenting intervention. PRF was assessed via interview (e.g. Parental Development Interview) or self-report questionnaire (e.g. The Parental Reflective Functioning Questionnaire) and was a key mechanism of change targeted by all interventions. These findings are consistent with empirical studies that found increased PRF to have a multitude of benefits for the parents, children and parent-child relationship (Borelli et al., 2012; Rostad & Whitaker, 2016; Ensink et al., 2017; Laranjo et al., 2010). In terms of other outcomes, in line with previous research (McMahon & Meins, 2012), there was a general trend towards reduced parenting stress following participation in a mentalization based parenting programme. Mixed findings were observed for parental depression and anxiety and parental emotional understanding. These findings are somewhat consistent with research that has found higher baseline PRF to be associated with a greater likelihood of remaining emotionally regulated during times of difficulty (Fonagy et al., 2018).

Three of the included studies measured parent-child interaction outcomes and found significant improvements in the parent-child relationship following interventions. Only five of the 10 studies assessed the impact of a group delivered mentalization-based intervention on child focused outcomes, with 4 studies assessing behavioural and emotional outcomes and one study assessing cognitive development. In general results were promising, with the majority demonstrating improvements in children's functioning following parental attendance at a mentalization based parenting programme. However, further research assessing parent-child interaction outcomes and child specific outcomes is needed to strengthen the evidence for group delivered mentalization-based interventions.

The findings of the current study are consistent with those of related reviews that included a range of mentalization-based treatments for children and adolescents (Byrne et al.,

2020), particularly in the area of improved PRF. The current review builds on the findings of previous studies by providing a synthesis of the content and design of group delivered mentalization-based parenting interventions. We extend past research by providing insights into the efficacy of specifically group delivered mentalization based parenting interventions.

Limitations

Methodologically, the findings of the review demonstrate that the evidence base for group delivered mentalization-based parenting interventions is still in its infancy. Particular weaknesses of the current literature include a lack of a clear framework of core content that should be included in a mentalization-based parenting group, lack of randomized controlled trials with an active treatment comparison group, limited long-term follow-up, and a lack of consistency in aims of the interventions (and hence a lack of consistency in outcome measures beyond PRF). The mentalization literature in terms of the concept, measurement and interventions have been focused on western cultures. This therefore limits the findings from these measures for non-white participants in these interventions. Further research is needed to understand the effectiveness of these types of intervention in non-western countries. Aival-Naveh, Rothschild-Yakar and Kurman (2019) suggest that mentalization is a universal skill of importance across cultures, however, they highlight that different dimensions of mentalizing may be more prominent in different cultures. In addition, they identified factors such as linguistics, values and parenting mediated the relationship between culture and mentalizing. Culture is therefore likely to also influence PRF. Therefore there is a need for future research on mentalizing and PRF across cultures with validation of measures and cultural adaptations made were neccesary. This will also be important in future development of mentalization-based parenting interventions.

The current paper provides a thorough review of the current available literature on group delivered mentalization-based parenting group interventions. However, there are some limitations that constrain the conclusions that can be drawn. Only published studies were included in the review so the risk of publication bias is high, as research that did not obtain significant results may not have been published. In addition, only papers available in English were included, which meant a number of potentially relevant papers published in other parts of Europe were not included. In relation to the inclusion criteria for this review, papers were only included if they referred to being "mentalization-based". The concept of what "mentalization-based" means, as noted, varies across the studies and is not clearly defined in the literature. There are other group parenting interventions that could arguably be defined as mentalization-based, but would not have been included if this was not explicitly stated in the research articles. In addition, even those included in the paper described interventions with varying elements, some of which may be seen to fit under different therapeutic modalities.

Clinical implications

Emerging evidence indicates that group delivered mentalization-based parenting interventions may be a beneficial intervention, however further research is needed. There is greater evidence for these types of interventions for parents with children (aged under 10) as opposed to parents of adolescents. Participants in these interventions are predominantly from western cultures, which limits the apllicability of these findings across cultures. The evidence is also currently for specific clinical populations where parents or children are known to have difficulties with emotional understanding and social interaction, and/or where children are

known to have experienced early adversity. Therefore, group delivered mentalization-based parenting interventions are potentially valuable treatment option for many health and social care services.

Future research

There is a need for further research to understand the efficacy of group delivered mentalization-based parenting interventions. This should include analysis of the different elements unique to these interventions including tests of the different mentalization based mechanisms hypothesised to improve parent-child outcomes. It will also be important for treatment fidelity to be assessed in future research and there is a clear need for studies to include longer-term follow-ups (e.g. 1 year and over). Based on the available evidence, we do not know if the initial improvements in PRF are maintained, or whether increased PRF leads to longer-term improvements for parents and children. There is a need for future research to include parents of different races and cultures, studies of fathers, and studies of parents of adolescents to better understand whether there are benefits of group delivered mentalization-based parenting interventions for these populations. Further studies using randomized controlled designs with an active control group would further strengthen the case that specific mentalization-based techniques are efficacious in improving PRF and other parent-child outcomes. It will be important for future studies to consistently examine the impacts on the child, parent and parent/child dyad as opposed to reflective functioning alone. Further, it will be important for a thorough economic analysis of the costs and benefits of group delivered mentalization-based parenting interventions, to inform the development of cost-effective clinical services. It is noted that a randomised control trial of the Reflective Fostering Programme (Midgley et al., 2021) is

also currently underway and the results of this will be important in considering the benefits of group delivered mentalization-based parenting interventions.

Conclusions

The current review examined a range of group delivered mentalization-based parenting interventions that varied in content, length and setting. Interventions varied in terms of content but often included psychoeducation, experiential group exercises and homework tasks. The length and setting of interventions did not appear to influence outcomes. Group delivered mentalization based parenting interventions consistently improve parental reflective functioning and emerging evidence indicates positive benefits for parents and children. Mentalization-based parenting interventions delivered in a group could have wide ranging effects for parents, children and wider society. However, more research using more rigorous designs (e.g. randomised controlled trials with an active treatment control group and long-term follow-up) are needed to test the efficacy and underlying mechanisms of group delivered mentalization based parenting interventions.

References

Aber, J., Slade, A., Berger, B., Bresgi, I., & Kaplan, M. (1985). The Parent Development Interview. Unpublished protocol, The City University of New York.

Abidin, R. R. (1995). Parenting Stress Index (3rd ed.). Odessa, FL: Psychological Assessment Resources.

Achenbach, T. M., & Edelbrock, C. S. (1983). Manual for the child: Behavior checklist and

    revised child behavior profile. Burlington: Department of Psychiatry, University of

    Vermont.

* Adkins, T., Luyten, P., & Fonagy, P. (2018). Development and preliminary evaluation of

    family minds: a mentalization-based psychoeducation program for foster parents. *Journal*

    of Child and Family Studies, *27*(8), 2519-2532. https://doi.org/10.1007/s10826-018-1080-x

* Adkins, T., Reisz, S., Hasdemir, D., & Fonagy, P. (2021). Family Minds: A randomized

    controlled trial of a group intervention to improve foster parents' reflective functioning.

    Development and psychopathology, 1-15. https://doi.org/10.1017/S095457942000214X

Aival-Naveh, E., Rothschild-Yakar, L., & Kurman, J. (2019). Keeping culture in mind: A

    systematic review and initial conceptualization of mentalizing from a cross-cultural

    perspective. *Clinical Psychology: Science and Practice*, *26*(4),

    e12300. https://doi.org/10.1037/h0101757

* Bain, K. (2014). New beginnings' in South Africa shelters for the homeless: Piloting of a

    group psycho- therapy interventions for high-risk mother-infant dyads. *Infant mental*

    health journal, *35*(6), 591-603. https://doi.org.10.1002/imhj.21457

* Bammens, A. S., Adkins, T., & Badger, J. (2015). Psycho-educational intervention increases

    reflective functioning in foster and adoptive parents. *Adoption & Fostering*, *39*(1), 38-50.

    https://doi.org.10.1177/0308575914565069

* Baradon, T., Fonagy, P., Bland, K., Lénárd, K., & Sleed, M. (2008). New Beginnings–an

    experience-based programme addressing the attachment relationship between mothers and

their babies in prisons. *Journal of Child Psychotherapy*, *34*(2), 240-258.

https://doi.org/10.1080/00754170802208065

Barlow, J., Sleed, M., & Midgley, N. (2021). Enhancing parental reflective functioning through

early dyadic interventions: A systematic review and meta-analysis. *Infant Mental Health

Journal*, *42*(1), 21-34. https://doi.org/10.1002/imhj.21896

Bateman, A., O'Connell, J., Lorenzini, N., Gardner, T., & Fonagy, P. (2016). A randomised

controlled trial of mentalization-based treatment versus structured clinical management for

patients with comorbid borderline personality disorder and antisocial personality

disorder. *BMC psychiatry*, *16*(1), 1-11. https://doi.org/10.1186/s12888-016-1000-9

Biringen, Z., Robinson, J.L., & Emde, R.N. (1998). Emotional Availability Scales (3rd ed.).

Unpublished manual, Colorado State University, Department on Human Development and

Family Studies, Fort Collins, CO.

Borelli, J. L., West, J. L., Decoste, C., & Suchman, N. E. (2012). Emotionally avoidant language

in the parenting interviews of substance-dependent mothers: Associations with reflective

functioning, recent substance use, and parenting behavior. *Infant mental health journal*,

33(5), 506-519. https://doi.org/10.1002/imhj.21340

Byrne, G., Murphy, S., & Connon, G. (2020). Mentalization-based treatments with children and

families: A systematic review of the literature. *Clinical Child Psychology and Psychiatry*,

25(4), 1022-1048. https://doi.org/10.1177/1359104520920689

Camoirano, A. (2017). Mentalizing makes parenting work: A review about parental reflective functioning and clinical interventions to improve it. *Frontiers in psychology*, *8*, 14. https://doi.org/10.3389/fpsyg.2017.00014

Ciliska, D., Miccouci, S., & Dobbins, M. (1998). Effective public health practice project. Quality assessment tool for quantitative studies. *Hamilton, On: Effective Public Health Practice Project*.

Cooper, A., & Redfern, S. (2015). *Reflective parenting: A guide to understanding what's going on in your child's mind*. Routledge.

*Enav, Y., Erhard-Weiss, D., Kopelman, M., Samson, A. C., Mehta, S., Gross, J. J., & Hardan, A. Y. (2019). A non randomized mentalization intervention for parents of children with autism. *Autism Research*, *12*(7), 1077-1086. https://doi.org/10.1002/aur.2108

Ensink, K., Bégin, M., Normandin, L., & Fonagy, P. (2017). Parental reflective functioning as a moderator of child internalizing difficulties in the context of child sexual abuse. *Psychiatry Research*, *257*, 361-366. https://doi.org/10.1016/j.psychres.2017.07.051

Ensink, K., Bégin, M., Normandin, L., Godbout, N., & Fonagy, P. (2017). Mentalization and dissociation in the context of trauma: Implications for child psychopathology. *Journal of Trauma & Dissociation*, *18*(1), 11-30. https://doi.org/10.1080/15299732.2016.1172536

Ensink, K., Normandin, L., Plamondon, A., Berthelot, N., & Fonagy, P. (2016). Intergenerational pathways from reflective functioning to infant attachment through parenting. *Canadian Journal of Behavioural Science/Revue canadienne des sciences du comportement*, *48*(1), 9. https://doi.org/10.1037/cbs0000030

Farkas, C., Strasser, K., Badilla, M. G., & Santelices, M. P. (2017). Mentalization in Chilean

    Educational Staff with 12-month-old children: Does it make a difference in relation to what

    children receive at home?. *Early Education and Development*, *28*(7), 839-857.

    https://doi.org/10.1080/10409289.2017.1287994

Feldman, R. (1998) Coding Interactive Behaviour manual. Unpublished manuscript. Israel, Bar-

    llan University.

Fonagy, P., & Bateman, A. (2008). The development of borderline personality disorder—A

    mentalizing model. *Journal of personality disorders*, *22*(1), 4-21.

    https://doi.org/10.1521/pedi.2008.22.1.4

Fonagy, P., Gergely, G., & Jurist, E. L. (Eds.). (2018). *Affect regulation, mentalization and the*

    development of the self. Routledge.

Fonagy, P., Steele, M., Steele, H., Moran, G. S., & Higgitt, A. C. (1991). The capacity for

    understanding mental states: The reflective self in parent and child and its significance for

    security of attachment. *Infant mental health journal*, *12*(3), 201-218.

    https://doi.org/10.1002/1097-0355(199123)12:3<201::AID-IMHJ2280120307>3.0.CO;2-7

Fonagy, P., & Target, M. (1997). Attachment and reflective function: Their role in self-

    organization. *Dev Psychopathol*, *9*(4), 679-700.

    https://doi.org/10.1017/S0954579497001399

Fonagy, P., & Target, M. (1998). Mentalization and the changing aims of child psychoanalysis.

    Psychoanalytic dialogues, *8*(1), 87-114. https://doi.org/10.1080/10481889809539235

Fonagy, P., & Target, M. (2006). The mentalization-focused approach to self pathology. *Journal of personality disorders*, *20*(6), 544-576. https://doi.org/10.1521/pedi.2006.20.6.544

Furlong, M., McGilloway, S., Bywater, T., Hutchings, J., Smith, S. M., & Donnelly, M. (2012). Behavioural and cognitive-behavioural group-based parenting programmes for early-onset conduct problems in children aged 3 to 12 years. *Campbell Systematic Reviews*, *8*(1), 1-239. https://doi.org/10.4073/csr.2012.12

George, C., Kaplan, N., & Main, M. (1985). The adult attachment interview (Unpublished protocol). *Berkeley: Department of Psychology, University of California*.

Gibaud-Wallston, J., & Wandersmann, L. P. (1978). Development and utility of the parenting sense of competence scale. Nashville: John F. Kennedy Center for Research on Education and Human Development.

Goodman, R. (1997). The strengths and difficulties questionnaire: A research note. Journal of Child Psychology and Psychiatry, 38, 581–589. https://doi.org/10.1111/j.1469-7610.1997.tb01545.x

Gottschalk, L. A., & Gleser, G. C. (1969). The measurement of psychological states through the content analysis of verbal behavior. Berkeley, CA: University of California Press.

Gross, J. J., & John, O. P. (2003). Individual differences in two emotion regulation processes: Implications for affect, relationships, and well-being. Journal of Personality and Social Psychology, 85 (2), 348–362. https://doi.org/10.1037/0022-3514.85.2.348

Karterud, S. (2015). *Mentalization-Based Group Therapy (MBT-G): A theoretical, clinical, and research manual*. OUP Oxford.

Kessler, R.C., Andrews, G., Colpe, L.J., Hiripi, E., Mroczek, D.K., Nor-man, S.L. et al. (2002). Short screening scales to monitor population prevalences and trends in non-specific psychological distress. Psychological Medicine, 32, 959–956. https://doi.org/10.1017}S0033291702006074

Laranjo, J., Bernier, A., Meins, E., & Carlson, S. M. (2010). Early manifestations of children's theory of mind: The roles of maternal mind-mindedness and infant security of attachment. *Infancy*, *15*(3), 300-323. https://doi.org/10.1111/j.1532-7078.2009.00014.x

Luiz, D., Faragher, B., Barnard, A., Knoesen, N., Kotras, N., Burns, L.E., & Challis, D. (2006). Griffiths Mental Developmental Scales-Extended Revised: 2 to 8 Years Analysis Manual. Oxford, United Kingdom: Hogrefe.

Luyten, P., Mayes, L. C., Nijssens, L., & Fonagy, P. (2017). The parental reflective functioning questionnaire: Development and preliminary validation. *PloS one*, *12*(5), e0176218. https://doi.org/10.1371/journal.pone.0176218

McMahon, C. A., & Meins, E. (2012). Mind-mindedness, parenting stress, and emotional availability in mothers of preschoolers. *Early Childhood Research Quarterly*, *27*(2), 245-252. https://doi.org/10.1016/j.ecresq.2011.08.002

Midgley, N., Alayza, A., Lawrence, H., & Bellew, R. (2018). Adopting Minds—a mentalization-based therapy for families in a post-adoption support service: preliminary evaluation and service user experience. *Adoption & Fostering*, *42*(1), 22-37. https://doi.org/10.1177/0308575917747816

*Midgley, N., Cirasola, A., Austerberry, C., Ranzato, E., West, G., Martin, P., ... & Park, T. (2019). Supporting foster carers to meet the needs of looked after children: A feasibility and pilot evaluation of the Reflective Fostering Programme. *Developmental Child Welfare*, *1*(1), 41-60. https://doi.org/10.1177/2516103218817550

Midgley, N., Irvine, K., Rider, B., Byford, S., Cirasola, A., Ganguli, P., ... & Wellsted, D. (2021). The Reflective Fostering Programme–improving the wellbeing of children in care through a group intervention for foster carers: a randomised controlled trial: study protocol for a randomised controlled trial. https://doi.org/10.21203/rs.3.rs-345315/v1

Midgley, N., & Vrouva, I. (Eds.). (2013). *Minding the child: Mentalization-based interventions with children, young people and their families*. Routledge.

Milford, R., & Oates, J. (2009). Universal screening and early intervention for maternal mental health and attachment difficulties. Community Practitioner, 82(8), 30–33.

Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. G. (2010). Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *Int J Surg*, *8*(5), 336-341. https://doi.org/10.1136/bmj.b2535

Murray D and Cox JL (1990) Screening for depression during pregnancy with the Edinburgh Depression Scale (EDDS). Journal of Reproductive and Infant Psychology, 8, 99–107. https://doi.org/10.1080/02646839008403615

Nolte, T., Bolling, D. Z., Hudac, C., Fonagy, P., Mayes, L. C., & Pelphrey, K. A. (2013). Brain mechanisms underlying the impact of attachment-related stress on social cognition. *Frontiers in human neuroscience*, *7*, 816. https://doi.org/10.3389/fnhum.2013.00816

Ordway, M. R., Sadler, L. S., Dixon, J., Close, N., Mayes, L., & Slade, A. (2014). Lasting effects

    of an interdisciplinary home visiting program on child behavior: Preliminary follow-up

    results of a randomized trial. *Journal of pediatric nursing*, *29*(1), 3-13.

    https://doi.org/10.1016/j.pedn.2013.04.006

Pereira, J., Vickers, K., Atkinson, L., Gonzalez, A., Wekerle, C., & Levitan, R. (2012). Parenting

    stress mediates between maternal maltreatment history and maternal sensitivity in a

    community sample. *Child abuse & neglect*, *36*(5), 433-437.

    https://doi.org/10.1016/j.chiabu.2012.01.006

Radloff, L. S. (1977). The CES-D scale: A self-report depression scale for research in the general

    population. *Applied psychological measurement*, *1*(3), 385-401.

    https://doi.org/10.1177/014662167700100306

Rostad, W. L., & Whitaker, D. J. (2016). The association between reflective functioning and

    parent–child relationship quality. *Journal of Child and Family Studies*, *25*(7), 2164-2177.

    https://doi.org/10.1007/s10826-016-0388-7

Sadler, L. S., Slade, A., Close, N., Webb, D. L., Simpson, T., Fennie, K., & Mayes, L. C. (2013).

    Minding the baby: Enhancing reflectiveness to improve early health and relationship

    outcomes in an interdisciplinary home-visiting program. *Infant mental health

    journal*, *34*(5), 391-405. https://doi.org/10.1002/imhj.21406

*Salo, S. J., Flykt, M., Mäkelä, J., Biringen, Z., Kalland, M., Pajulo, M., & Punamäki, R. L.

    (2019). The effectiveness of Nurture and Play: a mentalisation-based parenting group

    intervention for prenatally depressed mothers. *Primary health care research &

    development*, *20*. https://doi.org/10.1017/S1463423619000914

Shields, A., & Cicchetti, D. (1997). Emotion regulation among school-age children: The

    development and validation of a new criterion Q-sort scale. Developmental Psychology,

    33, 906–916. https://doi.org/10.1037/0012-1649.33.6.906

*Sieverson, C., Santelices, M. P., Farkas, C., Espinosa, N., Muzard, A., & Gómez, D. (2021).

    Effects of a mentalization-based group intervention with videofeedback for mothers of

    preschool children. *Journal of Infant, Child, and Adolescent Psychotherapy*, 1-14.

    https://doi.org/10.1080/15289168.2021.1879717

Slade, A., Aber, J.L., Bresgi, I., Berger, B., & Kaplan, M. (2004). The Parent Development

    Interview—Revised. Unpublished protocol, City University of New York, New York.

Slade, A., Holland, M. L., Ordway, M. R., Carlson, E. A., Jeon, S., Close, N., ... & Sadler, L. S.

    (2020). Minding the Baby®: enhancing parental reflective functioning and infant

    attachment in an attachment-based, interdisciplinary home visiting program. *Development

    and psychopathology*, *32*(1), 123-137. https://doi.org/10.1017/S0954579418001463

*Sleed, M., Baradon, T., & Fonagy, P. (2013). New Beginnings for mothers and babies in prison:

    A cluster randomized controlled trial. *Attachment & Human Development*, *15*(4), 349-

    367. https://doi.org/10.1080/14616734.2013.782651

Suchman, N. E., DeCoste, C. L., McMahon, T. J., Dalton, R., Mayes, L. C., & Borelli, J. (2017).

    Mothering From the Inside Out: Results of a second randomized clinical trial testing a

    mentalization-based intervention for mothers in addiction treatment. *Development and

    Psychopathology*, *29*, 617–636. https://doi.org/10/1017/S0954579417000220

Suchman, N. E., Ordway, M. R., de las Heras, L., & McMahon, T. J. (2016). Mothering from the

    Inside Out: Results of a pilot study testing a mentalization-based therapy for mothers

    enrolled in mental health services. *Attachment and Human Development*, *18*, 596–617.

    https://doi.org/10.1080/14616734.2016.1226371

Tamir, M., John, O. P., Srivastava, S., & Gross, J. J. (2007). Implicit theories of emotion:

    affective and social outcomes across a major life transition. *Journal of personality and*

    social psychology, *92*(4), 731. https://doi.org/10.1037/0022-3514.92.4.731

Tarren-Sweeney, M. (2013). The Brief Assessment Checklists (BAC-C, BAC-A): Mental health

    screening measures for school-aged children and adolescents in foster, kinship, residential

    and adoptive care. Children and Youth Services Review, 35, 771–779.

    https://doi.org/10.1016/j.childyouth.2013.01.025

Woolgar, M. (Unpublished). The Brief Parental Self-efficacy Scale.

Development of a brief parenting group intervention to improve children's understanding of emotions: A Delphi Study

Sarah Lavender

Manuscript prepared in line with referencing guidance for the journal Parenting: Science and Practice (Appendix A).

Word count: 8184

Abstract

Emotional and behavioural problems in childhood can have a significant impact on a child's wellbeing, health and educational attainment. These difficulties can often persist into adulthood leading to mental health difficulties and criminality. There is evidence to suggest that underlying these problems are difficulties in recognising and understanding emotions, an ability that is thought to develop in the context of the child and caregiver relationship. Therefore, parenting interventions aimed at helping parents to aid their child's emotional understanding could potentially lead to benefits for the child. This study aimed to systematically develop a relevant intervention, following Medical Research Council (MRC) guidance and using a Delphi Survey method technique to gather expert consensus on important elements of the intervention. In Round 1, interviews were conducted with academics and clinicians, parents and child and family practitioners with relevant experience. Themes generated in the areas of practicalities, creating a safe group space and intervention content from the Round 1 interviews were then used to create a survey. All participants (response rate: 86.4%) were asked to rate how important different potential elements of the intervention were to include and consider. The results indicated that all items achieved at least moderate consensus for inclusion. How results were used to inform the intervention is discussed and implications for clinical practice are addressed. This research has informed the development of a new parenting intervention which will be researched further in the form of feasibility and pilot trial studies.

Keywords: Parenting, Child, Intervention, Mental Health, Delphi Study

Introduction

Emotional and behavioural problems in childhood predict adverse outcomes through late childhood, adolescence and into adulthood such as mental and physical health problems, and criminality (Roza et al., 2003; Birmaher et al., 2004; Maughan & Collishaw, 2015; Kim-Cohen et al., 2003). These difficulties can have a significant impact on children and young people's (CYP) wellbeing, health and education (Collishaw, 2015) and are a substantial and increasing cause of worldwide disease burden (Murray et al., 2012; Patton et al. 2016). In the most recent figures available, approximately one in eight CYP aged 5 to 19 years old met criteria for a mental disorder, an increase from one in ten in previous years (Sadler et al., 2018). Many children experiencing mental health difficulties do not receive a clinical diagnosis (Patton et al., 2016) therefore these figures are likely to be an underestimate of the number of CYP experiencing emotional and behavioural problems. Further, prevalence of mental health problems in CYP may be even higher as a result of the Covid-19 pandemic due to the potential long-term impact of increased social isolation from peers and disrupted educational input (e.g., Adegboye et al., 2021; Mohler-Kuo et al., 2021; Nonweiler et al., 2020; Cost et al., 2021).

Due to the increasing prevalence of mental health problems in CYP, and research indicating that disadvantaged families are disproportionately affected by spending cuts to health service provision (e.g. reduced health coverage, restricted access to care), there have been resultant calls for preventative programmes to address early emerging behavioural and emotional difficulties as a public health priority (Collishaw et al., 2019; Department of Health and Social Care, 2017; National Assembly for Wales, Children, Young People and Education Committee, 2018; Collishaw & Sellers, 2020). However, given the financial constraints on services, there is a

need for cost effective and easily accessible preventative interventions to address emerging emotional and behavioural difficulties in CYP, before problems become more manifest.

Behavioural and emotional problems in childhood are associated with difficulties in recognising and understanding emotions (Morris et al., 2010; Olson et al., 2011). Mier et al. (2010) suggests emotion recognition is the prerequisite that allows the recognition of intentions, which leads to improved interpersonal interactions. Krueger and Eaton (2015) suggest deficits in parent and child emotional competence are a transdiagnostic contributor to mental health difficulties. There is evidence suggesting that accurate emotion recognition facilitates positive social interactions, with difficulties in emotion recognition predicting elevated behavioural problems (Izard et al., 2001; Wells et al., 2020). Directly teaching children to learn about emotions can have beneficial effects on interpersonal skills (empathy and interpersonal problem solving e.g., Webster-Stratton & Reid, 2003) and behaviour problems (Wells et al., 2020).

A child's ability to recognise emotions is thought to develop in the context of the child-caregiver relationship (Asen & Fonagy, 2012). When such relationships are marked by attachment security with a caregiver who encourages emotional expression, the child is more likely to learn to better recognise and understand their own and others' emotions (Slade et al., 2005). Eisenberg, Cumberland and Spinrad (1998) also highlighted that a parent's expression of emotions and reactions to child's emotions, directly impacts on children's understanding of emotions. There is a large body of literature to support this, and it has therefore been suggested that parental emotional understanding may be a critical target for intervention in childhood emotional and behavioural difficulties (Hajal & Paley, 2020).

Parental reflective functioning (PRF) involves the ability of a parent to be aware of their own emotions and behaviour alongside understanding their child's mental states and behaviours

(Fonagy et al., 1991). Camoirano (2017) reported in a narrative review of the literature that PRF was associated with the quality of caregiving and children's level of attachment security, promoting children's capacity for emotional regulation. Parents with higher PRF have been shown to be more able to experience difficult and emotionally activating relational exchanges without becoming overwhelmed (Borelli et al., 2016). Mentalization-informed interventions have been developed to target PRF and are gaining increased research support (e.g., Midgley & Vrouva, 2013; Byrne, Murphy & Connon, 2020). These interventions have been found to improve PRF in foster/ adoptive parents, mothers with mental health difficulties and substance misuse difficulties, and parents of children with a diagnosis of Autism Spectrum Disorder (Adkins et al., 2018; Midgley et al., 2019; Midgley et al., 2019b; Suchman et al., 2016; Byrne et al., 2019; Suchman et al., 2008; Enav et al., 2019).

Other parenting interventions promoting emotional learning have proved to be successful (Havighurst et al., 2020). Tuning into Kids is a 6-week (2 hour sessions) emotion-focused parenting programme developed in Australia, with a developing evidence-base in terms of positive effects on parent's emotional awareness and emotion coaching skills, decreased emotionally dismissive parenting, and reductions in parent and teacher reported child behaviour problems (Havighurst et al., 2009; Havighurst et al., 2010; Havighurst et al., 2013; Havighurst et al., 2015). Similarly, other parenting interventions focused on emotion learning or regulation have been shown to be effective in reducing parental emotional distress, negative parenting practices and child behaviour problems, such as, inattention, hyperactivity and emotional lability (Gaviţa et al., 2012; Herbert et al., 2013; Mason et al., 2016).

These interventions targeting parent and/or child emotion recognition, understanding and regulation tend to be quite lengthy, targeted at clinical or specialist populations, and require a

high degree of facilitator training. Given the need to make the most effective use of available resources (Alyward et al., 2013), there is a need for an evidence-based, easily accessible, and relatively brief parenting intervention to help parents to support their children to learn about emotions. An intervention such as this could be defined as a complex intervention; an intervention with interacting components that impact upon how the intervention will lead to a desired outcome (Craig et al., 2013). Complex interventions present a number of difficulties both practically and methodologically. The Medical Research Council (MRC) framework (Craig et al., 2013) for developing and evaluating complex interventions highlights the importance of the development phase of new interventions that aims to enhance intervention effectiveness. The MRC framework also stipulates that stakeholders should be involved during all stages of the intervention development and evaluation process. The Delphi Method is an approach that can be used to gather expert opinion and consensus (Keeney et al., 2011) and has been used in the development of complex interventions (Domoney et al., 2020).

The current study aims to develop a brief and accessible parent focused intervention that aims to help parents support their child's emotional understanding. It will focus on the systematic development of an effective intervention by incorporating the views of key experts including academics and clinicians with expertise in child and adolescent mental health, parents of children identified as experiencing early emerging behavioural and emotional problems, and child and family practitioners who routinely work with children in early to middle childhood and their parents. In line with recommended guidance, the study has included a broad range of experts during the development phase of the intervention (Craig et al., 2013; Surowiecki, 2004).

Method

In this study a two round Delphi method was used. The Delphi method is used to generate qualitative data, is exploratory in nature, and involves gathering expert opinion and generating consensus. The assumption is that the value of multiple expert opinions is greater than individual expert opinion (Habibi et al., 2014). The Conducting and Reporting Delphi Studies (CREDES) guidance (Jünger et al., 2017) informed the methodology, analysis, and reporting of outcomes in the current study.

Participants

Clinicians and Academics with Expertise in Child and Adolescent Mental Health

Clinicians and academics with considerable experience in working with parents and children were recruited through a snowball sampling technique. This technique included identifying expert authors in the literature and also utilising the professional networks of the research team. Twenty clinicians and academics were contacted to take part and eleven (all female) agreed to participate (55%). The participants included an educational psychologist, three academics with expertise in parent-child relationships and/or emotional development, five Clinical Psychologists working across different regions of NHS Wales, a non-UK Clinical Psychologist who has developed an emotion focused parenting intervention, and a Psychotherapist trained in Mentalization-Based Treatment for Families (MBT-F). See Table 1 for further demographic information.

Parents

Parents were recruited through the Neurodevelopmental Assessment Unit (NDAU) at Cardiff University (a research study of children aged 4-8 with emotional or behavioural difficulties). Eight parents who had previously indicated that they would be willing to take part in research were contacted. Six parents (five female and one male) consented to take part and were interviewed (75%). See Table 1 for further demographic information.

Child and Family Intervention Facilitators

Child and Family Intervention Facilitators were health and social care staff with experience in delivering parenting programmes without formal professional psychology or social work registration. They were recruited through a snowball sampling technique. Three Family Support Workers, two Graduate Mental health workers and two Assistant Psychologists were interviewed. All participants were female and had experience of running group-delivered parenting interventions. See Table 1 for further demographic information.

Table 1

Demographic information for three participant groups.

Demographics	Clinicians and Academics	Parents	Facilitators
Gender			
Male	0%	25%	0%
Female	100%	75%	71%
Information not provided	0%	0%	29%
Ethnicity			
White Welsh	27%	50%	14%
White English	9%	0%	0%
White Scottish	0%	0%	14%
White British	45%	50%	29%

Any other white background	18%	0%	14%
Information not provided	0%	0%	29%
Age			
18-24	0%	0%	0%
25-34	18%	25%	57%
35-44	36%	50%	0%
45-54	18%	25%	14%
55-64	27%	0%	0%
65-74	0%	0%	0%
Information not provided	0%	0%	29%
Education			
GCSEs or equivalent	0%	0%	0%
A Levels/ NVQ or equivalent	0%	50%	14%
Undergraduate degree or equivalent	0%	50%	14%
Masters Degree or equivalent	9%	0%	43%
Doctorate or equivalent	91%	0%	0%
Information not provided	0%	0%	29%
Type of parent/ caregiver			
Not a parent	18%	0%	57%
Biological parent	82%	75%	14%
Adoptive parent	0%	25%	0%
Foster parent	0%	0%	0%
Single parent	9%	25%	0%
Step parent	9%	0%	0%
Information not provided	0%	0%	29%

Design

In line with widely accepted guidance recommendations, a mixed methods Delphi

approach was used (Hasson et al., 2000). Qualitative data was collected via semi-structured

interviews with participants. The interviews from the three groups of experts were then analysed

using inductive Thematic Analysis to generate themes and sub themes for each of the three

groups of experts. The sub-themes for each of the three groups were then combined and

transformed into summary statements that were all combined to form a survey that was sent to all experts. Statements were rated in terms of importance to include or consider in the intervention on a 7-point Likert scale. A similar methodology has been utilised in previous intervention development research (Domoney et al., 2020). Cardiff University Ethics Committee granted ethical approval for the research (see Appendix C). All participants gave full informed consent to take part in the research (see Appendix D for information sheet and consent form).

Procedure

The Medical Research Council (MRC) guidance (Craig et al., 2013) on developing complex interventions was used as a framework for developing the intervention. The first stage involved examining existing evidence. A literature review using the terms Parent* intervention emotion*, Parent* training emotion*, Parent* group emotion*, Parent* intervention mentalis* and Parent* training mentalis* was conducted. The review identified 21 papers that described 13 different parenting interventions. All interventions tended to be lengthy (at least 6 weeks long), required a high degree of facilitator training, and were targeted at specific populations such as foster carers, adoptive parents and depressed mothers. This further highlighted the need for a brief intervention focused on helping parents to support their children to understand and regulate their emotions.

The second stage of intervention development entailed the production of a portfolio of information, designed by two clinical psychologists [supervisors of this doctoral thesis] with relevant experience of mentalization or emotion-focused interventions with children and families. The portfolio described the theoretical rationale, broad aims, basic proposed set-up, and a brief proposed outline of the programme content (see Appendix E). The portfolio was intended

as a "starting point" to enable and structure discussion in the Round 1 interviews. This portfolio was firstly sent to the Clinicians and Academic Expert group and they were asked to review the content. Semi-structured interviews were then conducted to canvass their views on the proposed content and delivery method format (see Appendix F for interview schedule). Interviews were conducted via the online video conferencing platform Zoom, and were audio-recorded for transcription.

The third stage of developing the intervention involved semi-structured interviews with Parents and Child and Family Intervention Facilitators. These participants were provided with an intervention portfolio like that sent to Clinicians and Academic, but with a less complex outline and theoretical rationale (see Appendix G). This portfolio was sent to parents and facilitators for review and they were subsequently asked questions in a semi-structured interview format via the online video conferencing platform Zoom (see Appendix H for interview schedule). The interviews were audio recorded for later transcription.

In the final stage, interviews from each of the three groups were analysed separately using thematic analysis (Braun & Clark, 2006: see "Data Analysis" section for more details). The sub-themes from the three groups were then combined and transformed into summary statements (see Appendix I). Summary statements from sub-themes generated across the three groups were then used to create one survey, using Qualtrics Survey Software, which was emailed to the three groups of experts (see Appendix J). The survey asked experts to rate the importance of each item for inclusion in the intervention. Ratings for each item were made on a Likert Scale of $1 - 7$ ranging from "unhelpful to include/ consider" to "essential to include/ consider". Responses were exported to Microsoft Excel for analysis.

Following these stages, the intervention materials were developed: a manual for facilitators with Powerpoint slides and a corresponding workbook for parents (see Appendix K for examples).

Data analysis

Thematic Analysis (Braun & Clarke, 2006) was used to analyse the data following six phases; familiarisng and immersing self in the data, generating initial codes, searching for themes, reviewing and refining themes, defining and naming themes and the writing up of the analysis. Separate analyses for the three groups were conducted to ensure themes across groups were not conflated. An inductive approach was used where the data was coded in relation to content, as opposed to a pre-existing theory or frame. In addition, the data was coded for semantic content rather than latent meaning.

The author transcribed all interviews, and transcripts were read twice to generate initial codes (see Appendix L for transcript extract with coding). Codes were assigned by the author and then sorted into potential themes. Initial themes were discussed in supervision and refined following discussion. Themes were finalised, summarised and quotes to exemplify the themes selected. The process was conducted using the NVivo 12 qualitative data analysis software package.

For the second round of the Delphi method, subthemes from the three analyses' were transformed into summary statements that experts rated on a 7-point Likert Scale. The mean, standard deviation, ranges and consensus for each item were calculated. Consensus on a summary statement was achieved if 60% of respondents marked within two adjacent response

points on the Likert Scale. This method has been used in two studies utilising a similar methodology to the present study to develop a mental health related intervention (Pezaro & Clyne, 2015; Domoney et al., 2020). There is no single definition of consensus across Delphi method studies and it therefore falls to the researcher to determine consensus (Jorn, 2015). Therefore, in order to understand different levels of consensus achieved it was agreed that statements that achieved between 60% and 79.5% consensus would be classified a moderate consensus and statements achieving between 79.6% and 100% would be classified as a high consensus.

For items that reached consensus for inclusion in the intervention, the researcher ensured that these were within the intervention materials. Similarly, if consensus was reached for items not to be included then this would be considered. For statements if 60% consensus was not achieved, the researcher planned to return to interview transcripts and previous knowledge of the literature to consider whether or not the item was important to include or consider in the intervention.

Quality Assurance and Reflexivity

Triangulation and Respondant Validation are two methods of assessing validity in qualitative research (Mays & Pope, 2000). The method of triangulation was used in the current study as participants from different groups (sources) holding different perspectives were interviewed. This allowed the researcher to look for patterns of convergence and divergence across groups. In addition, the Round 2 Survey acted as a form of respondent validation as it allowed participants to provide anonymous feedback on themes and subthemes generated as well as combining data gathered from the three different groups.

As a White Female Trainee Clinical Psychologist from Britain the author held westernised assumptions about emotions and emotional expression. In addition, the author had experience of Mentalisation Based Theory and treatment and during the later part of the project training in Dyadic Developmental Psychotherapy (a parenting approach originally developed for children whom have experienced developmental trauma). These factors may have influenced the initial information given to participants, the authors understanding of what was spoken about during interviews and the analysis process. The author attempted to remain open in their questioning and responses to interviewees. In addition, experts working in a diverse range of settings using different psychological theories and models were recruited. There was a risk that participants may simply acquiesce to the information presented in the intervention outline, therefore, the author took an active approach to encourage criticism and ensure that they were not defensive of the initial intervention outline.
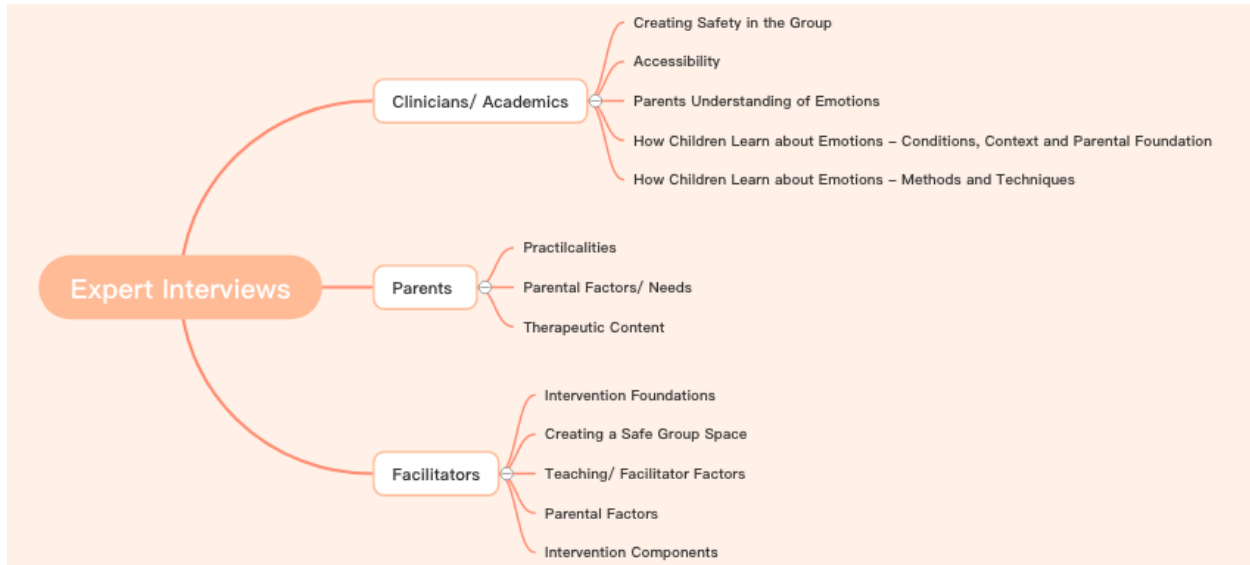
Results

Round 1: Interviews with experts

Figure 1 shows the themes identified in the analyses of the three groups; Clinicians and Academics, Parents and Facilitators. See Appendix M for figures of themes and subthemes from interviews with experts.

Figure 1

Themes from interviews with clinicians/ academics, parents and facilitators

Clinicians and Academics with Expertise in Child and Adolescent Mental Health

Table 2 outlines themes and subthemes with relevant quotes identified in the analysis of the interviews with Clinicians and Academics with Expertise in Child and Adolescent Mental Health (see Appendix N for further quotes). Five themes were identified: Creating Safety in the Group; Accessibility; Parents Understanding of Emotions; How Children Learn about Emotions – Conditions, Context and Parental Foundations; and How Children Learn About Emotions – Methods and Techniques.

Table 2

Themes and Subthemes with relevant quotes from interviews with Clinicians and Academics with Expertise in Child and Adolescent Mental Health

Themes	Subthemes	Quotes
Creating Safety in the Group	Relationship and support from other parents	"So that's another aspect of group based programs, they obviously have that support from other parents, they can see that they're not the only person going through these sorts of challenges so that aspect of having social support which they might not have otherwise" (Clinician/ Academic 10)
	Non-blaming/ judgmental of parents	"A learning environment where being able to make a mistake is ok, um that sense of I feel really strongly whatever intervention we're doing but particularly in talking to parents because it's so easy to shame and blame parents" (Clinician/ Academic 3)
	Trust in facilitator	"delicate balance of trusting the person enough to think that they've got enough expertise to be, to know their stuff about this and trust them but not wanting it to feel too much of a gap" (Clinician/ Academic 1)
	Ongoing engagement and holding in mind	"You may need a facilitator around if anything comes up afterwards or during the week, is there any way of contacting a facilitator if some difficult things come up for you" (Clinician/ Academic 3)
Accessibility	Accessible language and content	"would very young parents be able to understand this and would it be accessible um so thinking about the reading age in different areas. I think you know there's already a lot of what we do in the Psychology team is, I feel inaccessible for lots of the families that I work with" (Clinician/ Academic 2)
	Accessible timings and location	"one of the things that we find quite difficult with group based programs is finding a good time for parents" (Clinician/ Academic 1)
	Increased accessibility of skills through active participation	"So I think a lot of experiential work in the actual sessions with the parents themselves sort of role playing or talking through scenarios or watching scenarios and thinking about what that brings up for them" (Clinician/ Academic 4)
	Practical strategies and resources for parents	"practical techniques so they feel they can go away with something tangible"(Clinician/ Academic 11)
	Engagement difficulties working online	"we've done things with parents they're often on their iPhone which cuts the screen or the connections not very good or there's stuff going off in the background, which then distracts them or children are coming in so you know it's not perfect" (Clinician/ Academic 9)
	Engagement advantages working online	"I think the online space is working really well with our (name of intervention) programme so I think that's really viable" (Clinician/ Academic 8)
	Cultural considerations	"you have to think about cultural context there, um, and that is a bit of a Eurocentric white western way of ascribing and thinking about attachment and emotions, relationships" (Clinician/ Academic 10)
Parents Understanding of Emotions	Intergenerational patterns	"their own experiences of being parented and own history of being parented is really important being able to look at that and then seeing I guess how that gets played out in the here and now with their own children" (Clinician/ Academic 4)
	Parental emotional	"I bet there are parents who are themselves, are confusing certain emotions, particularly the negative emotions so I think that it is, it's

Themes	Subthemes	Quotes
	literacy	a very, emotion recognition it's very basic it's very simple skill but it just has to be taught" (Clinician/ Academic 5)
	Parental ability to understand and regulate their own emotions	"you actively work with the parent on thinking about their own emotional states, so when you come to thinking about a child's behavioural problem, or a difficult situation, you're not focusing on what the child is thinking or feeling when they're having a temper tantrum in the supermarket, you're thinking about what the parent is feeling, and you're helping them to make sense of their own emotional responses" (Clinician/ Academic 6)
Learn about Emotions – Conditions, Context and Parental Foundations	Parental acceptance of children's emotions	"the parents have to be able to respond in a way that communicates that it is ok to feel these feelings and that it's ok to talk about feelings" (Clinician/ Academic 8)
	The earlier developmentally the better	"it could be delivered to younger children because they'll be going through that process of getting to understand emotions anyway" (Clinician/ Academic 10)
	Importance of safe and warm parental relationships to facilitate emotional learning	"the more the parent is attentive and responsive to the child's needs the more they're going to feel emotionally regulated and by feeling emotionally regulated they're probably then more likely to identify different emotions and to express them as well and to have a language around emotions" (Clinician/ Academic 11)
	Parental reflective functioning	"what I think is key in parenting programs is developing reflective functioning for parents, so having a sense of look I can accurately guess your psychological state and reflect that back to you and give you an impression that will help you to know that we have different minds, separate minds, separate psychological states" (Clinician/ Academic 6)
	Context – system/ societal understandings	"For me it's about also recognising that parenting takes place in a wider context, that my capacity to engage with my child or the manner in which I engage with my child is going to be heavily influenced by work place pressures, my quality of relationship with my partner, whether or not I have other aspects of social support that are impinging to either promote or undermine my parenting" (Clinician/ Academic 7)
How Children Learn about Emotions – Methods and Techniques	Embedding emotional talk in everyday life	"teach them and work with them through play, is often the best way to do it so, um, using toys, using natural situations that occur, rather than trying to sit down and teach it" (Clinician/ Academic 9)
	Making space for curiosity and reflection	"having an adult too, um, name it, help you understand it, make their best guess but not impose their feeling or, um, on the child. So like lots of 'I wonder if this has happened' and that's why you're feeling like that?'" (Clinician/ Academic 2)
	Emotional attunement	"noticing when children are coming to you for comfort, and when they need help to organise their feelings, and when they need support to learn to play to do things for themselves, and have that support to be independent, and that's key to emotional development" (Clinician/ Academic 2)
	Naming emotions and modeling	"they might not necessarily have the language or the labels to put on it but just to start priming them about emotions at that early age will just help, it becomes a common universal language that they can relate to with all adults" (Clinician/ Academic 11
	Deepening parental understanding of behaviour	"making the link that an emotion, is not just a feeling of arousal internally, but it has communication so that is how we begin, and how this is important for development, and how it is linked to relationships and empathy" (Clinician/ Academic 5)

Creating Safety in the Group: A key theme that all Clinicians and Academics referred to was the importance of creating a safe group environment. A key component of the intervention that would facilitate this was *Support from other parents*. The validating and normalising experience of meeting parents with similar experiences in a supportive group environment was spoken about. A *Non-Blaming/Non-judgmental Approach* was also highlighted as important as parents can experience shame and feel blamed for their own or their child's difficulties. *Trust in Facilitators* was also mentioned as an important component for creating safety in the group. Clinicians and Academics referred to this trust being a balance between believing the facilitator had expertise in the area, and also having strong interpersonal skills to allow group members to feel at ease. Many referred to the importance of *Ongoing engagement and being held in mind* due to the group being potentially emotive. The importance of parents knowing how to access additional support if needed was also mentioned.

Accessibility: All clinicians and academics highlighted the importance of ensuring all aspects of the group were accessible for all parents. *Accessibility of language and content* and *Accessible timings and location* were raised. Many had experience of running parenting groups and often cited practical difficulties as one of the biggest challenges. Clinicians and academics also referred to *increased accessibility of skills through active participation*. They felt that learning often occurred through parents being active in a group, rather than didactic teaching. *Practical strategies and resources for parents* was highlighted as an important element of a group intervention, including ensuring parents had strategies that they could try at home and also resources to be able to look back at and practice what they learnt in the group. *Engagement difficulties working online,* included reduced group cohesion, lack of engagement and technical problems. The importance of experiencing emotion when trying to increase understanding of

emotions was spoken about, and concern that this could be reduced in an online intervention. Clinicians and academics were reflective about *Engagement advantages working online*, particularly in terms of how the COVID-19 pandemic had led them to feel that online group interventions were more viable than previously. Advantages of working online included parents being comfortable in their home, and reduced practical issues in terms of parking, travel and childcare. *Cultural considerations* were also highlighted as important in ensuring that the group was accessible to all parents. Many interviewed referred to the importance of considering the impact of cultural factors on the understanding and expression of emotion

   Parent Understanding of Emotions: Clinicians and academics spoke about parents increasing their understanding of emotions as an important element of the intervention that would then allow them to better help their children. *Intergenerational patterns* were mentioned as a factor that influences parents' understanding of emotion. There were some mixed views on whether highlighting these patterns would be an essential element of the intervention, but many felt it was important. There was concern about parents feeling safe enough to do so in a short intervention. *Parental emotional literacy* was also highlighted as an important component of the intervention, in order to ensure that parents have the language to help their child understand and learn about emotions. *Parental ability to understand and regulate their own emotions* was another key sub-theme identified in interviews as essential in allowing parents to teach their children about emotions.

   Learning about Emotions – Conditions, Context and Parental Foundations: Clinicians and academics were able to provide a wealth of information about how children best learn about emotions. Many spoke about foundational elements that were important in allowing this learning. *Parental acceptance of children's emotions,* both positive and negative, was highlighted as

important. Many of the clinicians and academics referred to how the earlier parents can be provided with the skills to help their child learn about emotions, then the better this would be for the child's development; *The earlier developmentally the better.* The *Importance of safe and warm parental relationships to facilitate emotional learning* was spoken about as an important element to be encouraged in the intervention. The parent's responsiveness to the child was raised as a way in which safety and warmth is created, and it was highlighted that without this, little learning was likely to occur. A number of clinicians referred to *Parental reflective functioning* being a key skill that the intervention should target to allow parents to help their child learn about and understand emotions. *Context – system/ societal understandings* was also highlighted as important to consider. Systemic and societal narratives around emotion were raised as contextual factors, influencing how successful an intervention may be.

How Children Learn about Emotions – Methods and Techniques: The final theme identified was more specifically about methods and techniques that facilitate a child's emotional learning. *Embedding emotional talk in everyday life* was spoken about by clinicians and academics as important for helping children to recognise and understand their own and others emotions. *Making space for curiosity and reflection* was raised in relation to allowing the development of emotional learning. The importance of *Emotional attunement* was referred to as enabling parents to recognise and understand the child's emotional experience, to allow them to regulate and help the child understand the experience. The majority of clinicians and academics spoke about the importance of parents *Naming emotions and modeling* appropriate responses to emotions. They spoke about this being essential for children to develop emotional language and understanding of others. Many spoke about the need for *Deepening parental understanding of behaviour* to understand their child's behaviour as varying emotional responses, and the

importance of identifying the emotion underlying the behaviour, and them supporting the child to understand this.

Parents

Table 3 outlines themes and subthemes with relevant quotes identified in the analysis of the interviews with Parents (see Appendix N for further quotes). Three themes were identified: Practicalities, Parental Factors/ Needs and Therapeutic Content.

Table 3

Themes and subthemes with relevant quotes from interviews with Parents.

Themes	Subthemes	Quotes
Practicalities	Parents juggling time	"I work full time and I work long hours" (Parent 1)
		"trying to juggle all that" (Parent 3)
	Comfortable sized group	"Yeah not too big and not too small so it feels really intense, um and too big you get lost so sort of a balance" (Parent 2)
	Accessible and relaxed setting	"I think if it felt a bit more if it was a bit more of an informal environment, I think it would it would be easier to speak rather than you know if it was right attend the university classroom so to speak it would be more, I think it would be better in a more relaxed environment" (Parent 4)
	Online accessibility	"it saves you getting a babysitter you're usually at work all day so you can do it in the evening and obviously geographically as well you can have people from all areas instead of just looking at a small area for people to travel to um so yeah it works really well in terms of accessibility" (Parent 2)
	Online reduces human connection	"I think it's harder to connect with someone online, unless it's sort of like a one on one or like just a few little people. I think if you've got a group of maybe 10 parents you wouldn't get to know them on that personal level, you know sort of chit chat that you would normally have in between like a tea break" (Parent 1)
Parental Factors/ Needs	Importance of parental peer support	"to meet peers for myself as well as for the children so yeah they're really good they're invaluable really" (Parent 3)
	Parental self-blaming	"be aware of maybe shame and guilt from the parent's point of view" (Parent 2)
	Awareness of how parents were parented	"the way you were parented does hugely impact the way you parent your children, so yeah, I think that needs to be done in a sensitive way" (Parent 3)
	Understanding the impact of global change and events on parenting	"I think it's just because of the world we live in they're emersed in the world of technology you know they're spoken to like, well they are they're little people but their spoken to like adults almost you know, they're expected to understand so much more and I think it's giving them it's almost giving them that sort of understanding of it with that comes a lot more responsibility on their emotions" (Parent 1)
Therapeutic Content	Encouraging communication	"I think that's the biggest thing with (child's name) is encouraging communication more than ever not to bottle things up" (Parent 4)
	Developing emotional talk	"our children often really don't know can't name their emotions although they are feeling the emotion" (Parent 2)
	Understanding what's underneath child's behaviour	"he wanted a tiny little sticker and you just think it's a tiny little sticker but he really wanted it and it was hard to calm him down but I think it was so much more than just this tiny little sticker" (Parent 3)

Themes	Subthemes	Quotes
	Developing practical strategies	"tool kit of strategies to use to help um de-escalate some behaviours" (Parent 4)
	Manageable home tasks	"Making them accessible flexible short and um sort of scaffolding what you want the parents to do" (Parent 2)
	Finding what works - recognising difference and changes over time	"I suppose just not every child's the same either so like it might work brilliantly for one child but for another it just doesn't… we've used so many different methods over the years, and some of them worked, and then they stopped working" (Parent 1)

Practicalities: Parents highlighted a number of practical elements of delivering a parenting intervention. *Parents juggling time* was spoken about by all parents including the competing demands they faced and how this could be a potential barrier to attending a group intervention. Parents also identified that a *Comfortable sized group* was important to them in allowing them to feel relaxed and able to engage. In addition, an *Accessible and relaxed setting* was key. There was a general agreement that a community-based setting with good access to local areas would be best. Parents also raised positives around *Online accessibility* as it reduced some of the common barriers to attending in person groups such as travel, parking and childcare. However, they also felt that *Online reduces human connection* and opportunities for connecting with parents in similar situations.

Parental Factors/ Needs: Parents also identified a number of important parental factors. They identified the *Importance of parental peer support* that a group intervention can facilitate. All parents said that they found it helpful to speak to other parents about their experiences. A number of parents spoke about *Parental self-blaming* if their child is having difficulties, and how this can lead to concerns that they might have done something 'wrong'. Parents spoke about feelings of guilt and the importance of an intervention not increasing these feelings of blame. Parents highlighted that there was benefit to raising *Awareness of how parents were parented*. All acknowledged that this could impact on the way they would parent their own child, but felt that this issue would need to be raised sensitively. Parents consistently identified *Understanding the impact of global change and events on parenting*. Multiple parents highlighted the impact of the COVID-19 pandemic and the demands of home schooling on children and families.

Therapeutic Content: The parents interviewed were able to offer knowledge on how they felt their children best learnt about emotions. All parents, in terms of helping their child to learn,

understand and cope with their emotions, mentioned *Encouraging communication*. *Developing emotional talk* was also highlighted in terms of needing to give children a language to communicate their emotions. *Understanding what's underneath child's behaviour* was raised as an important element. Parents spoke about needing to identify emotions or needs behind their child's behaviour. Parents also described the need for an intervention to involve *Developing practical strategies* to aid them in helping their child to understand their own and others emotions. Parents described needing multiple strategies and an acknowledgement that not all strategies work for everyone. They felt that there needed to be *Manageable home tasks* that were well structured. Parents also said it would be important to ensure that it was acknowledged that tasks might be difficult or not successful. *Finding what works - recognising difference and changes over time* was another key component that was spoken about by parents.

Child and Family Intervention Facilitators

Table 4 outlines themes and subthemes with relevant quotes identified in the analysis of the interviews with child and family intervention facilitator (see Appendix N for further quotes). Five themes were identified; Intervention foundations, Parental Factors, Teaching/ Facilitator Factors, Creating a Safe Group Space and Intervention Components.

Table 4

Themes and subthemes with relevant quotes from interviews with Child and Family Intervention Facilitators

Themes	Subthemes	Quotes
Intervention Foundations	Universally offered – all parents can benefit	"people are all going to find a benefit from it because we've all got, every child has got emotions" (Facilitator 4)
	Maximising connection – parents facing similar difficulties	"it could be so varied that actually the whole point of a group where connection is supposed to happen rapport and seeing similarities that wouldn't happen as easily…. I would say that more targeted would bring a better connection between people" (Facilitator 6)
	Transport – accessible location	"definitely transport and a venue would be the biggest hurdles I think" (Facilitator 1)
	Online more accessible and comfortable	"those parents or carers not having to drive, not having to get anywhere they're just already at home, it removes that anxiety of having to leave your house you know for a lot of people that's huge isn't it having to go to a group and it feels safer I think for people in their home" (Facilitator 4)
	Face to face more connected and nurturing	"I think obviously my personal preference would be to do it face-to-face because you get all the nurturing and everything that comes from it" (Facilitator 1)
	Community (not clinical) relaxed setting	"community based, so not coming into a hospital, not coming into like a clinic setting, um, I think makes it feel very health focused, and I think that's kind of scary and off-putting" (Facilitator 6)
Parental Factors	Parent understanding that they can facilitate change	"when we're called in they would like us to change their child rather than realising that they've got the power to change things themselves" (Facilitator 1)
	Complexities of confidentiality	"people knowing each other and going through confidentiality that has come up a few times um which can be really difficult because sometimes it's just kind of a oh I'm not going to that group point blank because I know this person" (Facilitator 7)
	Parental availability	"people have got so much going on in their everyday lives" (Facilitator 6)
	Preparing parents for difficult content	"I would actually warn them and say that session the week before next week we're going to be talking about this, this is what it's going to entail so you prepare them" (Facilitator 3)
Teaching/ Facilitator Factors	Knowledge of psychological development	"I think it's more about the skills that someone can bring, so if they're able to sort of know the background and the theories, I guess behind what we're teaching" (Facilitator 6)
	Supportive team around them	"really good team you work with so you are able to have clear goals and to make sure you always feedback you know and reflect on things" (Facilitator 5)

Themes	Subthemes	Quotes
	Ability to show fallibility / normalise	"I'm really open as well, and say 'I do lose it sometimes', you know, none of us are perfect" (Facilitator 1)
	Skillfully manage group dynamics	"I suppose it's about managing it and facilitating your group really when you get chatty big strong characters you can um keep them at bay if that makes sense without being disrespectful" (Facilitator 2)
	Use interactive and engaging approaches	"Well so kind of that interactive kind of what are they called like menti meters and you know things that they can input so that it feels um not as kind of talked at I suppose because I think sometimes that can be difficult" (Facilitator 7)
	Combine learning, informality and fun	"learn through fun having fun and learning without knowing they're learning" (Facilitator 5)
	Connecting with parents	"I guess it's really connecting with the parents in their struggles you know what I mean showing that we get it" (Facilitator 4)
Creating a Safe Group Space	Containment and empathy	"they're able to say oh my god I've had a really pants week this week and he's done that and he's done that. They're able to have that containment and they go home and are then able to then parent a bit more effectively" (Facilitator 2)
	Connecting with parental peers	"I'm just thinking about our parents and a lot of them seek just just the fact of meeting another parent going through similar difficulties um can be so much more reassuring and empowering" (Facilitator 6)
	Creating a supportive network outside of sessions	"checking in with you even if it's just a text just for reassurance to say oh you know how is it going, sometimes they take kindness to that you know rather than just rocking up the week after in the next session" (Facilitator 3)
	Facilitating parental solutions	"I think it's a massive, um, message when it comes from somebody who has actually done it. I think that's the way forward" (Facilitator 3)
Intervention Components	Accepting/ normalising emotion	"it's alright to feel these things… you're not allowed to feel jealous, you're not allowed to feel angry, you're not allowed to feel those negative feelings but actually it's alright to feel those and express them and deal with them, there's no point in keeping them inside" (Facilitator 2)
	Developing empathy for the child	"help them understand a little bit that children have a world of their own and their own language it's really important for us all to leave ours and live in theirs and come back" (Facilitator 5)
	Linking emotions to bodily sensations	"get them to understand what's going on in our heads but also in our bodies" (Facilitator 7)
	Giving parents emotional vocabulary	"developing emotional literacy and emotional vocabulary so for the parents to see the behaviour that they may or may not like but to express that vocalise it, so that the parents have got words or ways to communicate their behaviour rather than show it, so the emotional vocabulary would be the starting point" (Facilitator 1)

Themes	Subthemes	Quotes
	Simple/ accessible at home tasks with emphasis on reflection	"we're very informal about it, so we're like 'just see how it goes', you'll be feeding back in, but we don't want to be too formal, so you know they don't come back to group" (Facilitator 2)
	Understanding behaviours more deeply	"especially when behaviour comes in with the children, they see the management of behaviour and the understanding of behaviour as still two slightly different things" (Facilitator 1)
	Parents understanding own emotions and regulation	"So for instance asking them to explore their feelings what riles them up or what upsets them and how they deal with it helps them to relate it to their children. It's a bit of a light bulb moment sometimes" (Facilitator 2)
	Practical resources	"we very much gave them the equipment to use at home so they went home basically with a goody bag of stuff um so that that wasn't a barrier" (Facilitator 4)
	Parents learning to help child regulate emotions	"then being able to go, and you know, do some exercise, or go and draw, or go and play, or whatever it is to regulate it, and I sort of continuously say that it's about that role modeling" (Facilitator 7)
	Highlighting transgenerational effects	"it's made them reflect and they're already thinking about how their parenting effected them" (Facilitator 3)

Intervention Foundations: Facilitators identified a number of important factors prior to delivering a parenting intervention. A number of facilitators felt that the intervention should be *Universally offered – all parents can benefit.* Many also explained that if parents with similar difficulties were grouped together, then this may maximise connections, and parents would benefit more from the available peer-to-peer support; *Maximising connection – parents facing similar difficulties. Transport - accessible location* was highlighted as very important. Facilitators spoke about transport, parking and location being a key challenge. Facilitators described *Online as more accessible and comfortable* for parents. However, facilitators who had experience of both face-to-face and online delivery of parenting interventions said *Face to face more connected and nurturing.* All facilitators explained that a *Community (not clinical) relaxed setting* would be appropriate to allow parents to feel comfortable, and therefore aid their learning.

Parental Factors: Facilitators identified a number of parental factors important to consider in the intervention. Many facilitators spoke about the importance of *Parent understanding that they can facilitate change*. They referred to helping parents see their own role in being able to impact the child, in order to counteract beliefs around services "fixing" a child. The *Complexities of confidentiality* was also raised as an issue to consider, including if parents know each other, or sharing of personal information disclosed in the group outside of sessions. *Parental availability* was highlighted and facilitators acknowledged that it can be difficult to accommodate all parents, as their schedules and needs are varied. There was some consensus that parenting groups are not well attended if delivered in school holidays, or around school drop off/pick-up. *Preparing parents for difficult content* was also raised as important to include when delivering a group parenting intervention, in order for parents to feel safe and supported.

Teaching/ Facilitator Factors: Facilitators spoke about a number of factors in terms of teaching style and the facilitator, that impact on the success of a group parenting intervention. *Knowledge of psychological development* was identified as important for whoever would be delivering the intervention, in order to have the grounding and understanding of the concepts. Facilitators highlighted the importance of facilitators having a *Supportive team around them* including supervision and support to help manage difficulties and provide opportunities for learning and reflection. Most facilitators also highlighted that the *Ability to show fallibility / normalise* is an important factor. Many talked about how this aided connection and encouraged openness. Facilitators spoke about *Skillfully managing group dynamics* in order to maintain engagement. They described the need to *Use interactive and engaging approaches* to ensure parents are fully participating in the group. It was also highlighted that it is important to *Combine learning, informality and fun* to increase engagement and safety. Facilitators also mentioned the importance of *Connecting with parents* in enabling a parent to feel safe, be open and fully participate in a group intervention.

Creating a Safe Group Space: Facilitators highlighted the importance of creating a safe group space for parents and the importance of this for engagement. *Containment and empathy* was spoken about by all facilitators as essential for creating psychological safety and the importance of parents receiving this from facilitators to then enable them to provide this for their children. *Connecting with parental peers* was also highlighted as important by facilitators. Some spoke about this being a normalising and validating experience as well as providing other sources of support for a parent and opportunities to learn from other parents. *Creating a supportive network outside of sessions* was acknowledged as beneficial. Facilitators spoke about parents benefitting from having a follow-up call between sessions, as they felt that this improved

engagement. However, it was acknowledged that it could be difficult logistically with resource and time constraints. The importance of *Facilitating parental solutions* for difficulties faced by group members was considered as important. Facilitators favoured a non-expert stance in order to allow this to develop.

  Intervention Components: Facilitators identified a number of important intervention components. They highlighted *Accepting and normalising emotions* as an important process for the facilitator to be modelling to the parent, and for the parent to model to their child. Facilitators spoke about acknowledging the wider societal narratives around emotions. *Developing empathy for the child* was also raised as a key component in any parenting intervention about children's emotions. Facilitators described the importance of *Linking emotions to bodily sensations* and the lack of awareness of this in the general population. They highlighted that it can allow parents and children to better understand their own and others emotions. *Giving parents emotional vocabulary* was also mentioned by many of the facilitators as the basis for allowing parents to help their child understand emotions. *Simple/ accessible at home tasks with emphasis on reflection* were highlighted as important. Facilitators explained that helping parents in *Understanding behaviours more deeply* is crucial in order to develop abilities to understand the underlying emotion or need driving those behaviours. *Parents understanding own emotions and regulation* was seen as an important component for enabling parents to help their child learn about emotions. Facilitators highlighted the importance of providing parents with *Practical resources*, such as print outs and activities, to reduce barriers and also to consider families who may have less resources. A number of facilitators commented upon how an important aspect of the group should be *Parents learning to help child regulate emotions* to allow better understanding of how to cope with emotions. Facilitators discussed mixed experiences with

Highlighting transgenerational effects within families effectively, and in a safe and containing way for parents. Some facilitators felt that in a short intervention, that it may be more difficult to do, but many felt even introducing it, as an idea can be helpful for parents.

Round 2: Consensus Survey

From the subthemes identified by the three groups in Round 1, summary statements were created. The summary statements from all three groups were combined and sent to all participants who were interviewed in Round 1, with 19 out of 22 (86.4%) completing the consensus survey round. Of the three experts who did not complete the round two survey, one was a clinician/ academic, one was a parent and the other was an intervention facilitator. The summary statements and results are presented in Table 5. All items achieved the 60% consensus to be included or considered in the intervention. There was variation in the strength of consensus across the items; 58 of the 70 items achieved a high consensus (82.86%) and 12 achieved a moderate consensus (17.14%). How results from the Round 2 consensus survey were then used to inform the development of the intervention materials (see Appendix K) is detailed in the discussion.

Table 5

Summary statements with means, standard deviations, mode maximum/minimum scores and % consensus achieved.

Summary statement	Mean	SD	Mode	Min	Max	% Consensus
1. Facilitating the development of supportive relationships between parents that attend the group	6.63	1.13	7	3	7	94.44
2. Adopting a non-judgmental and non-blaming approach	7.50	1.03	7	3	7	94.44
3. Parents developing trust in the facilitator	7.25	0.86	7	4	7	94.44
4. Facilitators making contact with participants between intervention sessions to encourage engagement	5.31	1.18	5	2	7	77.78
5. Ensuring that language and content is accessible	7.44	0.70	7	5	7	100.00
6. Ensuring timings and location are accessible	7.06	0.96	7	4	7	94.44
7. Encouraging active participation in the intervention e.g. through role play, experiential exercises, group discussion	6.44	1.36	7	2	7	88.89
8. Providing practical strategies and resources for parents	7.19	0.85	7	5	7	100.00
9. Acknowledging that engagement can be difficult for parents in an online intervention	6.75	0.97	5	5	7	100.00
10. Acknowledging that an online intervention can be more accessible for some parents	6.50	1.06	5	4	7	88.89
11. Ensuring consideration is given to parents heritage and cultural backgrounds	6.94	0.99	7	5	7	100.00
12. Highlighting intergenerational patterns of parenting	6.13	1.25	5	3	7	83.33
13. Developing parents emotional literacy e.g. language around emotions	7.63	0.55	7	5	7	94.44
14. Developing parents ability to understand and regulate their own emotions	7.38	0.86	7	4	7	94.44
15. Providing parents with tools to be accepting of all children's emotions	7.13	0.84	7	4	7	94.44
16. Delivering the intervention when the child is at an early developmental stage	5.75	1.08	5	3	7	77.78
17. Highlighting and encouraging safe and warm parental child relationship to facilitate emotional learning	7.06	0.96	7	4	7	94.44
18. Improving parental reflective functioning	7.13	0.84	7	5	7	100.00
19. Acknowledging the impact of societal expectations on parents and children	6.50	1.00	5	4	7	94.44
20. Providing with skills to embed emotional talk in everyday life	6.88	0.83	7	5	7	100.00
21. Encouraging parents to make space for curiosity and reflection	6.69	1.11	7	4	7	88.89
22. Encouraging emotional attunement between parent and child	7.13	0.97	7	5	7	100.00
23. Encouraging parents to name emotions and model responses to emotions and coping with them	7.31	1.04	7	3	7	94.44
24. Providing parents with skills to deepen their understanding of behaviour e.g. emotions underlying behaviour	7.00	1.17	7	3	7	94.44
25. Appreciating the difficulties for parents juggling multiple demands on their time	6.38	1.28	7	3	7	83.33
26. Ensuring that the size of the group is comfortable for all	6.44	1.07	5	4	7	88.89
27. Providing an accessible and relaxed setting for the intervention	6.44	1.27	7	3	7	83.33
28. Ensuring that the intervention can be delivered online as well as in person	6.44	1.07	5	4	7	88.89
29. Acknowledging that there may be less human connection in an online intervention	6.56	1.04	7	4	7	88.89
30. Ensuring parents have peer support from other parents in the group	5.81	1.20	5	3	7	72.22
31. Highlighting and considering parental self-blame	6.00	1.71	7	1	7	77.78
32. Talking about how parents were parented themselves	5.94	1.67	7	2	7	66.67
33. Highlighting the impact of global change and events on parenting e.g. changes in technology, COVID-19 pandemic and lockdown	5.81	1.54	5	2	7	72.22
34. Providing parents with skills to improve communication with children	6.81	0.94	7	5	7	100.00
35. Developing parents ability to talk about emotions	7.00	1.11	7	3	7	94.44
36. Helping parents to understand what's going on underneath their child's behaviour	7.06	0.89	7	5	7	100.00
37. Providing parents with practical strategies to help children learn about emotions	7.06	0.83	7	5	7	100.00
38. Setting manageable at home tasks	6.50	1.17	5	3	7	94.44

Summary statement	Mean	SD	Mode	Min	Max	% Consensus
39. Acknowledging individual differences and that the same thing will not work for everyone and may change with age	6.63	1.28	7	3	7	88.89
40. Offering the intervention universally so that all parents could benefit	5.69	1.39	5	3	7	61.11
41. Offering the intervention to parents facing similar difficulties in order to facilitate connections	5.81	1.25	5	3	7	62.50
42. Ensuring the intervention takes place in an accessible location with good transport links	6.13	1.10	5	3	7	88.89
43. Acknowledging that engaging in an online intervention can be more accessible and comfortable e.g. not needing to travel, having home comforts at hand etc.	5.81	0.99	5	3	7	83.33
44. Acknowledging that a face to face intervention can be more nurturing and people can feel more connected	6.13	1.04	5	4	7	83.33
45. Ensuring the intervention takes place in a community (not clinical) relaxed setting	6.19	1.10	5	4	7	83.33
46. Parents understanding that they can facilitate change in their child	7.13	0.84	7	5	7	100.00
47. Addressing the complexities of confidentiality e.g. group members knowing each other or sharing information outside the group	6.69	1.47	7	3	7	83.33
48. Acknowledging that parents are juggling multiple demands	6.25	1.42	5	2	7	83.33
49. Preparing parents for difficult content	6.13	1.15	5	3	7	83.33
50. Facilitators having knowledge of psychological development	6.44	1.32	7	3	7	83.33
51. Facilitators having a supportive team around them	6.50	1.22	7	3	7	88.89
52. Facilitators having the ability to show fallibility and normalise emotions and difficulties	6.69	1.21	7	3	7	88.89
53. Facilitators being able to skillfully manage group dynamics	7.50	1.03	7	3	7	94.44
54. Using interactive and engaging approaches	7.31	0.79	7	5	7	100.00
55. Combining learning, informality and fun	6.44	1.18	7	4	7	83.33
56. Facilitators connecting with parents	6.81	1.26	7	3	7	88.89
57. Providing containment and empathy to parents	7.00	1.26	7	3	7	88.89
58. Facilitate connection between parental peers	5.75	1.57	5	2	7	77.78
59. Offering a supportive network outside of intervention sessions	5.25	1.41	5	2	7	66.67
60. Facilitating parental solutions to difficulties e.g. parents helping each other find answers to problems	6.06	1.54	7	3	7	72.22
61. Helping parents to be accepting of emotions and normalise children's experiences of emotion	7.25	0.86	7	5	7	100.00
62. Developing parental empathy for the child	7.31	0.79	7	5	7	100.00
63. Linking emotions to bodily sensations	6.75	0.97	5	5	7	100.00
64. Giving parents emotional vocabulary	7.25	0.98	7	4	7	94.44
65. Giving parents simple and accessible at home tasks with an emphasis on reflection	6.50	1.00	5	4	7	94.44
66. Deepening parental understanding of their child's behaviour	7.19	0.98	7	4	7	94.44
67. Helping parents to understand their own emotions and how to regulate these	7.06	1.02	7	4	7	94.44
68. Providing practical resources for parents to take away and use	6.50	1.06	7	4	7	88.89
69. Providing parents with skills to help their child regulate their emotions	7.06	1.02	7	4	7	94.44
70. Highlighting transgenerational effects on parenting	5.81	1.38	5	3	7	66.67

Discussion

This study aimed to develop a brief and accessible parenting intervention to help parents support their child's emotional learning. Following development of an initial portfolio of information describing a proposed intervention, the first Round of this Delphi study involved interviews with key experts including clinicians and academics, parents, and child and family intervention facilitators. Themes were generated regarding important aspects of the intervention. There was overlap in the themes generated by the different groups. All sub themes were transformed into summary statements, and all those who had initially participated in interviews, were invited to rate all the summary statements generated on the level of importance for inclusion in the intervention. Consensus on each of the items was then calculated.

Practicalities

Across all three groups, themes related to practicalities of the intervention were identified. For example, accessibility of the content including the language used, manageable at home tasks and providing parents with practical strategies and resources. There was also high consensus in the survey for these themes across the three expert groups. Active and interactive methods of engaging parents were themes identified by clinicians, academics and facilitators. In round two, high consensus across the three expert groups was achieved for both active and interactive intervention components. Ensuring the group is accessible in terms of timings and locations was also highlighted across groups, and again there was consensus that a community and not a clinic-based setting would fit best for this type of intervention. Facilitators and parents also highlighted the demands on parent's time and how this can pose a challenge for engagement in a group intervention. Therefore, the findings from the analysis suggested that all of these practical factors should be given

considerable consideration in the development of the intervention manual. These findings are in line with previous research on successful parenting interventions (Havighurst et al., 2009; Adkins et al., 2018; Herbert et al., 2013; Webster-Stratton, 2001).

In all groups there were common themes around the benefits and challenges of delivering the intervention online versus in person. In all groups the advantages of online delivery in terms of accessibility were acknowledged. Interviews were conducted during the COVID-19 pandemic, and many participants discussed how their views about the benefits of digitally delivered parenting interventions had increased since the pandemic. However, there was a common theme that an online parenting group would lead to a reduction in the connection that parents would feel with each other, and with the facilitators, as well as a concern that this could lead to individuals not fully engaging in the intervention. There was high consensus in the survey around these advantages and disadvantages of online working. Therefore, the analysis suggested that the intervention should be designed to be delivered *online or in person*, depending on service context, parental needs and preferences, and indeed the ongoing COVID-19 pandemic and associated restrictions. There is recent research suggesting that online parenting programs for children with emotional and behavioural problems can be effective (Florean et al., 2020). However, further research is needed to identify how this compares to an in person intervention as this research used waitlist controls as a comparator.

Finally, in relation to themes around practicalities, although the intervention was initially conceived as being targeted at those children with emerging emotional and behavioural difficulties, the analysis showed that there was only moderate consensus about whether it should be targeted in this way or offered universally. Hence, the analysis was not clear enough to suggest that the intervention should be

offered universally, but did indicate that although targeted at children with emotional

and behavioural difficulties, the level and type of these difficulties did not need to be

the same across all parents attending the group. This fits with research showing poor

emotion recognition and understanding underlies a number of different behavioural

and emotional difficulties in children and young people (Morris et al., 2010; Olson et

al., 2011). It may be that the intervention could be of benefit to many parents and

children but given limited healthcare resources it appears prudent that those

experiencing difficulties receive support (Department of Health and Social Care,

2017; National Assembly for Wales, Children, Young People and Education

Committee, 2018; Collishaw & Sellers, 2020).

Creating Safety

Creating safety in the group context was also highlighted across all three

expert groups. Themes of being non-blaming and non-judgemental of parents, as well

as showing empathy and providing containment, all achieved high consensus.

Therefore the analysis indicated that these components should be incorporated into

the intervention manual and materials, whilst acknowledging that facilitator style will

have an impact on the delivery of these therapeutic skills. The importance of this is

less well documented in parenting intervention literature. However, there is evidence

that a stronger therapeutic alliance in parenting group interventions leads to better

outcomes (Schmidt et al., 2014).

A number of facilitator factors including having knowledge of psychological

development, an ability to show fallibility, and skills in managing group dynamics all

achieved high consensus. Hence, these intervention components should inform the

recommendations for the facilitators approach to the delivery of the intervention, and

will be included in the intervention manual and any training for facilitators. A number

of successful parenting group interventions have used facilitators with knowledge of psychological development (Havighurst et al., 2009; Suchman et al., 2008; Enav et al., 2019). There is less evidence in relation to ability to show fallibility and managing group dynamics, which may be due to difficulties in measuring these factors. However, it is likely to contribute to a successful therapeutic alliance between parents and facilitators leading to more successful outcomes.

The importance of parental peer support was identified as a theme across all three expert groups. However, in the survey, these themes scored more moderately in terms of consensus with the exception of 'Relationships and support from other parents'. Similarly, modest consensus was achieved for themes related to creating a supportive network between parents outside of sessions, and promoting ongoing engagement by letting parents know that they are being 'held in mind' by the intervention team. Previous research would suggest that relationships with parental peers and facilitators are an important element of a group parenting intervention (Garcia et al., 2018). It appears that relationships with facilitators and between parents are important, but could potentially mean that the evolution of these relationships should remain flexible. Therefore, the analysis would indicate that the intervention manual should highlight the potential benefits of peer support, but not make any mandatory recommendations allowing facilitators to approach this flexibly, depending on the service context.

Intervention Content

There were many common themes identified in terms of intervention content that also achieved high consensus at Round 2. Parent's emotional literacy, often described as 'emotional talk', achieved a high consensus across the three expert groups. Increasing caregiver knowledge of emotions as well as the teaching of skills and techniques to help parent's better support their child's emotional development

was recommended for inclusion. Acceptance and normalising of emotion was also identified as a theme in the clinician and academic, and facilitator interviews, and then rated highly in the consensus survey by all participants. Similarly, in all groups a theme around deepening understanding of behaviour was identified, achieving high consensus for inclusion in the intervention. Other components achieving high consensus (and therefore supporting their inclusion in the manual and intervention materials) were naming emotions and modeling, encouraging communication, linking emotions to bodily sensations and embedding emotional talk in everyday life. These factors appear to fit with existing literature around teaching children directly to learn about emotions (Webster-Stratton & Reid, 2003; Hubble et al., 2015; Hunnikin et al., 2020; van Goozen, 2015). Therefore, providing skills to parents to directly teach their children may be an effective strategy for change.

Parents understanding of their own emotions, and being able to regulate themselves, was also highlighted as a theme which achieved high consensus. As such, the analysis indicated that skills and techniques related to helping parents understand their own emotions should be included in the intervention. This is in line with previous research (Hajal & Paley, 2020). The importance of safe and warm parental relationships to facilitate emotional learning, parental reflective functioning and developing empathy for the child achieved high consensus for inclusion in the intervention. These findings fit with the existing mentalization literature around optimal emotional development occurring in the context of a secure child-parent relationship and the evidence on parental reflective functioning (Asen & Fonagy, 2012; Meins et al., 2013; Sharp et al., 2007).

Preparing parents for difficult content, actively managing the complexities of confidentiality, and supporting parents to understand that they can facilitate change in

their children and indeed themselves, all received high consensus for inclusion. A theme that was identified across all expert groups but achieved only moderate consensus was around thinking about parents own experiences of being parented. It appears that there was less strength in the consensus for inclusion of this topic in the intervention. Therefore, on balance, the analysis suggested that enabling parents to reflect on their own experiences of being parented was an important element to include. However, that it should be done so sensitively, and in a non-directive way, allowing parents to share as little or much as they wished to. Prior research would suggest that this is an important element for a parenting intervention related to understanding emotions (Asen & Fonagy, 2012; Camoirano, 2017).

Limitations

The current study has a number of limitations. Firstly, the Delphi method can be applied in diverse and varied forms. Most commonly in the first round of a Delphi study participants are sent an anonymous survey, with open-ended questions. In the first round of this study participants were sent a brief rationale and outline of the proposed intervention (as has been done in previous research; Lewis et al., 2013). They were then asked detailed questions about parenting interventions, children's learning about emotions, as well as more specific questions about intervention content and delivery related issues in a semi-structured interview format. The information provided to participants prior to the interview may have led to some bias in responses given in the interview and they may have displayed some performance effects, feeling unable to be honest about their views during interviews. In addition, the author was aware of their own biases in terms of beliefs about emotions and emotional expression as informed by living in a white western culture and prior reading and training on relevant theories and models. The research team identified these risks before

commencing interviews, and the interviewer made concerted efforts to encourage critique and openness. It also appeared that participants did give critiques and comments that were not solely acquiescing to the information provided. The interview format as opposed to an open-ended survey format led to rich data being gathered from participants, and the survey in round 2 gave participants an opportunity to give anonymous feedback on the themes generated following the interviews.

Secondly, in this study three distinct groups of experts were identified which is not commonplace in a Delphi study. It is possible to question the expertise of the non-child and adolescent mental health specialists, parents and facilitators. However, there is increasing acknowledgement of the contribution and value of 'experts by experience' in Delphi studies, as well as evidence of high consensus agreement between expert by experience and professional groups (Jorm, 2015). MRC guidance (Craig et al., 2013) for developing and evaluating complex interventions highlights that stakeholders should be involved at all stages of the process. Therefore, the expertise of parents and facilitators was essential for informing the development of the intervention and this appeared to be an innovative way of combining views. A defined set of criteria for assessing participant's eligibility as an expert may have led to a more methodologically rigorous design. However, it was felt that a diverse range of experts from a wide range of backgrounds were recruited.

Finally, Delphi studies often involve multiple rounds of questioning to build consensus. In the current study only two rounds were used. However, given the high levels of consensus achieved in the second round it appears this was adequate and is also in line with studies using a similar methodology (Domoney et al., 2020).

Research Implications

This research has informed the development of materials for a parenting intervention for parents with children experiencing emotional or behavioural difficulties. As the intervention has been developed with input from a wide range of experts, parents and practitioners, it is worthy of further research. In line with the MRC Developing and Evaluating Complex Interventions Framework (Craig et al., 2013), initially, the intervention should undergo a feasibility and pilot trial, to inform whether and how the intervention should progress to a Randomized Control Trial. Feasibility questions should include how to identify services and participants for recruitment, testing the acceptability of the intervention and surrounding procedures, assessing the suitability and acceptability of outcome measurements, and calculating appropriate sample sizes. Refinements to the intervention can then therefore be made, before progressing to larger scale studies.

Clinical Implications

The current study has informed the development of a promising brief parenting intervention to help parents to support their children to learn about emotions. There is prior evidence to suggest that enhancing emotional understanding could have a wide range of impacts on emotional and behavioural problems in children (Morris et al., 2010; Olson et al., 2011). This intervention could therefore be an efficacious and cost effective option for both families and services and answers calls for preventative programmes to address early emerging behavioural and emotional difficulties (Department of Health and Social Care, 2017; National Assembly for Wales, Children, Young People and Education Committee, 2018; Collishaw & Sellers, 2020).

Conclusions

This study aimed to systematically develop a brief parenting group intervention aiming to improve children's understanding of emotions. Following MRC guidance and using a Delphi Survey method technique to gather expert consensus the important elements of the intervention have been established. This includes a number of practical elements, ways in which a safe group space can be established and intervention content to be included. All items generated in the first round achieved at least moderate consensus (in the second round) for inclusion in the intervention. The study gathered consensus from a wide range of experts and has been used to inform the development of the intervention. The intervention is likely to be a beneficial intervention for parents supporting children with emotional and behavioural problems and will now go onto to be researched further in the form of feasibility and pilot trial studies.

References

Adegboye, D., Williams, F., Collishaw, S., Shelton, K., Langley, K., Hobson, C., Burley, D., & van Goozen, S. (2021). Understanding why the COVID-19 pandemic-related lockdown increases mental health difficulties in vulnerable young children. *JCPP Advances*, *1*(1). https://doi.org/10.1111/jcv2.12005

Adkins, T., Luyten, P., & Fonagy, P. (2018). Development and preliminary evaluation of family minds: a mentalization-based psychoeducation program for foster parents. *Journal of Child and Family Studies*, *27*(8), 2519-2532. https://doi.org/10.1007/s10826-018-1080-x

Asen, E., & Fonagy, P. (2012). Mentalization-based therapeutic interventions for

    families. *Journal of Family Therapy*, *34*(4), 347-370.

    https://doi.org/10.1111/j.1467-6427.2011.00552.x

Aylward, M., Phillips, C., & Howson, H. (2013). Simply Prudent Healthcare–

    achieving better care and value for money in Wales–discussion paper. *The*

    Bevan commission, Cardiff.

    http://www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/Bevan%20Co

    mmission%20Simply%20Prudent%20Healthcare%20v1%2004122013.pdf

Birmaher, B., Williamson, D. E., Dahl, R. E., Axelson, D. A., Kaufman, J., Dorn, L.

    D., & Ryan, N. D. (2004). Clinical presentation and course of depression in

    youth: does onset in childhood differ from onset in adolescence?. *Journal of the*

    American Academy of Child & Adolescent Psychiatry, *43*(1), 63-70.

    https://doi.org/10.1097/00004583-200401000-00015

Borelli, J. L., St John, H. K., Cho, E., & Suchman, N. E. (2016). Reflective

    functioning in parents of school-aged children. *American Journal of*

    Orthopsychiatry, *86*(1), 24. https://doi.org/10.1037/ort0000141

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative*

    research in psychology, *3*(2), 77-101.

    http://.doi.org/10.1191/1478088706qp063oa

Byrne, G., Murphy, S., & Connon, G. (2020). Mentalization-based treatments with

    children and families: A systematic review of the literature. *Clinical Child*

    Psychology and Psychiatry, *25*(4), 1022-1048.

    https://doi.org/10.1177/1359104520920689

Byrne, G., Sleed, M., Midgley, N., Fearon, P., Mein, C., Bateman, A., & Fonagy, P. (2019). Lighthouse Parenting Programme: Description and pilot evaluation of mentalization-based treatment to address child maltreatment. *Clinical child psychology and psychiatry*, *24*(4), 680-693. https://doi.org/10.1177/1359104518807741

Camoirano, A. (2017). Mentalizing makes parenting work: A review about parental reflective functioning and clinical interventions to improve it. *Frontiers in psychology*, *8*, 14. https://doi.org/10.3389/fpsyg.2017.00014

Collishaw, S. (2015). Annual research review: secular trends in child and adolescent mental health. *Journal of Child Psychology and Psychiatry*, *56*(3), 370-393. https://doi.org/10.1111/jcpp.12372

Collishaw, S., Furzer, E., Thapar, A. K., & Sellers, R. (2019). Brief report: a comparison of child mental health inequalities in three UK population cohorts. *European child & adolescent psychiatry*, *28*(11), 1547-1549. https://doi.org/10.1007/s00787-019-01305-9

Collishaw, S., & Sellers, R. (2020). Trends in child and adolescent mental health prevalence, outcomes, and inequalities. *Mental Health and Illness of Children and Adolescents*, 63-73. https://doi.org/10.1007/978-981-10-2348-4_9

Cost, K. T., Crosbie, J., Anagnostou, E., Birken, C. S., Charach, A., Monga, S., Kelley, E., Nicolson, R., Maguire, J. L., Burton, C. L., Schachar, R. J., Arnold, P. D., & Korczak, D. J. (2021). Mostly worse, occasionally better: impact of COVID-19 pandemic on the mental health of Canadian children and adolescents. *European Child and Adolescent Psychiatry*, *0123456789*. https://doi.org/10.1007/s00787-021-01744-3

Craig, P., Dieppe, P., Macintyre, S., Michie, S., Nazareth, I., & Petticrew, M. (2013). Developing and evaluating complex interventions: the new Medical Research Council guidance. https://doi.org/10.1136/bmj.a1655

Domoney, J., Trevillion, K., & Challacombe, F. L. (2020). Developing an intervention for paternal perinatal depression: An international Delphi study. *Journal of Affective Disorders Reports*, *2*, 100033. https://doi.org/10.1016/j.jadr.2020.100033

Eisenberg, N., Cumberland, A., & Spinrad, T. L. (1998). Parental socialization of emotion. *Psychological inquiry*, *9*(4), 241-273. https://doi.org/10.1207/s15327965pli0904_1

Enav, Y., Erhard-Weiss, D., Kopelman, M., Samson, A. C., Mehta, S., Gross, J. J., & Hardan, A. Y. (2019). A non randomized mentalization intervention for parents of children with autism. *Autism Research*, *12*(7), 1077-1086. https://doi.org/10.1002/aur.2108

Florean, I. S., Dobrean, A., Păsărelu, C. R., Georgescu, R. D., & Milea, I. (2020). The Efficacy of Internet-Based Parenting Programs for Children and Adolescents with Behavior Problems: A Meta-Analysis of Randomized Clinical Trials. *Clinical Child and Family Psychology Review*, *23*(4), 510-528. https://doi.org/10.1007/s10567-020-00326-0

Fonagy, P., Steele, M., Steele, H., Moran, G. S., & Higgitt, A. C. (1991). The capacity for understanding mental states: The reflective self in parent and child and its significance for security of attachment. *Infant mental health journal*, *12*(3), 201-218. https://doi.org/10.1002/1097-0355(199123)12:3<201::AID-IMHJ2280120307>3.0.CO;2-7

Garcia, A. R., DeNard, C., Ohene, S., Morones, S. M., & Connaughton, C. (2018). "I am more than my past": Parents' attitudes and perceptions of the Positive Parenting Program in Child Welfare. *Children and Youth Services Review*, *88*, 286-297. https://doi.org/10.1016/j.childyouth.2018.03.023

Gaviţa, O. A., David, D., Bujoreanu, S., Tiba, A., & Ionuţiu, D. R. (2012). The efficacy of a short cognitive–behavioral parent program in the treatment of externalizing behavior disorders in Romanian foster care children: Building parental emotion-regulation through unconditional self-and child-acceptance strategies. *Children and Youth Services Review*, *34*(7), 1290-1297. https://doi.org/10.1016/j.childyouth.2012.03.001

Habibi, A., Sarafrazi, A., & Izadyar, S. (2014). Delphi technique theoretical framework in qualitative research. *The International Journal of Engineering and Science*, *3*(4), 8-13.

Hajal, N. J., & Paley, B. (2020). Parental emotion and emotion regulation: A critical target of study for research and intervention to promote child emotion socialization. *Developmental psychology*, *56*(3), 403. https://doi.org/10.1037/dev0000864

Hasson, F., Keeney, S., & McKenna, H. (2000). Research guidelines for the Delphi survey technique. *Journal of advanced nursing*, *32*(4), 1008-1015. https://doi.org/10.1046/j.1365-2648.2000.t01-1-01567.x

Havighurst, S. S., Radovini, A., Hao, B., & Kehoe, C. E. (2020). Emotion-focused parenting interventions for prevention and treatment of child and adolescent mental health problems: a review of recent literature. *Current Opinion in Psychiatry*, *33*(6), 586-601. https://doi.org/ 10.1097/YCO.0000000000000647

Havighurst, S. S., Wilson, K. R., Harley, A. E., & Prior, M. R. (2009). Tuning in to kids: an emotion-focused parenting program—initial findings from a community trial. *Journal of Community Psychology*, *37*(8), 1008-1023. https://doi.org/10.1002/jcop.20345

Havighurst, S. S., Wilson, K. R., Harley, A. E., Prior, M. R., & Kehoe, C. (2010). Tuning in to Kids: improving emotion socialization practices in parents of preschool children–findings from a community trial. *Journal of Child Psychology and Psychiatry*, *51*(12), 1342-1350. https://doi.org/10.1111/j.1469-7610.2010.02303.x

Havighurst, S. S., Wilson, K. R., Harley, A. E., Kehoe, C., Efron, D., & Prior, M. R. (2013). "Tuning into Kids": Reducing young children's behavior problems using an emotion coaching parenting program. *Child Psychiatry & Human Development*, *44*(2), 247-264. https://doi.org/10.1007/s10578-012-0322-1

Havighurst, S. S., Duncombe, M., Frankling, E., Holland, K., Kehoe, C., & Stargatt, R. (2015). An emotion-focused early intervention for children with emerging conduct problems. *Journal of abnormal child psychology*, *43*(4), 749-760. https://doi.org/10.1007/s10802-014-9944-z

Herbert, S. D., Harvey, E. A., Roberts, J. L., Wichowski, K., & Lugo-Candelas, C. I. (2013). A randomized controlled trial of a parent training and emotion socialization program for families of hyperactive preschool-aged children. *Behavior therapy*, *44*(2), 302-316. https://doi.org/10.1016/j.beth.2012.10.004

Hubble, K., Bowen, K. L., Moore, S. C., & Van Goozen, S. H. (2015). Improving negative emotion recognition in young offenders reduces subsequent crime. *PLoS one*, *10*(6), e0132035. https://doi.org/10.1371/journal.pone.0132035

Hunnikin, L. M., Wells, A. E., Ash, D. P., & Van Goozen, S. H. (2020). The nature and extent of emotion recognition and empathy impairments in children showing disruptive behaviour referred into a crime prevention programme. *European child & adolescent psychiatry*, *29*(3), 363-371. https://doi.org/10.1007/s00787-019-01358-w

Izard, C., Fine, S., Schultz, D., Mostow, A., Ackerman, B., & Youngstrom, E. (2001). Emotion knowledge as a predictor of social behavior and academic competence in children at risk. *Psychological science*, *12*(1), 18-23. https://doi.org/10.1111/1467-9280.00304

Jorm, A. F. (2015). Using the Delphi expert consensus method in mental health research. *Australian & New Zealand Journal of Psychiatry*, *49*(10), 887-897. https://doi.org/10.1177/0004867415600891

Jünger, S., Payne, S. A., Brine, J., Radbruch, L., & Brearley, S. G. (2017). Guidance on Conducting and REporting DElphi Studies (CREDES) in palliative care: recommendations based on a methodological systematic review. *Palliative medicine*, *31*(8), 684-706. https://doi.org/10.1177/0269216317690685

Keeney, S., McKenna, H., & Hasson, F. (2011). *The Delphi technique in nursing and health research*. John Wiley & Sons.

Kim-Cohen, J., Caspi, A., Moffitt, T. E., Harrington, H., Milne, B. J., & Poulton, R. (2003). Prior juvenile diagnoses in adults with mental disorder: developmental follow-back of a prospective-longitudinal cohort. *Archives of general psychiatry*, *60*(7), 709-717. https://doi.org/ 10.1001/archpsyc.60.7.709

Krueger, R. F., & Eaton, N. R. (2015). Transdiagnostic factors of mental

disorders. *World psychiatry : official journal of the World Psychiatric

Association (WPA)*, *14*(1), 27–29. https://doi.org/10.1002/wps.20175

Lewis, C., Roberts, N., Vick, T., & Bisson, J. I. (2013). Development of a guided

self-help (GSH) program for the treatment of mild-to-moderate posttraumatic

stress disorder (PTSD). *Depression and anxiety*, *30*(11), 1121-1128.

https://doi.org/10.1002/da.22128

Mason, W. A., January, S. A. A., Fleming, C. B., Thompson, R. W., Parra, G. R.,

Haggerty, K. P., & Snyder, J. J. (2016). Parent training to reduce problem

behaviors over the transition to high school: Tests of indirect effects through

improved emotion regulation skills. *Children and youth services review*, *61*,

176-183. https://doi.org/10.1016/j.childyouth.2015.12.022

Maughan, B., & Collishaw, S. (2015). Development and psychopathology: a life course

perspective. *Rutter's child and adolescent psychiatry*, *6*, 1-16.

https://doi.org/10.1002/9781118381953

Mays, N., & Pope, C. (2000). Assessing quality in qualitative research. *Bmj*, *320*(7226),

50-52. https://doi.org/10.1136/bmj.320.7226.50

Meins, E., Centifanti, L. C. M., Fernyhough, C., & Fishburn, S. (2013). Maternal mind-

mindedness and children's behavioral difficulties: Mitigating the impact of low

socioeconomic status. *Journal of abnormal child psychology*, *41*(4), 543-553.

https://doi.org/10.1007/s10802-012-9699-3

Midgley, N., Besser, S. J., Fearon, P., Wyatt, S., Byford, S., & Wellsted, D. (2019). The

Herts and Minds study: feasibility of a randomised controlled trial of

Mentalization-Based Treatment versus usual care to support the wellbeing of

children in foster care. *BMC psychiatry*, *19*(1), 1-11.

https://doi.org/10.1186/s12888-019-2196-2

Midgley, N., Cirasola, A., Austerberry, C., Ranzato, E., West, G., Martin, P., ... & Park, T. (2019). Supporting foster carers to meet the needs of looked after children: A feasibility and pilot evaluation of the Reflective Fostering Programme. *Developmental Child Welfare*, *1*(1), 41-60.

https://doi.org/10.1177/2516103218817550

Midgley, N., & Vrouva, I. (Eds.). (2013). *Minding the child: Mentalization-based interventions with children, young people and their families*. Routledge.

Mier, D., Lis, S., Neuthe, K., Sauer, C., Esslinger, C., Gallhofer, B., & Kirsch, P. (2010). The involvement of emotion recognition in affective theory of mind. *Psychophysiology*, *47*(6), 1028-1039. https://doi.org/10.1111/j.1469-8986.2010.01031.x

Mohler-kuo, M., Dzemaili, S., Foster, S., Werlen, L., & Walitza, S. (2021). Stress and mental health among children/adolescents, their parents, and young adults during the first COVID-19 lockdown in Switzerland. *International Journal of Environmental Research and Public Health*, *18*(9).

https://doi.org/10.3390/ijerph18094668

Morris, A. S., Silk, J. S., Steinberg, L., Terranova, A. M., & Kithakye, M. (2010). Concurrent and longitudinal links between children's externalizing behavior in school and observed anger regulation in the mother–child dyad. *Journal of Psychopathology and Behavioral Assessment*, *32*(1), 48-56.

https://doi.org/10.1007/s10862-009-9166-9

Murray, C. J., Vos, T., Lozano, R., Naghavi, M., Flaxman, A. D., Michaud, C., ... &
Haring, D. (2012). Disability-adjusted life years (DALYs) for 291 diseases and
injuries in 21 regions, 1990–2010: a systematic analysis for the Global Burden
of Disease Study 2010. *The lancet*, *380*(9859), 2197-2223.
https://doi.org/10.1016/S0140-6736(12)61689-4

National Assembly for Wales, Children, Young People and Education Committee.
(2018). Mind over Matter. Retrieved from
https://www.assembly.wales/laid%20documents/cr-ld11522/cr-ld11522-e.pdf.

Nonweiler, J., Rattray, F., Baulcomb, J., Happé, F., & Absoud, M. (2020). Prevalence
and Associated Factors of Emotional and Behavioural Difficulties during
COVID-19 Pandemic in Children with Neurodevelopmental Disorders.
Children, *7*(9), 128. https://doi.org/10.3390/children7090128

Olson, S. L., Lopez-Duran, N., Lunkenheimer, E. S., Chang, H., & Sameroff, A. J.
(2011). Individual differences in the development of early peer aggression:
integrating contributions of self-regulation, theory of mind, and
parenting. *Development and psychopathology*, *23*(1), 253–266.
https://doi.org/10.1017/S0954579410000775

Patton, G. C., Sawyer, S. M., Santelli, J. S., Ross, D. A., Afifi, R., Allen, N. B., ... &
Viner, R. M. (2016). Our future: a Lancet commission on adolescent health and
wellbeing. *The Lancet*, *387*(10036), 2423-2478. https://doi.org/10.1016/S0140-6736(16)00579-1

Pezaro, S., & Clyne, W. (2015). Achieving consensus in the development of an online
intervention designed to effectively support midwives in work-related

psychological distress: protocol for a Delphi study. *JMIR research protocols*, *4*(3), e107. https://doi.org/10.2196/resprot.4766

Roza, S. J., Hofstra, M. B., Van Der Ende, J., & Verhulst, F. C. (2003). Stable prediction of mood and anxiety disorders based on behavioral and emotional problems in childhood: A 14-year follow-up during childhood, adolescence, and young adulthood. *American Journal of Psychiatry*, *160*(12), 2116-2121. https://doi.org/10.1176/appi.ajp.160.12.2116

Schmidt, F., Chomycz, S., Houlding, C., Kruse, A., & Franks, J. (2014). The association between therapeutic alliance and treatment outcomes in a group triple P intervention. *Journal of Child and Family Studies*, *23*(8), 1337-1350. https://doi.org/10.1007/s10826-013-9792-4

Sadler, K., Vizard, T., Ford, T., Marchesell, F., Pearce, N., Mandalia, D., ... & McManus, S. (2018). Mental health of children and young people in England, 2017. Retrieved from https://dera.ioe.ac.uk/32622/1/MHCYP%202017%20Summary.pdf

Sharp, C., Croudace, T. J., & Goodyer, I. M. (2007). Biased mentalizing in children aged seven to 11: Latent class confirmation of response styles to social scenarios and associations with psychopathology. *Social Development*, *16*(1), 181-202. https://doi.org/10.1111/j.1467-9507.2007.00378.x

Slade, A., Grienenberger, J., Bernbach, E., Levy, D., & Locker, A. (2005). Maternal reflective functioning, attachment, and the transmission gap: A preliminary study. *Attachment & Human Devlopment*, *7*(3), 283-298. https://doi.org/10.1080/14616730500245880

Suchman, N., DeCoste, C., Castiglioni, N., Legow, N., & Mayes, L. (2008). The Mothers and Toddlers Program: Preliminary findings from an attachment-based parenting intervention for substance-abusing mothers. *Psychoanalytic Psychology*, *25*(3), 499. https://doi.org/10.1037/0736-9735.25.3.499

Suchman, N. E., Ordway, M. R., de las Heras, L., & McMahon, T. J. (2016). Mothering from the Inside Out: Results of a pilot study testing a mentalization-based therapy for mothers enrolled in mental health services. *Attachment and Human Development*, *18*, 596–617. https://doi.org/10.1080/14616734.2016.1226371

Surowiecki, J. (2004). The wisdom of crowds: Why the many are smarter than the few and how collective wisdom shapes business. *Economies, Societies and Nations*, *296*(10.5555), 1095645.

van Goozen, S. H. (2015). The role of early emotion impairments in the development of persistent antisocial behavior. *Child Development Perspectives*, *9*(4), 206-210. https://doi.org/10.1111/cdep.12134

Webster-Stratton, C. (2001). The incredible years: Parents, teachers, and children training series. *Residential treatment for children & youth*, *18*(3), 31-45. https://doi.org/10.1300/J007v18n03_04

Webster-Stratton, C., & Reid, M. J. (2003). Treating conduct problems and strengthening social and emotional competence in young children: The Dina Dinosaur treatment program. *Journal of emotional and behavioral disorders*, *11*(3), 130-143. https://doi.org/10.1300/J007v18n03_04

Wells, A. E., Hunnikin, L. M., Ash, D. P., & Van Goozen, S. H. (2020). Children with behavioural problems misinterpret the emotions and intentions of others. *Journal of abnormal child psychology*, *48*(2), 213-221. https://doi.org/10.1007/s10802-019-00594-7

Appendices

Appendix A: Author guidelines for Parenting: Science and Practice

About the Journal

Parenting is an international, peer-reviewed journal publishing high-quality, original research. Please see the journal's Aims & Scope for information about its focus and peer-review policy.

Please note that this journal only publishes manuscripts in English.

Parenting accepts the following types of article: original articles.

Open Access

You have the option to publish open access in this journal via our Open Select publishing program. Publishing open access means that your article will be free to access online immediately on publication, increasing the visibility, readership and impact of your research. Articles published Open Select with Taylor & Francis typically receive 32% more citations* and over 6 times as many downloads** compared to those that are not published Open Select.

Your research funder or your institution may require you to publish your article open access. Visit our Author Services website to find out more about open access policies and how you can comply with these.

You will be asked to pay an article publishing charge (APC) to make your article open access and this cost can often be covered by your institution or funder. Use our APC finder to view the APC for this journal.

Please visit our Author Services website or contact openaccess@tandf.co.uk if you would like more information about our Open Select Program.

*Citations received up to Jan 31st 2020 for articles published in 2015-2019 in journals listed in Web of Science®.
**Usage in 2017-2019 for articles published in 2015-2019.

Peer Review and Ethics

Taylor & Francis is committed to peer-review integrity and upholding the highest standards of review. Once your paper has been assessed for suitability by the editor, it will then be double blind peer reviewed by independent, anonymous expert referees. Find out more about what to expect during peer review and read our guidance on publishing ethics.

Preparing Your Paper

Structure

Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).

Word Limits

Please include a word count for your paper. There are no word limits for papers in this journal.

Style Guidelines

Please refer to these quick style guidelines when preparing your paper, rather than any published articles or a sample copy.

Please use American spelling style consistently throughout your manuscript.

Please use double quotation marks, except where "a quotation is 'within' a quotation". Please note that long quotations should be indented without quotation marks.

Submissions to Parenting: Science and Practice should follow the style guidelines described in the Publication Manual of the American Psychological Association (6th ed.). Merriam-Webster's Collegiate Dictionary (11th ed.) should be consulted for spelling. Funding details: Please supply all details required by your funding and grant-awarding bodies as follows: For single agency grants. This work was supported by the under Grant. For multiple agency grants This work was supported by the under Grant; under Grant ; and under Grant . COI Disclosure Form Parenting requires each co-author of each accepted manuscript to fill out the ICMJE Form for Disclosure of Potential Conflicts of Interest. Please use the "COI Disclosure Form" designation to upload these forms. We will need to receive them before accepting your manuscript for publication. Please click here to download the COI disclosure form. Ethics The Editor and Taylor & Francis Group are committed to the highest academic, professional, legal, and ethical standards in publishing work in this journal. To this end, we have adopted a set of guidelines, to which all submitting authors are expected to adhere, to assure integrity and ethical publishing for authors, reviewers, and editors. Taylor & Francis is a member of the Committee of Publications Ethics (COPE). COPE aims to provide a forum for publishers and editors of scientific journals to discuss issues relating to the integrity of their work, including conflicts of interest, falsification and fabrication of data, plagiarism, unethical experimentation, inadequate subject consent, and authorship disputes. For more information on COPE please visit http://publicationethics.org.

Formatting and Templates

Papers may be submitted in Word or LaTeX formats. Figures should be saved separately from the text. To assist you in preparing your paper, we provide formatting template(s).

Word templates are available for this journal. Please save the template to your hard drive, ready for use.

If you are not able to use the template via the links (or if you have any other template queries) please contact us here.

References

Please use this reference guide when preparing your paper.

Taylor & Francis Editing Services

To help you improve your manuscript and prepare it for submission, Taylor & Francis provides a range of editing services. Choose from options such as English Language Editing, which will ensure that your article is free of spelling and grammar errors, Translation, and Artwork Preparation. For more information, including pricing, visit this website.

Checklist: What to Include

1.   **Author details.** All authors of a manuscript should include their full name and affiliation on the cover page of the manuscript. Where available, please also include ORCiDs and social media handles (Facebook, Twitter or LinkedIn). One author will need to be identified as the corresponding author, with their email address normally displayed in the article PDF (depending on the journal) and the online article. Authors' affiliations are the affiliations where the research was conducted. If any of the named co-authors moves affiliation during the peer-review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after your paper is accepted. Read more on authorship.

2.   Should contain an unstructured abstract of 250 words.

3.   You can opt to include a **video abstract** with your article. Find out how these can help your work reach a wider audience, and what to think about when filming.

4.   Between 3 and 5 **keywords**. Read making your article more discoverable, including information on choosing a title and search engine optimization.

5.   **Funding details.** Please supply all details required by your funding and grant-awarding bodies as follows:
For single agency grants
This work was supported by the [Funding Agency] under Grant [number xxxx].
For multiple agency grants
This work was supported by the [Funding Agency #1] under Grant [number xxxx]; [Funding Agency #2] under Grant [number xxxx]; and [Funding Agency #3] under Grant [number xxxx].

6.   **Disclosure statement.** This is to acknowledge any financial interest or benefit that has arisen from the direct applications of your research. Further guidance on what is a conflict of interest and how to disclose it.

7.   **Biographical note.** Please supply a short biographical note for each author. This could be adapted from your departmental website or academic networking profile and should be relatively brief (e.g., no more than 200 words).

8.   **Data availability statement.** If there is a data set associated with the paper, please provide information about where the data supporting the results or analyses presented in the paper can be found. Where applicable, this should include the hyperlink, DOI or other persistent identifier associated with the data set(s). Templates are also available to support authors.

9.   **Data deposition.** If you choose to share or make the data underlying the study open, please deposit your data in a recognized data repository prior to or at the time of submission. You will be asked to provide the DOI, pre-reserved DOI, or other persistent identifier for the data set.

10.   **Supplemental online material.** Supplemental material can be a video, dataset, fileset, sound file or anything which supports (and is pertinent to) your paper. We publish supplemental material online via Figshare. Find out more about supplemental material and how to submit it with your article.

11.   **Figures.** Figures should be high quality (1200 dpi for line art, 600 dpi for grayscale and 300 dpi for color, at the correct size). Figures should be supplied in one of our preferred file formats: EPS, PDF, PS, JPEG, TIFF, or Microsoft Word (DOC or DOCX) files are acceptable for figures that have been drawn in Word. For information relating to other file types, please consult our Submission of electronic artwork document.

12.   **Tables.** Tables should present new information rather than duplicating what is in the text. Readers should be able to interpret the table without reference to the text. Please supply editable files.

13.   **Equations.** If you are submitting your manuscript as a Word document, please ensure that equations are editable. More information about mathematical symbols and equations.

14.   **Units.** Please use SI units (non-italicized).

Using Third-Party Material in your Paper

You must obtain the necessary permission to reuse third-party material in your article. The use of short extracts of text and some other types of material is usually permitted, on a limited basis, for the purposes of criticism and review without securing formal permission. If you wish to include any material in your paper for which you do not hold copyright, and which is not covered by this informal agreement, you will need to obtain written permission from the copyright owner prior to submission. More information on requesting permission to reproduce work(s) under copyright.

Submitting Your Paper

This journal uses Taylor & Francis' Submission Portal to manage the submission process. The Submission Portal allows you to see your submissions across Taylor & Francis' journal portfolio in one place. To submit your manuscript please click here.

If you are submitting in LaTeX, please convert the files to PDF beforehand (you will also need to upload your LaTeX source files with the PDF).

Please note that *Parenting* uses Crossref™ to screen papers for unoriginal material. By submitting your paper to *Parenting* you are agreeing to originality checks during the peer-review and production processes.

On acceptance, we recommend that you keep a copy of your Accepted Manuscript. Find out more about sharing your work.

Data Sharing Policy

This journal applies the Taylor & Francis Basic Data Sharing Policy. Authors are encouraged to share or make open the data supporting the results or analyses presented in their paper where this does not violate the protection of human subjects or other valid privacy or security concerns.

Authors are encouraged to deposit the dataset(s) in a recognized data repository that can mint a persistent digital identifier, preferably a digital object identifier (DOI) and recognizes a long-term preservation plan. If you are uncertain about where to deposit your data, please see this information regarding repositories.

Authors are further encouraged to cite any data sets referenced in the article and provide a Data Availability Statement.

At the point of submission, you will be asked if there is a data set associated with the paper. If you reply yes, you will be asked to provide the DOI, pre-registered DOI, hyperlink, or other persistent identifier associated with the data set(s). If you have selected to provide a pre-registered DOI, please be prepared to share the reviewer URL associated with your data deposit, upon request by reviewers.

Where one or multiple data sets are associated with a manuscript, these are not formally peer reviewed as a part of the journal submission process. It is the author's responsibility to ensure the soundness of data. Any errors in the data rest solely with the producers of the data set(s).

Publication Charges

There are no submission fees, publication fees or page charges for this journal.

Color figures will be reproduced in color in your online article free of charge. If it is necessary for the figures to be reproduced in color in the print version, a charge will apply.

Charges for color figures in print are $400 per figure (£300; $500 Australian Dollars; €350). For more than 4 color figures, figures 5 and above will be charged at $75 per figure (£50; $100 Australian Dollars; €65). Depending on your location, these charges may be subject to local taxes.

Copyright Options

Copyright allows you to protect your original material, and stop others from using your work without your permission. Taylor & Francis offers a number of different license and reuse options, including Creative Commons licenses when publishing open access. Read more on publishing agreements.

Complying with Funding Agencies

We will deposit all National Institutes of Health or Wellcome Trust-funded papers into PubMedCentral on behalf of authors, meeting the requirements of their respective open access policies. If this applies to you, please tell our production team when you receive your article proofs, so we can do this for you. Check funders' open access policy mandates here. Find out more about sharing your work.

My Authored Works

On publication, you will be able to view, download and check your article's metrics (downloads, citations and Altmetric data) via My Authored Works on Taylor & Francis Online. This is where you can access every article you have published with us, as well as your free eprints link, so you can quickly and easily share your work with friends and colleagues.

We are committed to promoting and increasing the visibility of your article. Here are some tips and ideas on how you can work with us to promote your research.

Article Reprints

You will be sent a link to order article reprints via your account in our production system. For enquiries about reprints, please contact Taylor & Francis at reprints@taylorandfrancis.com. You can also order print copies of the journal issue in which your article appears.

Queries

Should you have any queries, please visit our Author Services website or contact us here.

Appendix B: EPHPP (Effective Public Health Practice Project) – Quality Assessment Tool for Quantitative Studies

QUALITY ASSESSMENT TOOL FOR QUANTITATIVE STUDIES

EPHPP
Effective Public Health Practice Project

COMPONENT RATINGS

A)   SELECTION BIAS

(Q1)   Are the individuals selected to participate in the study likely to be representative of the target population?
1   Very likely
2   Somewhat likely
3   Not likely
4   Can't tell

(Q2)   What percentage of selected individuals agreed to participate?
1   80 - 100% agreement
2   60 – 79% agreement
3   less than 60% agreement
4   Not applicable
5   Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

B)   STUDY DESIGN

Indicate the study design
1   Randomized controlled trial
2   Controlled clinical trial
3   Cohort analytic (two group pre + post)
4   Case-control
5   Cohort (one group pre + post (before and after))
6   Interrupted time series
7   Other specify _____
8   Can't tell

Was the study described as randomized? If NO, go to Component C.
No   Yes

If Yes, was the method of randomization described? (See dictionary)
No   Yes

If Yes, was the method appropriate? (See dictionary)
No   Yes

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

l

C) CONFOUNDERS

(Q1) Were there important differences between groups prior to the intervention?
1. Yes
2. No
3. Can't tell

The following are examples of confounders:
1. Race
2. Sex
3. Marital status/family
4. Age
5. SES (income or class)
6. Education
7. Health status
8. Pre-intervention score on outcome measure

(Q2) If yes, indicate the percentage of relevant confounders that were controlled (either in the design (e.g. stratification, matching) or analysis)?
1. 80 – 100% (most)
2. 60 – 79% (some)
3. Less than 60% (few or none)
4. Can't Tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

D) BLINDING

(Q1) Was (were) the outcome assessor(s) aware of the intervention or exposure status of participants?
1. Yes
2. No
3. Can't tell

(Q2) Were the study participants aware of the research question?
1. Yes
2. No
3. Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

E) DATA COLLECTION METHODS

(Q1) Were data collection tools shown to be valid?
1. Yes
2. No
3. Can't tell

(Q2) Were data collection tools shown to be reliable?
1. Yes
2. No
3. Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

2

F) WITHDRAWALS AND DROP-OUTS

(Q1)   Were withdrawals and drop-outs reported in terms of numbers and/or reasons per group?
    1   Yes
    2   No
    3   Can't tell
    4   Not Applicable (i.e. one time surveys or interviews)

(Q2)   Indicate the percentage of participants completing the study. (If the percentage differs by groups, record the lowest).
    1   80 -100%
    2   60 - 79%
    3   less than 60%
    4   Can't tell
    5   Not Applicable (i.e. Retrospective case-control)

RATE THIS SECTION	STRONG	MODERATE	WEAK	
See dictionary	1	2	3	Not Applicable

G) INTERVENTION INTEGRITY

(Q1)   What percentage of participants received the allocated intervention or exposure of interest?
    1   80 -100%
    2   60 - 79%
    3   less than 60%
    4   Can't tell

(Q2)   Was the consistency of the intervention measured?
    1   Yes
    2   No
    3   Can't tell

(Q3)   Is it likely that subjects received an unintended intervention (contamination or co-intervention) that may influence the results?
    4   Yes
    5   No
    6   Can't tell

H) ANALYSES

(Q1)   Indicate the unit of allocation (circle one)
    community   organization/institution   practice/office   individual

(Q2)   Indicate the unit of analysis (circle one)
    community   organization/institution   practice/office   individual

(Q3)   Are the statistical methods appropriate for the study design?
    1   Yes
    2   No
    3   Can't tell

(Q4)   Is the analysis performed by intervention allocation status (i.e. intention to treat) rather than the actual intervention received?
    1   Yes
    2   No
    3   Can't tell

3

119

GLOBAL RATING

COMPONENT RATINGS
Please transcribe the information from the gray boxes on pages 1-4 onto this page. See dictionary on how to rate this section.

A	SELECTION BIAS	STRONG	MODERATE	WEAK	
		1	2	3	
B	STUDY DESIGN	STRONG	MODERATE	WEAK	
		1	2	3	
C	CONFOUNDERS	STRONG	MODERATE	WEAK	
		1	2	3	
D	BLINDING	STRONG	MODERATE	WEAK	
		1	2	3	
E	DATA COLLECTION METHOD	STRONG	MODERATE	WEAK	
		1	2	3	
F	WITHDRAWALS AND DROPOUTS	STRONG	MODERATE	WEAK	
		1	2	3	Not Applicable

GLOBAL RATING FOR THIS PAPER (circle one):

1	STRONG	(no WEAK ratings)
2	MODERATE	(one WEAK rating)
3	WEAK	(two or more WEAK ratings)

With both reviewers discussing the ratings:

Is there a discrepancy between the two reviewers with respect to the component (A-F) ratings?

No   Yes

If yes, indicate the reason for the discrepancy

1	Oversight
2	Differences in interpretation of criteria
3	Differences in interpretation of study

Final decision of both reviewers (circle one):

1	STRONG
2	MODERATE
3	WEAK

4

Quality Assessment Tool for Quantitative Studies Dictionary

The purpose of this dictionary is to describe items in the tool thereby assisting raters to score study quality. Due to under-reporting or lack of clarity in the primary study, raters will need to make judgements about the extent that bias may be present. When making judgements about each component, raters should form their opinion based upon information contained in the study rather than making inferences about what the authors intended.

A)   SELECTION BIAS

(Q1) Participants are more likely to be representative of the target population if they are randomly selected from a comprehensive list of individuals in the target population (score very likely). They may not be representative if they are referred from a source (e.g. clinic) in a systematic manner (score somewhat likely) or self-referred (score not likely).

(Q2) Refers to the % of subjects in the control and intervention groups that agreed to participate in the study before they were assigned to intervention or control groups.

B)   STUDY DESIGN

In this section, raters assess the likelihood of bias due to the allocation process in an experimental study. For observational studies, raters assess the extent that assessments of exposure and outcome are likely to be independent. Generally, the type of design is a good indicator of the extent of bias. In stronger designs, an equivalent control group is present and the allocation process is such that the investigators are unable to predict the sequence.

Randomized Controlled Trial (RCT)

An experimental design where investigators randomly allocate eligible people to an intervention or control group. A rater should describe a study as an RCT if the randomization sequence allows each study participant to have the same chance of receiving each intervention and the investigators could not predict which intervention was next. If the investigators do not describe the allocation process and only use the words 'random' or 'randomly', the study is described as a controlled clinical trial.

See below for more details.

Was the study described as randomized?

Score YES, if the authors used words such as random allocation, randomly assigned, and random assignment.

Score NO, if no mention of randomization is made.

Was the method of randomization described?

Score YES, if the authors describe any method used to generate a random allocation sequence.

Score NO, if the authors do not describe the allocation method or describe methods of allocation such as alternation, case record numbers, dates of birth, day of the week, and any allocation procedure that is entirely transparent before assignment, such as an open list of random numbers of assignments.
If NO is scored, then the study is a controlled clinical trial.

Was the method appropriate?

Score YES, if the randomization sequence allowed each study participant to have the same chance of receiving each intervention and the investigators could not predict which intervention was next. Examples of appropriate approaches include assignment of subjects by a central office unaware of subject characteristics, or sequentially numbered, sealed, opaque envelopes.

Score NO, if the randomization sequence is open to the individuals responsible for recruiting and allocating participants or providing the intervention, since those individuals can influence the allocation process, either knowingly or unknowingly.

If NO is scored, then the study is a controlled clinical trial.

Controlled Clinical Trial (CCT)
An experimental study design where the method of allocating study subjects to intervention or control groups is open to individuals responsible for recruiting subjects or providing the intervention. The method of allocation is transparent before assignment, e.g. an open list of random numbers or allocation by date of birth, etc.

Cohort analytic (two group pre and post)
An observational study design where groups are assembled according to whether or not exposure to the intervention has occurred. Exposure to the intervention is not under the control of the investigators. Study groups might be non-equivalent or not comparable on some feature that affects outcome.

Case control study
A retrospective study design where the investigators gather 'cases' of people who already have the outcome of interest and 'controls' who do not. Both groups are then questioned or their records examined about whether they received the intervention exposure of interest.

Cohort (one group pre + post (before and after)
The same group is pretested, given an intervention, and tested immediately after the intervention. The intervention group, by means of the pretest, act as their own control group.

Interrupted time series
A time series consists of multiple observations over time. Observations can be on the same units (e.g. individuals over time) or on different but similar units (e.g. student achievement scores for particular grade and school). Interrupted time series analysis requires knowing the specific point in the series when an intervention occurred.

C)   CONFOUNDERS

By definition, a confounder is a variable that is associated with the intervention or exposure and causally related to the outcome of interest. Even in a robust study design, groups may not be balanced with respect to important variables prior to the intervention. The authors should indicate if confounders were controlled in the design (by stratification or matching) or in the analysis. If the allocation to intervention and control groups is randomized, the authors must report that the groups were balanced at baseline with respect to confounders (either in the text or a table).

D)   BLINDING

(Q1) Assessors should be described as blinded to which participants were in the control and intervention groups. The purpose of blinding the outcome assessors (who might also be the care providers) is to protect against detection bias.

(Q2) Study participants should not be aware of (i.e. blinded to) the research question. The purpose of blinding the participants is to protect against reporting bias.

E) DATA COLLECTION METHODS

Tools for primary outcome measures must be described as reliable and valid. If 'face' validity or 'content' validity has been demonstrated, this is acceptable. Some sources from which data may be collected are described below:

Self reported data includes data that is collected from participants in the study (e.g. completing a questionnaire, survey, answering questions during an interview, etc.).

Assessment/Screening includes objective data that is retrieved by the researchers. (e.g. observations by investigators).

Medical Records/Vital Statistics refers to the types of formal records used for the extraction of the data.

Reliability and validity can be reported in the study or in a separate study. For example, some standard assessment tools have known reliability and validity.

F) WITHDRAWALS AND DROP-OUTS

Score **YES** if the authors describe BOTH the numbers and reasons for withdrawals and drop-outs.

Score **NO** if either the numbers or reasons for withdrawals and drop-outs are not reported.

The percentage of participants completing the study refers to the % of subjects remaining in the study at the final data collection period in all groups (i.e. control and intervention groups).

G) INTERVENTION INTEGRITY

The number of participants receiving the intended intervention should be noted (consider both frequency and intensity). For example, the authors may have reported that at least 80 percent of the participants received the complete intervention. The authors should describe a method of measuring if the intervention was provided to all participants the same way. As well, the authors should indicate if subjects received an unintended intervention that may have influenced the outcomes. For example, co-intervention occurs when the study group receives an additional intervention (other than that intended). In this case, it is possible that the effect of the intervention may be over-estimated. Contamination refers to situations where the control group accidentally receives the study intervention. This could result in an under-estimation of the impact of the intervention.

H) ANALYSIS APPROPRIATE TO QUESTION

Was the quantitative analysis appropriate to the research question being asked?

An intention-to-treat analysis is one in which all the participants in a trial are analyzed according to the intervention to which they were allocated, whether they received it or not. Intention-to-treat analyses are favoured in assessments of effectiveness as they mirror the noncompliance and treatment changes that are likely to occur when the intervention is used in practice, and because of the risk of attrition bias when participants are excluded from the analysis.

GLOBAL RATING

COMPONENT RATINGS
Please transcribe the information from the gray boxes on pages 1-4 onto this page. See dictionary on how to rate this section.

A	SELECTION BIAS	STRONG	MODERATE	WEAK	
		1	2	3	
B	STUDY DESIGN	STRONG	MODERATE	WEAK	
		1	2	3	
C	CONFOUNDERS	STRONG	MODERATE	WEAK	
		1	2	3	
D	BLINDING	STRONG	MODERATE	WEAK	
		1	2	3	
E	DATA COLLECTION METHOD	STRONG	MODERATE	WEAK	
		1	2	3	
F	WITHDRAWALS AND DROPOUTS	STRONG	MODERATE	WEAK	
		1	2	3	Not Applicable

GLOBAL RATING FOR THIS PAPER (circle one):

1	STRONG	(no WEAK ratings)
2	MODERATE	(one WEAK rating)
3	WEAK	(two or more WEAK ratings)

With both reviewers discussing the ratings:

Is there a discrepancy between the two reviewers with respect to the component (A-F) ratings?

No   Yes

If yes, indicate the reason for the discrepancy

1   Oversight
2   Differences in interpretation of criteria
3   Differences in interpretation of study

Final decision of both reviewers (circle one):   1   STRONG
2   MODERATE
3   WEAK

4

Appendix C: Ethical approval

From: psychethics <psychethics@cardiff.ac.uk>
Sent: 20 March 2020 14:01
To: Sarah Lavender <LavenderSR@cardiff.ac.uk>
Cc: Christopher Hobson <HobsonCW@cardiff.ac.uk>
Subject: Ethics Feedback - EC.19.11.12.5756R2

Dear Sarah,

The Ethics Committee has considered your revised PG project proposal: The development of a brief psychoeducational parenting group which aims to increase emotional learning and reduce externalising behaviours in 5-8 year old children (EC.19.11.12.5756R2).

The project has been approved.

Please note that if any changes are made to the above project then you must notify the Ethics Committee.

Best wishes,

Adam Hammond

School of Psychology Research Ethics Committee

Neurodevelopment Assessment Unit
Cardiff University Centre for Human Developmental Science
School of Psychology
Cardiff, CF10 3AT

NDAU

thewaterloofoundation*

CUCHDS
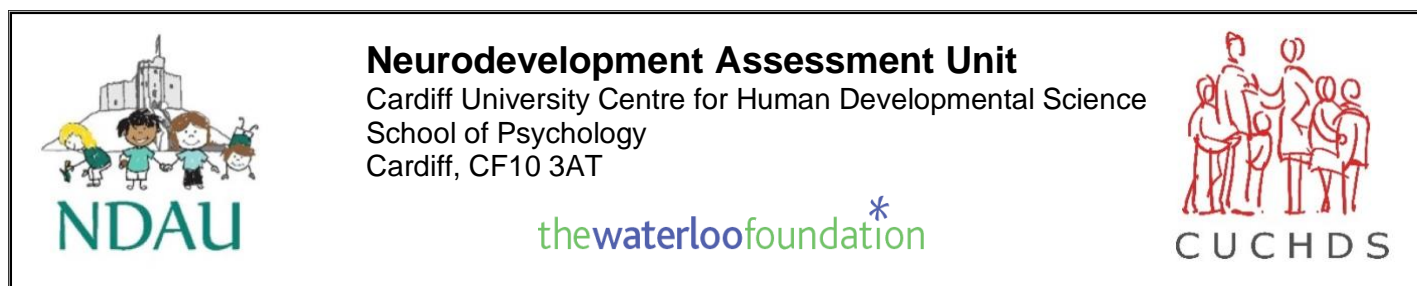
Study Information Sheet

(for Experts by Profession or Experience)

We would like to invite you to take part in a research study. Before deciding, we would like you to understand why we are doing this research and what it would involve. It would be very helpful if you could take a few minutes to read this information.

What is the purpose of this research study?

The Neurodevelopment Assessment Unit (NDAU) is part of the School of Psychology at Cardiff University, and is funded by the Waterloo Foundation. The NDAU is run by a group of scientists interested in understanding the social, emotional and behavioural problems experienced by young children. We work with children and parents to assess and understand different skills that are important for their learning and behaviour. We are interested in how young children understand emotions and how this influences their behaviour. We are going to develop a parenting intervention that aims to help parents to improve their own and their child's emotional learning and understanding of emotions. It is hoped this will impact children's behaviours positively. The intervention will also provide tips and techniques for managing difficult behaviour.

Why have we been invited to take part?

As an expert by profession or experience (either as a clinician, academic, teacher or parent), the research team would value your opinions in informing the development of the parenting intervention.

Do we have to take part?

No, it is up to you to decide to take part or not. Even once you have provided consent, you are still free to withdraw at any time without giving a reason.

What will happen if we decide to take part?

If you decide to take part you will be sent a portfolio of information about the intervention including rationale, structure and content via email. You will then take part in a semi-structured interview via Zoom, a video conferencing platform, facilitated by a trainee Clinical Psychologist. The interview will be recorded. You are also likely to be contacted by a member of the research team once the intervention

126

has been fully developed to gain your feedback on this. You might be invited to a further interview if we feel that further input is necessary (you would not be obliged to take part).

What are the possible advantages and disadvantages of taking part?

There are no risks involved in taking part. The interview and reviewing the portfolio will take up time but may offer the opportunity to share ideas and knowledge.

Will our information be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. All information is stored securely and the data gathered will be in an anonymised form. The audio file from the interview will be transcribed and all identifiable information will be removed.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the Director of the NDAU, Professor Stephanie van Goozen (contact details below).

What will happen to the results of this study?

The scientific results of the study will be analysed and studied by the research team; only members of the research team will have access to the data. The data may be reported in scientific papers and published in journals, and may be presented at conferences. You will not be personally identifiable in our description of our findings.

I am interested in taking part, what should I do next?

Please consider this information sheet and the attached consent form and email Sarah Lavender (lavendersr@cardiff.ac.uk) to inform us whether you will be willing to take part of have any further questions. If we have not heard anything within two weeks, we will send one further reminder email.

What if I have concerns about this research?

If you have any concerns or complaints about this project, please direct these in the first instance to: psychethics@cardiff.ac.uk. The data controller is Cardiff University and the Data Protection Officer is Matt Cooper CooperM1@cardiff.ac.uk . The lawful basis for the processing of the data you provide is consent.

Contact details of the research team:

Sarah Lavender, Trainee Clinical Psychologist, lavendersr@cardiff.ac.uk

Dr Chris Hobson, Clinical Psychologist/ Senior Academic Tutor, hobsoncw@cardiff.ac.uk

Professor Stephanie van Goozen, Director of the NDAU, vangoozens@cardiff.ac.uk

Neurodevelopment Assessment Unit
Cardiff University Centre for Human Developmental Science
School of Psychology
Cardiff, CF10 3AT

thewaterloofoundation*

NDAU

CUCHDS

Study Consent Form

(for Experts by Profession or Experience)

1.	I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2.	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected.

3.	I agree to take part in the study.

4.	I am happy for the research team to contact me following adaptations to the parenting group to gain feedback on changes.

_____ _____ _____
Name Date Signature

Appendix E: Intervention outline for Clinicians and Academics

Encouraging Children to Learn about Emotions Parent Intervention

Theoretical Rationale

Recognising and understanding emotions both in oneself and in others is a key part of adaptive development. The ability to regulate and recognise emotion is a skill that develops in the context of the child-caregiver relationship (Asen and Fonagy, 2012). When such relationships are marked by attachment security with a caregiver who encourages emotional expression, the child is more likely to learn to better recognise and understand their own and others' emotions, and therefore to have more successful affect regulation and attention control (Meins et al., 2001; Oppenheim and Koren-Karie, 2002; Slade et al., 2005). There is evidence to suggest that problems in a parent's ability to understand their own and others' emotional states is linked to children's behaviour problems (Meins, Centifanti, Fernyhough, & Fishburn, 2013; Sharp, Croudace, & Goodyer, 2008).

Research has highlighted that interventions aimed at parenting behaviours should be delivered early due to the significant beneficial effects it can have on a child's early socioemotional development (Boivin et al., 2005). Many parenting interventions aimed at supporting parents with younger children who are exhibiting difficulties tend to focus on behavioural approaches to parenting (e.g., the Incredible Years Parenting Programme; Webster-Stratton and Reid, 2003). Current research at Cardiff University provides evidence that teaching children to directly learn about emotions has a positive effect on emotional and behavioural difficulties and peer relationships (Hubble et al., 2015; Hunnikin et al., 2020; Hunnikin, 2018; van Goozen, 2015). At the same time, mentalization-informed interventions, that promote emotion skills within a child or their carers, are starting to gain increased research support (e.g., Midgley and Vrouva, 2013; Adkins, Luyten & Fonagy, 2018). Other parenting interventions promoting emotional learning have also proved to be successful (Havinghurst et al., 2009; Gaviţa et al., 2012; Herbert et al., 2013; Mason et al., 2016; Kaplan et al., 2016). However, interventions tend to be quite lengthy, targeted at clinical or specialist populations, and require a high degree of facilitator training.

Disruption to emotional learning can lead to a wide variety of mental health and behavioural problems in children, and can ultimately contribute to these problems continuing in adolescence and beyond. Often children are not seen in clinical services until the child has developed significant difficulties, when opportunities for early intervention have been missed. Therefore, there is a need for evidence-based, preventative, easily accessible, and relatively brief interventions that focus on educating parents in non-clinical settings (e.g. within schools or community settings). The project aims to develop and design the content of a brief psychoeducational parenting intervention about encouraging children's emotional learning and skills. It is important that the intervention is developed so that non-clinical staff can easily be trained in delivering it.

Broad Aims of the Intervention

- To provide parents with information about what we know about the benefits of encouraging children to learn about emotions (Motivational component).
- For parents to learn about what children's behaviour might be telling us, so they can better understand their child's emotions (Encouraging curiosity/parental reflective functioning component).
- For parents to be better equipped to encourage the child's emotional learning during and after challenging/stressful situations (Maintaining emotional encouragement in the face of difficulties component).
- To provide techniques and games to use at home that will include 1:1 play/bonding times, specific emotion related games and reading (Specific skill development/ activities component).

Basic set-up

Length: Four 1.5 hours weekly sessions. Follow-up calls two weeks after end of intervention.

Delivery: This will be flexible. Sessions will be designed to be delivered face to face or via a video conferencing platform e.g. Zoom. Parents will be provided with a workbook prior to the group that will contain intervention material, homework tasks and a reflective log.

Referral criteria: Parents of children aged 4-7 years old.

Number of participants: Up to 10 per session. Given the age range, the project will attempt to allocate parents to sessions based on smaller child age ranges where possible.

Outcome measures to be used pre and post intervention and at 2-month follow-up.

Intervention outline

SESSION 1

a. *Boundaries and Ground Rules*

b. *What are we talking about?*

Information -

- Children understanding their own emotions and the emotions of others
- Different levels of empathy and validation
- Primary and secondary emotions
- Difference between emotions and feelings

c. *How can children learn about emotions?*

Discussion - How do children learn about their emotions and the emotions of others? Where are we ever taught about emotions? Acknowledge the lack of teaching about emotions across the population.

Information –

- Learning through "everyday" occurrences (e.g. affective mirroring examples with pictures; tone of voice, facial expressions, showing interest and curiosity to encourage child to speak)
- Facilitators to give examples from their own lives
- Active teaching (e.g. talking through a problem when it occurs, asking how they felt, telling them how you feel, asking them how they thought X, Y, or Z felt; discussing emotions of characters in books or television programmes/films)
- Facilitators to role-play an example of active teaching/ video clip demonstrating this.

d. *What might get in the way?*

Discussion - Examples of where some children might take longer to learn e.g. ASD, family traditions/ patterns, family working/ childcare patterns etc.

e. *At home task*

Introduction to reflective diary and emotions cards (pictures of facial expressions and cartoons when people might feel certain emotions) to be coloured in and used as an emotions recognition game.

SESSION 2

a. *At home task feedback*

b. *What happens when we misinterpret ourselves or others?*

Task - Video clip depicting a scenario where somebody has misinterpreted the emotions of others (this will be taken from a film, as yet undecided).

Discussion - What is going on, draw out thoughts, emotions and behaviour for each character.

c. *Emotion recognition*

Information -

- Children with emotion recognition difficulties may experience behavioural difficulties
- Give examples of consequences of misinterpreting facial expressions.

d. *Emotions and Stress*

Discussion - Ask for examples of stressful events that children might experience (e.g. changes at home, bullying, accidents etc.).

Information –

- Explore possible impacts of stressful events e.g. feeling more threatened, anxious, nightmares and avoidance.
- Give a diagram of the brain and explain the Amygdala threat response

- Explain that the ability to understand own emotions and others emotions can aid memory processing and act as a buffer against negative impacts of stressful events.

e. *At home tasks*

- Picture stories: Images of family scenes with questions to prompt discussion about the emotions and thoughts of each family member.
- Story time: Reading a book or watching a film together and identifying and discussing characters emotions (book and film suggestions will be made and questions provided to guide the discussion).
- Drawing emotions: Picking an emotion out of a hat and child and parent each drawing a picture of the emotion then discuss pictures together.

SESSION 3

a. *At home task feedback*

b. *Challenges of Parenting*

Task – Identify what emotions were acceptable in parent's own family home when they were a child. A house metaphor will be used with a diagram in the workbook e.g. emotions that were acceptable are placed in the house, emotions that were sometimes acceptable are placed in the garden and emotions that were not acceptable are placed down the road. Participants will be made aware that they should only share what they feel comfortable sharing.

Discussion – What emotions do you find it difficult to tolerate and help your child manage? Is this linked to your experiences of emotions as a child?

c. *What is going on underneath and how we impact on each other?*

Video clip of child/ parent interaction.

Discussion - What might different people be thinking? E.g. parent: they don't respect me, they're being difficult on purpose and child they're not interested and they don't love me.

Information –

- Give example of unhelpful cycles of emotions, thoughts and behaviour
- Facilitators to give an example from their own life if possible, to normalise that unhelpful cycles occur in every family

d. *At home tasks*

- Turtle technique: A scripted story that can be told to children to help them manage their emotions. Technique can also be practiced by parents. Step 1: Recognise your feelings. Step 2: Stop, Step 3: Tuck inside your shell and take 3 deep breaths. Step 4:

132

Come out when you are calmer and talk about a solution. Adaptations of analogy to older child or to child's specific interests will be discussed.

- Emotions Snap: Game of Snap with different emotions written on each card. When there is a match on the cards the person has to look at the emotion. They then describe a situation that made them feel the emotion or describe a situation that they think would lead to the other players feeling that emotion.

SESSION 4

a. *At home task feedback*

b. *Exit routes from typical cycles*

Task - think of typical cycles in your own family and ideas of exit routes

Discussion - Information on possible exit routes

c. *How to help child understand their emotions and behaviours*

Discussion -

- Learn more about what children's behaviour might be telling us so we can help them to better understand their emotions (Encouraging curiosity/parental reflective functioning).
- Maintaining emotional encouragement in the face of behaviours that might lead to "emotional shutdown" parental responses.

d. *Further at home tasks and techniques*

Reflective Questioning: List of reflective questions to be provided to parents to help them encourage reflexivity in children

Breathing and relaxation techniques

Family sport/ board game tournaments: Rounder's, assault course, penalty shootout, Junior Scrabble, Junior Monopoly, Snakes and Ladders – guidance given to parents on labelling emotions throughout and on resolving conflict that may arise.

Emotions treasure hunt: Clue's provided in the workbook to lead to different emotions that can be placed around the family home.

Appendix F: Interview Schedule for Clinicians and Academics

1. In relation to the theoretical rationale, do you think in its current form it is understandable? Do you have any general comments?

   a. Do you think there is a need for a short-term parenting intervention specifically about encouraging their children to learn about emotions? (why/why not?)

   b. What theories do you consider should drive such an intervention?

   c. Would you suggest any changes to the overall rationale for the group?

   d. If such a short-term group could be developed that that is effective in giving parents tools to encourage their children learning about emotions:

      i. which settings do you think it should/could be delivered, and by whom?

      ii. Would you foresee other methods of delivery to increase its impact (e.g., web/app-based; self-help guide/manual)

      iii. Do you feel that it should be delivered to targeted populations (e.g., parents of children with emotional or behavioural difficulties, or developed so that it is suitable to be offered universally?)

2. Do you think the broad aims of the group are helpful? Do you think any other aims should be included and any of the current aims should be removed?

3. What do you think about the basic set up of the intervention that has been proposed – timings, spacing etc?

4. What do you think about the proposed content of Session 1? Do you have any additional ideas that you think should be included?

5. What do you think about the proposed content of Session 2? Do you have any additional ideas that you think should be included?

6. What do you think about the proposed content of Session 3? Do you have any additional ideas that you think should be included?

7. What do you think about the proposed content of Session 4? Do you have any additional ideas that you think should be included?

8. Do you have any additional games, activities or techniques that you think parents should be given during the group that would be effective and engaging in enabling their children to learn about emotions or to try out at home?

Encouraging Children to Learn about Emotions

As much as children can bring joy and laughter, they are developing and learning, which means they often have a variety of emotions and behaviours which for a parent can be really challenging in terms of how best to help a child. We know from research that the more children learn about their own emotions, the easier they will find it to manage their emotions and behaviour as they grow older.

We are aiming to develop a parenting group that supports parents on how best to help their child to learn about emotions. By helping parents to recognise and understand the emotions of their children, and how best to respond, the group will aim to have a positive impact on parent's confidence and give some tools to help their children's development. The group will also provide tips and techniques for managing common difficulties that parents might experience.

There is a need for a short-term intervention focused on encouraging children to learn about emotions that can be delivered in community settings to lots of parents. Often parents are offered help when things have become very difficult, this intervention would be brief compared to other interventions and easily accessible for parents.

Set up of the intervention

- Four 1.5-hour or two 3-hour weekly sessions
- Sessions will be designed to be delivered face to face or via a video conferencing platform e.g. Zoom.
- Parents will be provided with a workbook prior to the group containing information
- The group will be aimed at parents of children aged 4-7 years old
- Up to 10 people per group

Intervention outline

SESSION 1

    f. Boundaries and Ground Rules

    g. Information about emotions

    h. Discussion about how children learn about emotions

    i. What might make it difficult for children to learn about emotions

    j. At home task

SESSION 2

    f.   At home task feedback

    g.   Misinterpreting emotions

    h.   Recognising emotions

    i.   Emotions and Stress

    j.   At home tasks

SESSION 3

    e.   At home task feedback

    f.   Challenges of Parenting

    g.   Thinking about how parents were parented

    h.   At home tasks

SESSION 4

    e.   At home task feedback

    f.   Strategies for coping with emotions

    g.   How to help child understand their emotions and behaviours

    h.   Further at home tasks and techniques

Appendix H: Interview schedules for Parents and Facilitators

Parents

1a. How many children do you have and what are their ages?

1b. Have you attended parenting groups before?

1c. What have you valued about the groups you have attended (if anything) and what have you found difficult (if anything)?

2. Following on from the outline you have read and my explanation of the group we are planning to develop, from your point of view, how interested would you be in attending a short-term parenting intervention specifically about encouraging their children to learn about emotions? (why/why not?)

3. In general, what factors would make you likely to attend a parenting group?

4. What factors would make you unlikely to attend a parenting group?

5. What do you see as the advantages and disadvantages of an online parenting group or a face to face parenting group?

6. What setting, size of group and timings would you ideally like for a parenting group?

7. How do you feel about at home tasks between sessions?

8. Are you likely to feel comfortable to think about your own emotions and how you have been parented in a group?

9. Do you have any comments about anything else outlined in the document about the intervention?

Facilitators

1. In your experience what are some of the key ingredients of an effective parenting intervention?

2. In your experience what are some of the best ways to encourage children to learn about emotions? Any activities, games ideas etc.

3. Do you think there is a need for a short-term parenting intervention specifically about encouraging their children to learn about emotions? (why/why not?)

4. If such a short-term group could be developed that that is effective in giving parents tools to encourage their children learning about emotions:

   i)   What settings do you think it should/could be delivered, and by whom?
   ii)   What do you think about delivering the intervention online compared to face to face?

iii)   Do you feel that it should be delivered to targeted populations (e.g., parents of children with emotional or behavioural difficulties, or developed so that it is suitable to be offered universally?)

5. In your experience what are some of the common difficulties in delivering effective parenting interventions?

6. In your experience how willing are parents to reflect on their own experiences of being parented and their ability to understand and regulate their own emotions?

7. Do you have any comments about anything else outlined in the document about the intervention?

Appendix I: Themes and sub-themes with associated summary statements

Number	Clinicians and Academics	Theme	Operationalised – How important is it to cover or consider the following
1	Creating safety in the group	Relationships and support from other parents	Facilitating the development of supportive relationships between parents that attend the group
2		Non-blaming/ judgemental of parents	Adopting a non-judgemental and non-blaming approach
3		Trust in facilitator	Parents developing trust in the facilitator
4		Ongoing engagement and holding in mind	Facilitators making contact with participants between intervention sessions to encourage engagement
5	Accessibility	Accessible language and content	Ensuring that language and content is accessible
6		Accessible timings and location	Ensuring timings and location are accessible
7		Increased accessibility of skills through active participation	Encouraging active participation in the intervention e.g. through role play, experiential exercises, group discussion
8		Practical strategies and resources for parents	Providing practical strategies and resources for parents
9		Engagement difficulties working online	Acknowledging that engagement can be difficult for parents in an online intervention
10		Engagement advantages working online	Acknowledging that an online intervention can be more accessible for some parents
11		Cultural considerations	Ensuring consideration is given to parents heritage and cultural backgrounds
12	Parents understanding of emotions	Intergenerational patterns	Highlighting intergenerational patterns of parenting
13		Parental emotional literacy	Developing parents emotional literacy e.g. language around emotions
14		Parental ability to understand and regulate their own emotions	Developing parents ability to understand and regulate their own emotions
15	How children learn about emotions – conditions, context and parental foundations	Parental acceptance of children's emotions	Providing parents with tools to be accepting of all children's emotions
16		The earlier developmentally the better	Delivering the intervention when the child is at an early developmental stage
17		Importance of safe and warm parental relationships to facilitate emotional learning	Highlighting and encouraging safe and warm parental child relationship to facilitate emotional learning
18		Parental reflective functioning	Improving parental reflective functioning
19		Context – system/ societal understandings	Acknowledging the impact of societal expectations on parents and children
20	How children learn about emotions – Methods and techniques	Embedding emotional talk in everyday life	Providing parents with skills to embed emotional talk in everyday life
21		Making space for curiosity and reflection	Encouraging parents to make space for curiosity and reflection
22		Emotional attunement	Encouraging emotional attunement between parent and child
23		Naming emotions and modelling	Encouraging parents to name emotions and model responses to emotions and coping with them
24		Deepening parental understanding of behaviour	Providing parents with skills to deepen their understanding of behaviour e.g. emotions underlying behaviour
Number	**Parents**	**Theme**	**Operationalised**

Number		Theme	Operationalised
25	Practicalities	Parents juggling time	Appreciating the difficulties for parents juggling multiple demands on their time
26		Comfortable sized group	Ensuring that the size of the group is comfortable for all
27		Accessible and relaxed setting	Providing an accessible and relaxed setting for the intervention
28		Online accessibility	Ensuring that the intervention can be delivered online as well as in person
29		Online reduces human connection	Acknowledging that there may be less human connection in an online intervention
30	Parental factors/ needs	Importance of parental peer support	Ensuring parents have peer support from other parents in the group
31		Parental self-blaming	Highlighting and considering parental self-blame
32		Awareness of how parents were parented	Talking about how parents were parented themselves
33		Understanding the impact of global change and events on parenting	Highlighting the impact of global change and events on parenting e.g. changes in technology, COVID-19 pandemic and lockdown
34	Therapeutic content	Encouraging communication	Providing parents with skills to improve communication with children
35		Developing emotional talk	Developing parents ability to talk about emotions
36		Understanding what's underneath child's behaviour	Helping parents to understand what's going on underneath their child's behaviour
37		Developing practical strategies	Providing parents with practical strategies to help children learn about emotions
38		Manageable at home tasks	Setting manageable at home tasks
39		Finding what works – recognising difference and change over	Acknowledging individual differences and that the same thing will not work for everyone and may change with age
Number	**Facilitators**	**Theme**	**Operationalised**
40	Intervention foundations	Universally offered – all parents can benefit	Offering the intervention universally so that all parents could benefit
41		Maximising connection – parents facing similar difficulties	Offering the intervention to parents facing similar difficulties in order to facilitate connections
42		Transport – accessible location	Ensuring the intervention takes place in an accessible location with good transport links
43		Online more accessible and comfortable	Acknowledging that engaging in an online intervention can be more accessible and comfortable e.g. not needing to travel, having home comforts at hand etc.
44		Face to face more connected and nurturing	Acknowledging that a face to face intervention can be more nurturing and people can feel more connected
45		Community (not clinical) relaxed setting	Ensuring the intervention takes place in a community (not clinical) relaxed setting
46	Parental factors	Parent understanding that they can facilitate change	Parents understanding that they can facilitate change in their child
47		Complexities of confidentiality	Addressing the complexities of confidentiality e.g. group members knowing each other or sharing information outside the group
48		Parental availability	Acknowledging that parents are juggling multiple demands
49		Preparing parents for difficult content	Preparing parents for difficult content
50	Teaching/ facilitator factors	Knowledge of psychological development	Facilitators having knowledge of psychological development
51		Supportive team around them	Facilitators having a supportive team around them
52		Ability to show fallibility / normalise	Facilitators having the ability to show fallibility and normalise emotions and difficulties

53		Skilfully manage group dynamics	Facilitators being able to skilfully manage group dynamics
54		Use interactive and engaging approaches	Using interactive and engaging approaches
55		Combine learning, informality and fun	Combining learning, informality and fun
56		Connecting with parents	Facilitators connecting with parents
57	Creating a safe group space	Containment and empathy	Providing containment and empathy to parents
58		Connecting with parental peers	Facilitate connection between parental peers
59		Creating a supportive network outside of sessions	Offering a supportive network outside of intervention sessions
60		Facilitating parental solutions	Facilitating parental solutions to difficulties e.g. parents helping each other find answers to problems
61	**Intervention components**	Accepting/ normalising emotion	Helping parents to be accepting of emotions and normalise children's experiences of emotion
62		Developing empathy for child	Developing parental empathy for the child
63		Linking emotions to bodily sensations	Linking emotions to bodily sensations
64		Giving parents emotional vocabulary	Giving parents emotional vocabulary
65		Simple/ accessible at home tasks with emphasis on reflection	Giving parents simple and accessible at home tasks with an emphasis on reflection
66		Understanding behaviours more deeply	Deepening parental understanding of their child's behaviour
67		Parents understanding own emotions and regulation	Helping parents to understand their own emotions and how to regulate these
68		Practical resources	Providing practical resources for parents to take away and use
69		Parents learning to help child regulate emotions	Providing parents with skills to help their child regulate their emotions
70		Highlighting transgenerational effects	Highlighting transgenerational effects on parenting

Appendix J – Example of Qualtrics survey sent to experts in Round 2

School of Psychology

Q1. Facilitating the development of supportive relationships between parents that attend the group

1 - Not necessary to include/ consider	2	3 - Could include/ consider	4	5 - Helpful to include/ consider	6	7 - Essential to include/ consider
O	O	O	O	O	O	O

Q2. Adopting a non-judgemental and non-blaming approach

1 - Not necessary to include/ consider	2	3 - Could include/ consider	4	5 - Helpful to include/ consider	6	7 - Essential to include/ consider
O	O	O	O	O	O	O

Q3. Parents developing trust in the facilitator

1 - Not necessary to include/ consider	2	3 - Could include/ consider	4	5 - Helpful to include/ consider	6	7 - Essential to include/ consider
O	O	O	O	O	O	O

Appendix K – Examples of intervention materials

EmotiCoach

EmotiCoach

A short-term intervention for helping parents to help their children learn about emotions

Workbook for Parents

A short-term intervention for helping parents to help their children learn about emotions

Facilitator Manual
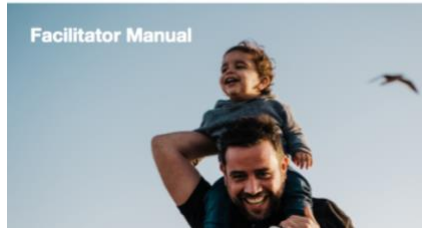
Session 4:
Duration: 90 Minutes

a. At home tasks feedback (15 minute)

- Ask if parents were able to make time for themselves
- Ask for feedback on emotions snap and drawing emotions
- Also ask about any reflections from the tasks in the previous session

b. Emotions and Stress (15 minutes)

Ask for examples of stressful events that children might experience (e.g. changes at home, bullying, accidents, tests at school, death of a family member, financial strain).

Explore possible impacts of stressful events e.g. feeling more threatened, anxious, nightmares and avoidance.

Give a diagram of the brain and show video of the amygdala threat response (slide 12)
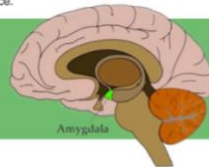
Amygdala

Play up to 1.23
https://www.youtube.com/watch?v=8YykPJy1iLQ

Explain that the ability to understand own emotions and others emotions can aid memory processing and act as a buffer against negative impacts of stressful events. Also highlight that this is not irreversible damage.

---

c. Stress bucket (30 minutes)

The Stress Bucket

Explain the stress bucket analogy – different things continually fill it and then something eventually can lead to it over flowing (slide 13)

Ask parents what contributes to their stress bucket – may wish to use a menti meter word cloud or ask them to fill it out in their workbooks (p.21)

Ask parents what contributes to their child's stress bucket – may wish to use menti meter word cloud or ask them to fill it out in their workbooks (p.21)

Discuss the similarities and differences in the answers given

Discuss how there are some stresses that we can remove but there are others that are an inevitable part of life

Explain how it is important that we find ways of releasing some of the stress by being able to turn on the tap and let some drip out (slide 14)

Put parents into small groups or breakout rooms and ask them to discuss different ways they can release things from their own stress bucket and their children's stress buckets (can also fill out in their workbooks p.22)

Ask groups to feedback

Discuss how depending on the emotions the child is experiencing they may need activities that energise them or activities to calm themselves down

Energisers: Singing nursery rhymers, jumping up and down, dancing/ singing to music, jigsaw puzzle, catching game, hide and seek, clapping games

Calmers: Breathing exercises e.g. finger or flower breathing, fiddle toys, calm water or wildlife sounds, worry beads, pushing the wall, sleeping lions, follow the leader – mirroring actions of another such as slow hand movements

---

Worksheet 3 – Reflective Questions/ Phrases

That person looks (emotion), do you think they might be (emotion)?

What do you think is making that person feel (emotion)?

What emotion do you think that person might be feeling?

I don't know if I've got this right but are you (emotion) because ......

happened at school today?

I'm feeling really (emotion) today because of...... How are you feeling?

I think you are feeling really (emotion). I can see that you are......

I think what is going on is......

You are so (emotion) right now. I'm here for you.

What do you do when you are feeling (emotion)?

I'm wondering if you are feeling a bit like this?

Tell me about something that made you feel (emotion) today

Worksheet 4 – Breathing exercises

Finger Breathing

Stretch you hand out like a star. Use a finger on your other hand to trace up and down your fingers on the hand like a star. Breathe in through your nose as you slide up your finger and out through your mouth as you slide down. Keep going until you have traced your whole hand.

Start Here

Flower Breathing

Make sure you are sitting comfortably. Imagine you are holding a flower. Imagine the color and smell of that flower. Then take in a deep breath, pretending to smell that flower. Then exhale and pretend to blow the flower petals. Keep going until you feel calmer.

Balloon Belly Breathing

- Think of your belly as a balloon.
- Place your hand on your belly, feel it rise and fall.
- Take a deep breath in, through your nose to fill your baloon/belly.
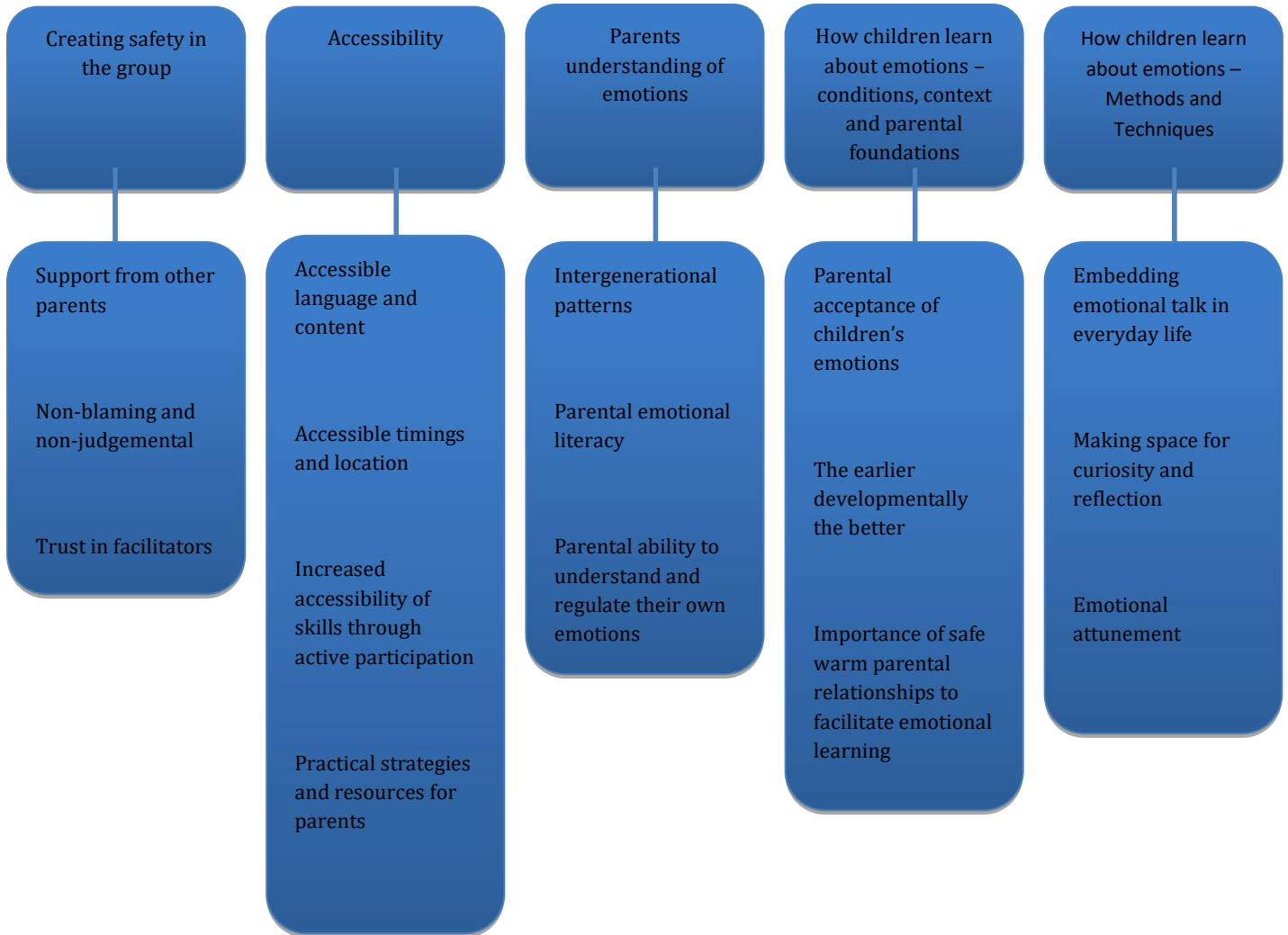- Hold your breath for 3 seconds.

Appendix L - Coding ==Excerpt==

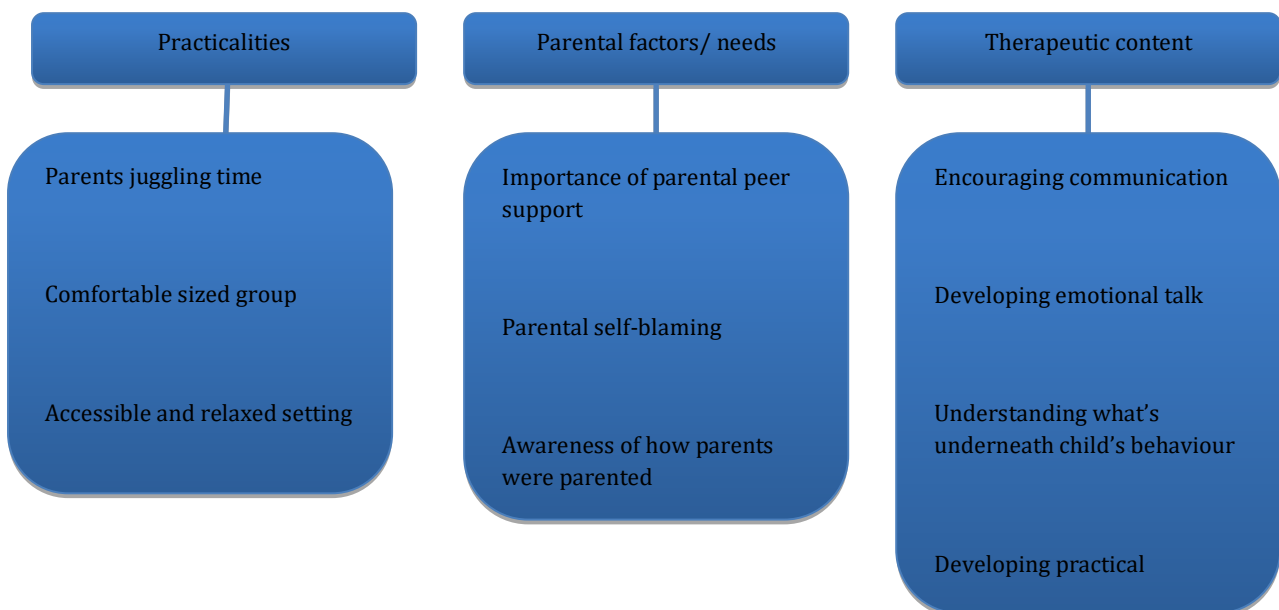| Transcript Clinician/Academic 6	Code	Subtheme	Theme
SL: Ok first question so in your experience what are some of the key ingredients of an effective parenting intervention? 6: Um I think firstly um I think the most effective ingredient of any parenting intervention is that it needs to focus on the emotional state of the parent to start of a lot of programs quite quickly go into thinking about the child and getting the parent to think about the child, mentalize about the child, imagine what the child is thinking. I think before we can do that we have to feel as though we've been understood as parents so it's really essential that I think that any intervention begins with not just making a parent feel comfortable ad open that they can talk but that you actively work with the parent on thinking about their own emotional states so when you come to thinking about a child's behavioural problem or a difficult situation you're not focusing on what the child is thinking or feeling when they're having a temper tantrum in the supermarket you're thinking about what the parent is feeling and you're helping them to make sense of their own emotional responses so I think if I put it in terms of your mentalizing yourself, your getting them to mentalize and think about themselves first because then they're more able to regulate their own affects and feelings you know their own sort of state in that moment then they're going to be much more able to apply that to the child and I think sometimes we jump far too quickly into getting people to think about the child when actually it's not going to be the quality of that thinking is not going to be necessarily very rich because their in a state themselves so there needs to be a lot of empathy, a lot of validating about the parents experience and a lot of helping them to understand almost mapping out what's going on in their mind in these interactions or their mind when their emotions are being aroused um and they're having all different kinds of thoughts and feelings about those emotions. I think that needs to happen first and then people feel quite held and contained and then it becomes easier to think about what the child is thinking and feeling. I think that is the most important ingredient and I think it's where most often parenting programs go wrong is that they immediately focus on the child so I think that's my big thing. Um I think the next thing as well is there needs to be a lot of experiential work in parenting programmes um and not experiential work that kind of um sets up a task at home which is beyond the parents capacity. You know I think sometimes a lot of tasks get set up at home and the parent is not helped to kind of you know engage in that task in their own home environment. So I think a lot of experiential work in the actual sessions with the parents themselves sort of role playing or talking through scenarios or watching scenarios and thinking about what that brings up for them. So if you're asking a parent to go home and read a book with a child or asking a parent to go home and maybe have a conversation about what happened at school that day we actually don't know what that's going to be like for the parent so you're then asking the parent to kind of think about their child and try this new activity when we really don't have a sense of how they might feel about undertaking that activity so I think there needs to be um you know a lot of time spent in the group thinking about those tasks that I do think are important there needs to be a kind of task or something	Focusing on parent before child Mentalizing the child Making parents feel comfortable Parents understanding own emotional responses Parents regulating own emotional responses Giving parents empathy and validation Parents understanding own emotional responses Containing parents Focusing on parent before child Ensuring at home tasks are achievable for parents Need for experiential work Ensuring at home tasks are prepared for in session Ensuring content is accessible Ensuring at home	Parental ability to understand and regulate their own emotions Parental reflective functioning Ongoing engagement and being held in mind Parental ability to understand and regulate their own emotions Non-blaming and non-judgemental Parental ability to understand and regulate their own emotions Non-blaming and non-judgemental/ Parental ability to understand and regulate their own emotions Accessible language and content Increased accessibility of skills through active participation Practical strategies and resources for parents Accessible language and content	Parents understanding of emotions How children learn about emotions – conditions, context and parental foundations Creating safety in the group Parents understanding of emotions Creating safety in the group Parents understanding of emotions Creating safety in the group Parents understanding of emotions Accessibility

that goes on in the home environment that's practical and experiential with the child but I think it needs much more discussion in the group or in the individual session before they go home and do it often it's left to the end and now you're going to go home and try this and it's like wah and we have no idea, we don't check out what that's going to be like for them so I think there needs to be a lot of checking out with the parent how they imagine that task is going to be for them and beyond just ensuring um agreement and maintenance you know beyond just getting their agreement but really helping the parent think about what it's going to be like for them doing that with their child. It's going to increase their participation and it's going to increase the likelihood that it will be successful. So I think they are my two main things empathise with the parent first, focus on the parents emotional state first get that a bit settled and then any kind of activities you've got planned then again need to come back to what it's going to be like for the parent. SL: Yeah yeah ok brilliant that's great and my next question is so in your experience what are some of the best ways to encourage children to learn about emotions? 6: (Laughs) Through their parents SL: (Laughs) I thought so yeah 6: No really I think we're talking about a parent's capacity to engage in reflective functioning, we're talking about a parent's capacity to recognise their own emotional states as being separate from their child's and to be able to then help the child recognise what emotions might be emerging in them and their thoughts and feelings in relation to those kinds of emotions so I think the best way to help children is for them to have good quality time with adults who can actually help them regulate you know um I also think there is something about a more explicit teaching that can go on with children. You know so as well as having this quite lived experience of being understood which is I think key I think you can do a lot of um talking with books and stories which also help them understand that there's a language out there around it, there's a way of thinking about it and it's ok. I think there's something about normalising conversations around emotions which is quite important because I think it still doesn't happen enough.	tasks are practical Need for experiential work in session Nurturing parents – checking in on them Parent understanding own emotional responses Focusing on parent before child Importance of parents in learning about emotion Child learning from regulated adult Children learning about emotion through everyday experience Normalising emotions	Increased accessibility of skills through active participation Non-blaming and non-judgemental/ Parental ability to understand and regulate their own emotions Importance of safe warm parental relationships to facilitate emotional learning Emotional attunement Embedding emotional talk in everyday life	Creating safety in the group Parents understanding of emotions How children learn about emotions – conditions, context and parental foundations How children learn about emotions – Methods and Techniques

Appendix M – Themes and subthemes from three groups

Clinicians and Academics with Expertise in Child and Adolescent Mental Health

Creating safety in the group	Accessibility	Parents understanding of emotions	How children learn about emotions – conditions, context and parental foundations	How children learn about emotions – Methods and Techniques
Support from other parents Non-blaming and non-judgemental Trust in facilitators	Accessible language and content Accessible timings and location Increased accessibility of skills through active participation Practical strategies and resources for parents	Intergenerational patterns Parental emotional literacy Parental ability to understand and regulate their own emotions	Parental acceptance of children's emotions The earlier developmentally the better Importance of safe warm parental relationships to facilitate emotional learning	Embedding emotional talk in everyday life Making space for curiosity and reflection Emotional attunement

Parents

Practicalities	Parental factors/ needs	Therapeutic content
Parents juggling time Comfortable sized group Accessible and relaxed setting	Importance of parental peer support Parental self-blaming Awareness of how parents were parented	Encouraging communication Developing emotional talk Understanding what's underneath child's behaviour Developing practical

Child and Family Intervention Facilitators

Intervention foundations	Creating a safe group space	Teaching/ facilitator factors	Parental factors	Intervention components
Universally offered – all parents can benefit	Parent understanding that they can facilitate change	Knowledge of psychological development	Containment and empathy	Accepting/ normalising emotion
Maximising connection – parents facing similar difficulties	Complexities of confidentiality	Supportive team around them	Connecting with parental peers	Developing empathy for the child
Transport – accessible location	Parental availability	Ability to show fallibility/ normalise	Creating a supportive network outside of sessions	Linking emotions to bodily sensations
Online more accessible and comfortable		Skilfully manage group dynamics		Giving parents emotional vocabulary
Face to face more connected and nurturing		Use interactive and engaging approaches		Simple/ accessible at home tasks with emphasis on reflection
				Understanding behaviours more deeply

Appendix N – Additional Quotes

Clinicians and Academics with Expertise in Child and Adolescent Mental Health

Themes	Subthemes	Quotes
Creating Safety in the Group	Relationship and support from other parents	"they could actually hear from other parents about what their experiences are and you know they could actually create a bit of a um support network for each other" (Clinician/Academic 1) "the advantage as well is if you can do it as a group session with parents you can share experience and there are always positives of that" (Clinician/Academic 5) "I think parents work well in groups together you know because they can learn from one another and I think that is helpful" (Clinician/Academic 6)
	Non-blaming/ judgmental of parents	"being good enough is important and not being perfect and not expecting to be a perfect parent" (Clinician/Academic 2) "people are very wary of you being judgemental of them and we've always taken a very much sort of try to be as respectful as possible with parents and say well these are some ideas and you know your family best" (Clinician/Academic 8) "you're not talking over them, you're not devaluing them in anyway um and you're working with them at their level, you're not trying to um be the professional all the time therefore kind of putting a hierarchy into it but you know that their coming as parents, their offering so there's an equality to it" (Clinician/Academic 9)
	Trust in facilitator	"we've got quite a bit of evidence that shows actually the facilitator is actually really important in the group um what they do and what they say does actually influence parents" (Clinician/Academic 10) "facilitators who can um have people skills so align with the people that they're working with, who take the time, whatever the content of the parenting program is, who take some time to get to know who they're working with, the family. All those sort of person to person skills that aren't written into parenting programs" (Clinician/Academic 3) "I think you want both facilitators to role model and having facilitators who can make mistakes, who can correct one another, who can be quite human in their responses. I think that is what can help people to feel safe to learn and engage in a program" (Clinician/Academic 6)
	Ongoing engagement and holding in mind	"one of the things that always comes up is um maintaining contact with parents so yes you have your group session on online session or whatever with parents but one of the key things that keeps coming up in the literature particularly recently um around kind of digital parenting programs is maintaining that contact in between the group sessions so having that weekly phone call um if possible" (Clinician/Academic 10) "does there need to be a degree of a follow up afterwards. You know do you need then another session every four weeks or does it need to kind of convert into a bit more of a parent support group" (Clinician/Academic 9)
Accessibility	Accessible	"really nice and accessible that they might um and I guess with terminology that feels less you know brainy I suppose" (Clinician/Academic 1)

	language and content	"I think also maybe some practical there's a sense of theory and that it's backed by research but making sure that's really accessible" (Clinician/Academic 11)
		"You would also need to know about parents literacy and be thinking about the literacy levels and size of font and colours" (Clinician/Academic 5)
	Accessible timings and location	"Well I think short is good as well. I think it's really interesting. I would like to see it trialled because parents do find it really hard to commit to lots of so just on that practical base" (Clinician/Academic 3)
		"by putting it in a schools settings or an early years setting um it's less stigmatising so I think parents are much more able to engage in it" (Clinician/Academic 6)
		"Providing you have it at the right time, you know when you you want to have it at a time when you haven't got kids coming in and out the whole time because it's hard to talk about your child who you are very angry with or not coping very well with if they're in the space as well" (Clinician/Academic 8)
	Increased accessibility of skills through active participation	"just observing someone doing a particular behaviour is often not enough to learn the behaviour they have to actually practice it themselves" (Clinician/Academic 10)
		"role play again is one of those words that sets people off but it's brilliant you've got to do it" (Clinician/Academic 3)
		"when you're trying to change the way people respond to emotions you've got to you've got to do it with action, you've got to use role play because people just don't get it at an intellectual level only" (Clinician/Academic 8)
	Practical strategies and resources for parents	"I actually think you could do less you know rather than I mean taking out a lot of the teaching bit and putting more of a just encouraging reflection in the parent and some more simple strategies" (Clinician/Academic 6)
		"just you know being able to go back and read over things in your own time is always helpful isn't it. Even if that's in a booklet form or you know anything like that it's good just to have it to go back to" (Clinician/Academic 1)
	Engagement difficulties working online	"so we quickly turned it into an online version which we've just done and um some of the feedback we've gotten is that they really missed that social support that kind of group dynamic and it came out in the interviews as well as being really important for their own mental wellbeing" (Clinician/Academic 10)
		"you don't know how much somebody has engaged they could just mute themselves, turn off the screen and go put the washing on and just you know miss a whole chunk of it" (Clinician/Academic 11)
		"I think for me the biggest drawback when doing any work on emotions is not being able to do the live interpersonal in a room stuff and for me that's huge at the moment" (Clinician/Academic 4)
	Engagement advantages working online	"online learning element where you could do it in your own time in your own home um just thinking that sometimes that sort of decreases pressure around things" (Clinician/Academic 1)
		"it's very accessible um and it's something that can be delivered without having to wait for a room space so for parents in need of it now that would be really useful" (Clinician/Academic 11)

		"I would probably have said no and I would have said no it has to be person to person but now I think and not just because of you know we will come out of lockdown so it's really worth a go and especially in um sort of more rural areas" (Clinician/Academic 3)
	Cultural considerations	"Yeah it's just some of the work that we've done in eastern Europe um men are specifically taught not to show their emotions because it's seen as a sign of weakness so just something to just consider" (Clinician/Academic 10) "Videos clips need to be again culturally and sensitively diverse" (Clinician/Academic 5)
Parents Understanding of emotions	Intergenerational patterns	"it's really good to think about different families and their own experiences of being parented and what kind of household they grew up in in terms of emotional expression and that kind of thing and that they may not realize that they sort of shy away from certain emotions" (Clinician/Academic 7) "what experiences are difficult to tolerate so and how were you treated so if you were upset how did your mum or dad react and how did that make that ok for you or more difficult for you and what have you learnt from that" (Clinician/Academic 11) "intergenerational trauma I think that would there's much more of an understanding now isn't it that trauma is past on intergenerationally when needs of parents aren't you know met then they pass their unmet needs onto their children and um that breaking that cycle of disadvantage of families" (Clinician/Academic 2)
	Parental emotional literacy	"how capable are they to deliver such an intervention for their children if they actually need some help themselves learning about their own emotions and regulation and expression" (Clinician/Academic 11) "I think that ties into for parents to be better equipped to help the parent encourage the child's emotional learning during and after challenging stressful situations. I guess that's what we're trying to expand upon that aim as in order to do that you really need to spend time with the parents focusing on their own processes" (Clinician/Academic 6)
	Parental ability to understand and regulate their own emotions	"parents need to learn that and they do need to learn to manage their own emotional responses. It's really difficult if your child is being really provocative or screaming at you or doing something they shouldn't it's really hard not to just go rah and respond so to teach parents to go oh lets take a step back is brilliant" (Clinician/Academic 1) "parents who are struggling for their own reasons it might be their own wellbeing or their own life circumstances um find it really hard to tune in as a result of those thing" (Clinician/Academic 4) "I think it requires than parents can reflect on their own history of emotions before they actually respond to their kids emotions, I think that's really integral and that they have to be able to regulate their emotion in the moment so they've got to be in a more calmer space in order to teach and respond to their kids around emotion" (Clinician/Academic 8)
How Children Learn about Emotions – Conditions, Context and Parental	Parental acceptance of children's emotions	"yeah when things get tough it's being able to still sit alongside and support because that I guess is a main that's when normally it would go out the window" (Clinician/Academic 11) "I don't think you can just tell kids what to do. You can't just instruct them in skills it's got to come from parents responding in a way that shows that they accept and validate and can accept and hold the child and that's the thing that often gets missed in sort of skills focused programmes" (Clinician/Academic 7)

Foundations		
	The earlier developmentally the better	"I think the earlier you can do this the better" (Clinician/Academic 1) "that's my experience that parents have said that have done those kind of interventions have said we wished we had it sooner" (Clinician/Academic 2) "working with a younger age group parents are still very positive and keen to work and as the children get older it sort of parents are gradually more giving up" (Clinician/Academic 5)
	Importance of safe and warm parental relationships to facilitate emotional learning	"the experience of learning in a relationship is the most important so having somebody reflect back to you your internal state and the more accurate that is the better " (Clinician/Academic 2) "they need to be in a safe place so they need to be with somebody, another adult that they trust so that secure base, trusted adult, trusted other um usually that's better if it's you know a significant other so that rather than a professional doing that directly with a child it's you know the parent" (Clinician/Academic 3) "it has to be within a relationship where an adult can self-regulate um that would be my big number 1 um otherwise I think it's really hard for children to learn about emotions" (Clinician/Academic 4)
	Parental reflective functioning	"helping parents even just at the level of being able to think about their child's inner world" (Clinician/Academic 3) "seeing clinically working with parents who are struggling not in a big way but in day to day with kind of tuning into their children and um yeah being able to imagine what is going on for them and I think everything else falls out from around that" (Clinician/Academic 4) "helping the parent identify what's going on in that cycle for them, what might be happening for their child, what their child might be thinking and feeling in that cycle because then that will help you plan an exit route" (Clinician/Academic 6)
	Context – system/ societal understandings	"the family also acts within the system and for this to be really effective it's about how the wider systems are working so that everybody that's then part of the child's system works with that child to develop so all the parts of the system so you know the school or the setting that the child goes to also need to be aware of what's happening" (Clinician/Academic 9) "I guess is systemic thinking and working with the whole system so I'm just thinking about those kids that might learn emotion regulation in the classroom and be able to do that but then not at home and not being able to transfer those skills to a different settings" (Clinician/Academic 4) "I think schools are a great stable environment for children particularly for those who come from the most difficult households so schools that's why we work with schools why we suggest interventions that teachers can implement in order to help the children we see so we use the sort of school environment as a sort of vehicle to improve functioning in the children" (Clinician/Academic 5)
How Children Learn about Emotions – Methods and Techniques	Embedding emotional talk in everyday life	"read books to their children so part of that is identifying characters emotions and then trying to link that then to something that has happened in the child's life so if there's a picture for example of a character who looks sad then do you remember last week this happened and you felt sad" (Clinician/Academic 10) "I think for children you know those moments of learning from what's actually happening in their real life experiences as well" (Clinician/Academic 2)

			"watch films and look for emotions in others and the children can't recognise them in themselves but can often pick them out in characters in movies or in a soap or something so I think being really broad in the materials used is important" (Clinician/Academic 4)
		Making space for curiosity and reflection	"it's quite a nice stance for parents to take where they're just wondering with their kids about how they might be feeling rather than asking" (Clinician/Academic 7) "I think that sort of trying to help them wonder what's going on for their child to have some understanding that their child's behaviour" (Clinician/Academic 3) "almost being curious with children about things so not telling them the answers but doing a bit of I wonder why that is" (Clinician/Academic 9)
		Emotional attunement	"what they might need is their parent to come in and calm them so it might be that we would say to the parent you know go over to your child, hold their hands, breathe for them and say if you can't I'm going to do some deep breaths for you right now look into my eyes we'll do it together" (Clinician/Academic 1) "can we spend time together and enjoy each other and then that attunement came from there and from attunement came co-regulation and learning about emotions so that's what she would, when she was feel really stuck she would just go back to that and that was really helpful for me" (Clinician/Academic 4)
		Naming emotions and modelling	"running commentary kind of about noticing how somebody might be feeling and reflecting it back to them or even just doing a lot of talking about how you feel or I guess over labelling of emotions" (Clinician/Academic 1) "just about being able to help children who aren't developmentally able to understand and make sense of their emotions to do that so help children make sense of the meaning of what their experiencing or feeling and what their experiencing name it" (Clinician/Academic 2) "I think key I think you can do a lot of um talking with books and stories which also help them understand that there's a language out there around it, there's a way of thinking about it and it's ok. I think there's something about normalising conversations around emotions which is quite important" (Clinician/Academic 6)
		Deepening parental understanding of behaviour	"I suppose what you want parents to take away from that is that they might be behaving in a way that is difficult but it's because they've misunderstood what's happening so perhaps the way they've responded would be perfectly reasonable if their interpretation of that situation was correct" (Clinician/Academic 7) "It seems so basic to say but parents don't always understand that their children's behaviour has got meaning and that it is a communication of what's going on for them" (Clinician/Academic 3) "Um that's good to be understanding what's underneath the behaviour that's really critical so many people will be there to try and fix their child's behaviour and they're not enquiring or thinking at all" (Clinician/Academic 8)

Parents

Themes	Sub-themes	Quotes
Practicalities	Parents juggling time	"to actually kind of not to be to worried about ticking the boxes from the school but also worrying about their mental health and going ok on a school day…. trying to juggle all that and even though I feel I am fairly good with the mindfulness and everything but when you're in the thick of it" (Parent 3) "it would just be having the concentration really you know because I'm a single father of an 8 year old boy so you know I'm always being kept on my toes to be honest with you" (Parent 4)
	Comfortable sized group	"I find I mean because I'm not really one for group training any way I prefer smaller groups or one to ones" (Parent 3) "I find it quite easy to speak in front of people but I think the smaller the group the less intimidated people would be to speak up and it's easier to get to know people in smaller groups isn't it" (Parent 4)
	Accessible and relaxed setting	"community centres are always a good one as well um because it's centralised" (Parent 1) "I think if it felt a bit more if it was a bit more of an informal environment I think it would it would be easier to speak rather than you know if it was right attend the university classroom so to speak it would be more I think it would be better and a more relaxed environment" (Parent 4)
	Online accessibility	"I suppose with online now you don't have to travel you can set up in your house" (Parent 1) "I have been enjoying online training recently" (Parent 3)
	Online reduces human connection	"In terms of then those one to one chats that's harder isn't it I think often in parenting groups that is where you gain a lot so I know we did um with the talking to other parents who are going through the same thing that's not so easy to do um virtually" (Parent 3) "you just get more of a sense of feel of atmosphere and tone with face to face" (Parent 4)
Parental Factors/ Needs	Importance of parental peer support	"I think when you're looking at groups often that huge side benefit is that peer to peer support where you're sort of all in the same boat together and also I think parents are more likely to attend if there is if they know there might be a positive outcome for something they're worried about with their child" (Parent 2) "being able to talk to another parent about you know how they've maybe dealt with certain things and even if it's not group specific to do with that weeks topic you are able to sort of communicate and bond a little bit better I think with parents I think that are going through the same thing um because of additional needs or you know a fostering situation or something like that" (Parent 1)
	Parental self-blaming	"Yeah just thinking either me or my child's broken because it's just not working something's just not working but actually there is a strategy out there for them there is something they can use but it's just finding it" (Parent 1) "when you do have that judgement mental things going on" (Parent 3)
	Awareness of	"I know we certainly have we've looked at you know well because I think you've got to decide when you've got these challenging behaviours how you're

	how parents were parented	how are you going to deal with that? Are you going to deal with it in the same manner that you were brought up in, did that work as an adult do you find that you responded to that, how did that impact you as a child you know how did you feel about it um and then sort of applying that onto your child" (Parent 1) "I think it does hugely impact the way you were parented does hugely impact the way you parent your children so yeah I think that needs to be done in a sensitive way" (Parent 2)
	Understanding the impact of global change and events on parenting	"you could almost say that all children have experienced some form of trauma because of the lockdown and their parents responses" (Parent 2)
Therapeutic Content	Encouraging communication	"it's talking about you don't talk to them at the point of the emotion you talk about it afterwards but not long enough after it that they've forgotten um and you talk about how they felt and then it's a lot of the I wonder stuff I wonder if um you know I just after a meltdown I wonder if you were doing that because" (Parent 2) "you say like use your words and sometimes that's quite patronising with them as well use your words so yeah it's trying to" (Parent 3)
	Developing emotional talk	"we normally start to find that his behaviour will just derail or he'll start doing things and we're like how have we gone from zero to this um and it's when you then manage to speak to him about it he was like I just got angry and you're like well we understand that he's gotten angry but it's at which point you know could this could we have prevented it if he had said to us I'm feeling angry" (Parent 1)
	Understanding what's underneath child's behaviour	"we need to think about why these things are happening and so you know they're stealing to fill this need or there are and then what you do as a family to it is it is really difficult but what you do as a family to lead them to um to meet the need and to prevent it from sort of escalating' (Parent 2) "you know with me I've got a little trick I know him well enough I know a bit of eye contact and a cwtch and the truth will come out you know" (Parent 4)
	Developing practical strategies	"ah we've tried so many different strategies over the years um so I think for us it's almost um there's always things that we can do as parents to help him but it's almost helping him so it's the pointers to give to us for us to give to him almost that would really benefit" (Parent 1)
	Manageable home tasks	"I think it's almost like absolutely have at home tasks because they can be helpful and they are helpful but it's maybe just sort of reminding parents that if it's not suitable for your child or it's you know not suitable for your lifestyle or what not that's absolutely fine" (Parent 1) "Just as long as they're fun because he's doing home schooling and getting it wouldn't be as long as I can fit it into daily life" (Parent 3)
	Finding what works – recognising difference and changes over time	"we try to do a lot of things but it's just yeah because they change over night" (Parent 3) "He's the type of kid he's not cut out for the academic life and I know you shouldn't judge people at 8 years old but he's rough and tumble he likes to do things with his hands" (Parent 4)

Child and Family Intervention Facilitators

Themes	Subthemes	Quotes
Intervention Foundations	Universally offered – all parents can benefit	"I think it should be universal as I said there's a lack of understanding of what empathy is in my opinion just across the board" (Facilitator 1) "I think everybody should be offered it everybody benefits from it" (Facilitator 2) "I believe when parents are getting ready to become parents they need to go to a parenting school that was my dream having a school for parents where they would go there talk about their worries have support on their own worries and then learn how to bring a child into the world and how to teach them about emotions so universal" (Facilitator 5)
	Maximising connection – parents facing similar difficulties	"grouping people together dependent on their health condition so that they could do so that they could connect it a bit more to their experiences" (Facilitator 4) "you know is there a difference between my child's got these behavioural problems but your child is fine so kind of how are we marrying together" (Facilitator 7)
	Transport – accessible location	"we have taxi's picking parents up sometimes the taxi services aren't working well and there's usually quite there's usually something there's never the two hours where it goes smoothly it's usually we start late and then you've got to we're trying to chase ah yeah it can be a bit like that so there's quite a few hurdles sometimes" (Facilitator 3) "I think lots of families may require support may be don't have access to transport from more rural areas" (Facilitator 6)
	Online more accessible and comfortable	"you've got that side of being comfortable in your own home so parents might open up better because they're not in a room with other people so they're more able to open up more at home" (Facilitator 2) "I think it's great saving parents parking time, stress on the street, rearranging appointments um they can feel comfortable in their own home" (Facilitator 5) "I've heard from parents anyway um is that actually it's convenient in terms of you can just switch on your computer and you're there especially if you've got your children kind of in the house and nowhere else" (Facilitator 7)
	Face to face more connected and nurturing	"I think when we're in person it's that we would always when people come in offer to make them a cup of tea give them a biscuit and that I think really helped calm people and feel settled and relaxed in the group but we can't do that over zoom" (Facilitator 4) "sometimes you know signal or not hearing very well which you know is technical and the vibe sometimes it's a little bit more harder I find when you start something new and you don't know people or to read the room" (Facilitator 5)

		"I would prefer my suggestion would be that it's more effective in person um to be able to gain that empathy" (Facilitator 6)
	Community (not clinical) relaxed setting	"I am a massive advocate for getting stuff out into the community um I think our NHS buildings aren't great and they come to enough appointments do you know what I mean parents are constantly going to hospital or centres" (Facilitator 4) "I think that learning is hugely effected by the setting I think it shouldn't be in a school setting or a health setting because that is connected with specific needs the children have I think it should be in a completely different building a completely different environment where you can promote calmness" (Facilitator 5) "I think categorically not a clinical setting would be my answer um and somewhere that just feels a lot yeah more kind of I don't know yeah just a nice kind of homely sort of vibe to it you know community vibe to it um were you can relax and get into it" (Facilitator 7)
Parental Factors	Parent understanding that they can facilitate change	"Well I don't need anyone to tell me how to parent you know that type of thing I don't need anyone to tell me about that" (Facilitator 2) "I think one of the biggest ones which we had in both groups is that thing of parents wanting support for the child not the parenting group for them and that's really difficult isn't it how you manage that because in both settings I've come across parents carers saying yeah I've done loads of training courses it's them you need to see" (Facilitator 4) "they're often like why aren't you seeing my child um which is an interesting dynamic which sometimes we have to address head on we don't need to see your child um we're just going to work with you " (Facilitator 6)
	Complexities of confidentiality	"I suppose we have to be careful sometimes because we're working in small communities a lot of the time and so there's been situations where there's people that shouldn't have been in a group together um that's always fun" (Facilitator 1)
	Parental availability	"they couldn't join until a certain day so we've had to kind of reschedule groups um obviously again where childcare may be concerned um I think it might be ideal for some but not for all so you can but try can't we" (Facilitator 1) "Yeah especially if you've got a 1 and a half 2 year old climbing up your leg you know in it tough times for them" (Facilitator 3) "it's really tricky because yeah they'll be people who say evening would be better because then someone else will be there to look after them or that's worse because there's no one there to look after you know it's literally yeah polar opposites so yeah I guess it's just that balance of trying to make it best for them" (Facilitator 7)
	Preparing parents for difficult content	"I'm guessing really this is why it's really important to understand who is coming to your group and what their needs are so when you try to open things you know it's going to be painful for someone or an open wound because parenting is also bringing your painful kind of experiences" (Facilitator 5) "I think it's so important to do though it's just tentatively doing that in a way that feels safe for them to do that um and yeah I guess that comes with the ground rules you know you would go through at the beginning kind of just always going back to that" (Facilitator 7)
Teaching/ Facilitator	Knowledge of psychological	"I'm just thinking it should be the best maybe match would be someone coming from Psychology world who knows you know emotions and underlying needs that might irrelevant to the teaching you know it can be about you know development and emotion development" (Facilitator 5)

Factors	development	"I think that can be really helpful rather than who like as in a specific band or a specific profession I think it's more about the skills that someone can bring so if they're able to sort of know the background and the theories I guess behind what we're teaching and understanding the brain in terms of emotion regulation and being able then to communicate that to the families" (Facilitator 6)
	Supportive team around them	"really good team you work with so you are able to have clear goals and to make sure you always feedback you know and reflect on things what your goals are where you want to go and every after every um when you finish a session you kind of reflect on it you know where you standing" (Facilitator 5) "saying for example like we're from a team of psychology I think it's really helpful to say um and I really like that we say we're a team and I emphasise how we draw on our team so rather than saying we're bringing in a expert" (Facilitator 6)
	Ability to show fallibility / normalise	"And us sharing we don't share too much I share stuff because it's relatable we're not going to sit there and say to do x y and z and they'll probably sit there and think well what do you know so they need to get a grasp of sometimes we've gone through stuff as well" (Facilitator 2) "I think that's the thing I get down to their level to be honest and I just say it how it is I'm not one of those workers whose stringent with my professional hat on and do my thing I'm there to help my family the best I can" (Facilitator 3)
	Skilfully manage group dynamics	"we do have rules we have um say group rules but we try not call it that again just trying to keep it light you know" (Facilitator 3) "what to do with it um yeah I don't know I guess there's just the usual like yeah if people don't get on with people and how you kind of manage that um and if they kind of start rubbing each other up the wrong way" (Facilitator 7)
	Use interactive and engaging approaches	"So we'll start off facilitators will role play and then we ask for volunteers the parents would always play the child in that situation unless they really don't want to but it's a precarious situation for the parent being the parent um but that's really quite powerful sometimes some people are mortified because they see themselves some people are really upset yeah it can be a really poignant moment in your group" (Facilitator 1) "we do a lot of pairing the parents up um to interact we do a lot through activities because um like for me I'm um kinaesthetic and visual learner so I portray my delivery to people who may struggle like I would so if it was just audioed and I just had to read it it's not going to sink in at all I need to get in there' (Facilitator 3) "I think to talk about emotions it's to make it as interactive as possible" (Facilitator 4)
	Combine learning, informality and fun	"myself and the co-facilitator we do it in a very informal way" (Facilitator 2) "we always ask them straight away would they like tea or coffee that's a big one we take biscuits and I think it's just putting a smile on your face, put a smile on your face make them feel welcome" (Facilitator 3) "Yeah you just want to be like ok relax now so I think that was a major of our role as well is creating that sort of um atmosphere of calm and people coming to group get quite nervous" (Facilitator 4)
	Connecting with parents	"Um I think getting you've got to get that relationship with the parent to help break through if that makes sense for them to open up to you building up that relationship with the parent um is massive so they're able to open up and actually tell you what's going on in order for you to help them" (Facilitator 2)

		"I'm there to help my family the best I can that's what I try and do so I let them know that you know and I make them feel comfortable" (Facilitator 3)
		"Oh so I would say for me being very honest I think that content is obviously important in terms of what you're giving parents but for me it's the connections that you make so yourself as a professional with the group" (Facilitator 7)
Creating a Safe Group Space	Containment and empathy	"I think it would start with the containment so empathy from myself understanding the parents perspective first and why it's so hard for them" (Facilitator 1)
		"I guess it's really connecting with the parents in their struggles you know what I mean showing that we get it" (Facilitator 4)
		"if you can create a safe place and be containing and yeah I guess then the connections with the group and how you kind of encourage those I suppose in a really safe and containing way" (Facilitator 7)
	Connecting with parental peers	"to know that they are not the only ones facing difficulties or having trouble and when they can um when they feel like their issues are reflected within the group that can help as well" (Facilitator 1)
		"I think the groups that do go well the participants it groups that go well are when they form a group themselves, they bond" (Facilitator 2)
		"um being able to have other parents to talk to um so that it's the lived experience yeah I think is really important" (Facilitator 7)
	Creating a supportive network outside of sessions	"and we always find by the 10 weeks our groups generally run 10 weeks they don't want to leave us by those 10 weeks they want to know what so yeah they want to keep going because you form kind of like an outside bubble an extended family to talk to and stuff so it's short if you think about that aspect of it" (Facilitator 2)
		"perhaps one of the sessions or in between the sessions um connect those two like bring it a little bit" (Facilitator 5)
		"being able to have that safe place for them if something does pop up that's difficult or they can get signposted to somewhere you know if that's come up um but I do like I say I do think it's so important" (Facilitator 7)
	Facilitating parental solutions	"what's going to come from yeah our discussions even if it's one to one I often say we're just going to talk and see whether and I say I'm going to throw out some hypotheses I don't say that but some guesses and they might not be right but I want to sort of come to a conclusion together to think about this" (Facilitator 6)
		"for me it's being very open and honest with them in terms of we're not the expert on you or your child um so that's a very up front thing that I will say constantly to parents um is that they know them best and they know themselves best and what we're going to do is marry that theory with lived experience and kind of you know marry it together to be a helpful intervention" (Facilitator 7)
Intervention Components	Accepting/ normalising emotion	"normalise all of these emotions so just because I think for us it was um there's something wrong with my child whereas we're like no all these emotions are really normal so we're all the same there's nothing they don't need anything they don't need to see a psychologist or anything like that um so we did that for all of the emotions" (Facilitator 4)
		"I often get a parent to like reflect on a time that they've flipped their lid… getting parents then to think about a time maybe something like that has happened because it is it's very normal and normalising it" (Facilitator 6)

			"like I say I think people feel guilty if they're showing certain emotions and obviously depending on what emotion is going to be shown in what particular way but yeah it's that kind of understanding that we're all human and we all have emotions and to normalise that" (Facilitator 7)
		Developing empathy for child	"how must the child feel so how do you think the child feels in this situation so they'll say well and then I'll say well what about me how do I feel in this situation but for the first time they're experiencing the empathy for the child not for the parent that's usually kind of flooded and very emotional so that's a really poignant moment" (Facilitator 1)

"Ah yeah massive that's huge yeah so I do a lot with empathy with families um just for them to be able to give children I work can I talk about that without saying names?" (Facilitator 3)

"let's think about her emotions and empathy and things like that whereas other parents are just like yes this is my child I understand them they're out of control sort of things where it's just more bringing in that empathy into the conversation" (Facilitator 6) |
| | | Linking emotions to bodily sensations | "we have migraines in our mind in our brain when we feel overloaded quite often what have you. They feel it in their belly" (Facilitator 3)

"we just talk about how they're quite big and small and we feel them different and how different are they in our bodies and what do they do and stuff like that" (Facilitator 6) |
| | | Giving parents emotional vocabulary | "You've got to name them you've got to keep identifying these feelings and saying ah I can see you're feeling a little bit x, y or z and see what they're feeling and name it instead of saying oh stop doing whatever start naming feelings" (Facilitator 2)

"so we then as parents and the adults which actually input some the words to help them understand what it is and that's all empathy isn't it you know I understand you that you're angry you know that's the word they learn that that's the feeling that associates with that and it's just helpful" (Facilitator 3) |
| | | Simple/ accessible at home tasks with emphasis on reflection | "we're very informal about it so we're like just see how it goes you'll be feeding back in but we don't want to be too formal so you know don't come back to group if you don't do this because that's then oh I'm not going because I didn't do my homework so we do try to make it you know not such a big deal" (Facilitator 1)

"we never pin point it onto one person you know because we wouldn't want to put them on the spot but it is literally right how did it go and would you like to feed this back to the group you know" (Facilitator 3) |
| | | Understanding behaviours more deeply | "all these feelings but haven't got a clue how to vocalise or say oh mummy I'm feeling a little bit depressed today or whatever they express that in a behaviour so it's looking past the behaviour and naming the feelings" (Facilitator 2)

"it's really important when we speak to parents to um help them understand a little bit that children have a world of their own and their own language it's really important for us all to leave ours and live in theirs and come back" (Facilitator 5)

"I wonder why sue is feeling really moody today I wonder if it's because she hasn't had a good nights sleep and that's a even if it's wrong that's ok but using sort of um start talking about emotions so they can start actually thinking oh that's not right or maybe actually it is or I don't know why I've been feeling this way and sort of start guessing" (Facilitator 6) |
| | | Parents | "you grow as a parent you also have your feelings and it's also important for parents to be able to be teaching about feelings whilst understanding theirs |

		understanding own emotions and regulation	um because sometimes I'm just thinking it's difficult for parents they don't they just signed up for something where they don't know themselves how to handle" (Facilitator 5) "but also it's for me so with one mum we were talking about the volcano and she really struggled she was a mum who was really honest in saying I struggle with my emotions not to flip my lid she loses her cool a lot she described her parenting style as losing her cool on a very short fuse and so she would say like I need to so when something happened with her child she had to step away to allow herself to calm down" (Facilitator 6)
		Practical resources	"the resource is another thing so if you want to send something by post did they receive it did they not do they have a thing to print it it's practical all these practical things um yeah I think that is it" (Facilitator 5) "I often try and put in as much but I don't know whether this is just because of the population I work with in terms of ASD so they need very visual structured work sheets and so I often send the materials workbooks um something like concrete to remind them" (Facilitator 6)
		Parents learning to help child regulate emotions	"Yeah the reciprocal nature of the and mums and dads understanding that a child in the early years they can't self-regulate independently so that old school method of sit on the stairs and get yourself together or get upstairs in your bedroom and count to 10 until you calm down it doesn't work for a child under a certain age so that they have to help the child regulate and name the emotion" (Facilitator 1) "I actually believe that there's a big emphasis needs to be made for children to understand what's going on for themselves to learn how to self-regulate because you know as they grow older they don't really need an adult or an older person telling them how to deal with it their learning it by themselves" (Facilitator 3) "so it's really hard they need the support to be able to bring their lids back down um and just sort of trying to put that on them that's what we're aiming for because for example like anxiety big emotions aren't going to go away they're going to be there all through life and we're going to skill them up" (Facilitator 6)
		Highlighting transgenerational effects	"I just think we're drumming up those feelings and instinctively they come out so we will get to hear something they might not disclose all but they definitely begin that journey of reflection… it's made them reflect and they're already thinking about how their parenting effected them" (Facilitator 1) "most people want to talk about their parenting that want to be able to express it and get it off their chest to be able to move forward if they haven't had such a great one if that makes sense and even if you've got the ones that sit quietly through that session you can tell that they're reflecting on how things were and have a bit of a light bulb moment of ah ok I can see what's happening here" (Facilitator 2) "you just see these little light bulbs going off or you see someone else connecting with someone in the group going oh my god that's how I was parented too or yeah I was always told that you know and you can see how powerful that is as well" (Facilitator 7)