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Becoming Therapeutic Agents: A Grounded Theory of Mothers' Process when Implementing Cognitive
Behavioural Therapy at home with an Anxious Child

By

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A thesis submitted to the Department of Psychology
In conformity with the requirements for the degree of
Doctorate in Clinical Psychology

Queen's University
Kingston, Ontario, Canada
(September 2015)

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Abstract

The premise of parent-centered programs for parents of anxious children is to educate and train caregivers in the sustainable implementation of cognitive behaviour therapy (CBT) in the home. The existing operationalization of parent involvement however, does not address the systemic, parent, or child factors that could influence this process. The qualitative approach of grounded theory was employed to examine patterns of action and interaction involved in the complex process of carrying out CBT with one's child in one's home. A grounded theory goes beyond the description of a process, offering an explanatory theory that brings taken-for-granted meanings and processes to the surface. The theory that emerged from the analysis suggest that CBT implementation by mothers of anxious children is characterized by the evolution of mothers' perception of their child and mothers' perception of their role as well as a shift from reacting with emotion to responding pragmatically to the child. Changes occur as mothers *recognize the crisis, make links* between the treatment rationale, child's symptoms, and their own parenting strategies, *integrate* tenets of CBT for anxiety, and eventually focus on *sustaining therapeutic gains* through natural life transitions. Mothers whose anxious child made threats of suicide and/or engages in non-suicidal self-injury experience distinct phases and challenges. The theory widens our understanding of mothers' role, therapeutic engagement, process, and decision-making. It allows clinicians to provide better support, anticipate difficulties, and to respond accordingly. The theory generates also new hypotheses regarding parent involvement in the treatment of pediatric anxiety disorders, and proposes novel research avenues that aim to maximize the benefits of parental involvement in the treatment of pediatric anxiety disorders.

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Acknowledgements

To simply say thank you hardly seems adequate, but I would like to warmly thank the many people who helped develop, maintain, and ultimately complete this project. Without a doubt, this project would never have seen the light of day without my supervisors' support. Dr. Sarosh Khalid-Khan and Dr. Kate Harkness, I am most appreciative of your time, support, and thought-provoking suggestions that pushed my reasoning and writing forward. Dr. Khalid-Khan, I always appreciated how we could discuss serious research and professional manners as well as have a good laugh. Dr. Harkness, thank you for encouraging me to be critical of my analytical skills and writing. Dr. Salinda Horgan, I cannot express enough gratitude for your expertise and patience in the last two years. Thank you for challenging my sometimes stubborn thoughts, and introducing me to a completely new approach to inquiry. I am also grateful to my committee member, Dr. Wendy Craig, who helped me think outside the box when looking for a new research direction. Your ability to see the "big picture" played an important role in crafting this project. Dr. Chris Bowie, thank you for your thoughtful comments and for posing questions that allowed me to further the development of the research questions.

Many others played an important educative and supportive role. The members of the research steering committee, Dr. Julie Blais and Mrs. Leanne Tonge, and Nina Buchenrieder, I thank you for offering your time and thoughtful consideration throughout the research process. Thank you to soon-to-be-Doctor Daniel Hagel, who introduced me to qualitative research and was always available for questioning. Your answers were always detailed, thoughtful, and helpful. To my friends and colleagues, Cynthia Dolizsar, Megan Mahoney, Sylvia Magrys, Amy O'Neil, Allisha Patterson, Kate Sutton, and Erica Refling, thank you for your valuable advice and bottomless support. I appreciate that you can be constructively critical as well as kind-hearted. To my sister Negar Pishva, thank you for believing in me when I nearly threw in the towel on numerous occasions. Karl Oczkowski, you parachuted into my life and gave me the courage to keep writing when things were difficult. Your presence in my life has made

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me a better person. Thank you for helping me navigate the rules of English grammar! Thank you to my parents, Farideh and Mamad, who believed in me before I ever did. Angele Beaulieu, Teo Buzea, Dianne Flint, Eva Matian, Dr. Kevin Parker, Dr. Tony Eccles, and the Toucan crew, thank you. To so many other friends, colleagues, family members, and strangers who in their own way inspired me to finish.

This dissertation represents more than a research project. It has been a journey in personal and professional growth. It has defined many (perhaps *too* many?) years of my life. I cannot believe that years of blood (paper cuts!), sweat, and tears have finally come to fruition. I am done – or at least nearly!

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Statement of Originality

(Required only for Division IV Ph.D.)

I hereby certify that all of the work described within this thesis is the original work of the author. Any published (or unpublished) ideas and/or techniques from the work of others are fully acknowledged in accordance with the standard referencing practices.

Rana Pishva

August, 2015

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Chapter 1

Introduction

Anxiety disorders are among the most common psychiatric disorders in children (Costello, Mustillo, Erkanli, Keeler, & Angold, 2003). They have been associated with significant impairments in academic performance and social functioning (Costello & Angold, 1995; Kendall, 1992; La Greca & Lopez, 1998), as well as long-term mental health difficulties such as depression and substance abuse (Kendall, Safford, Flannery-Schroeder, & Webb, 2003; Kessler et al., 2011; Pine, Cohen, Gurley, Brook, & Ma, 1998; Wittchen, Kessler, Pfister, & Lieb, 2000). Interventions for childhood anxiety disorders traditionally include a combination of anti-anxiety medication and cognitive behavioural therapy (Ollendick & King, 1998 for a review). Cognitive Behavioural Therapy (CBT) is a multidimensional intervention that aids anxious patients to recognize and alter cognitive biases, and eliminate avoidant and/or compulsive behaviours and physiological arousal that underlie symptoms of anxiety (Beck, 1995; Kendall & Suveg, 2006). Interventions are typically child-centered, in that they aim to alter the child's behaviour, cognitions, and emotions. Child-focused CBT compared to no treatment has been shown to be effective in treating pediatric anxiety disorders, with therapeutic gains maintained for up to a year after termination of treatment (e.g., Barrett, Dadds, & Rapee, 1996; Cartwright-Hatton, Roberts, Chitsabesan, Fothergill, & Harrington, 2004; Kendall, 1994; Kendall, Flannery-Schroeder, Panichelli-Mindel, Southam-Gerow, Henin, & Warman, 1997). Unfortunately, up to 40% of anxious children and children who take part in CBT do not experience significant post-treatment improvement (Kendall & Hedtke, 2006; Kendall, Hudson, Gosch, Flannery-Schroeder, & Suveg, 2008; Southam-Gerow, Kendall, & Weersing, 2001) however, when combined with medications, treatment success rate can increase to 80% (Walkup et al., 2008).

The heterogeneous presentation of anxiety disorders and their high comorbidity rate with other disorders can complicate treatment and influence outcome (Garber & Weersing, 2010; Micco & Ehrenreich, 2010; Seligman & Ollendick, 1998). Remission rates after 12 weeks for children treated with

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CBT, medications, or a combination of both has been shown to be lower for those with a comorbid internalizing disorder such as depression (Ginsburg et al., 2011). These findings are concerning given that comorbidity rates of anxiety and mood disorders range from 6% to 70% in clinical samples (Angold et al., 1999; Axelson & Birmaher, 2001; Beidel, Turner, & Morris, 1999; Costello et al., 2003; Masi, Mucci, Favilla, Romano, & Poli, 1999; Seligman & Ollendick, 1998). The presence of an anxiety disorder in adolescence has also been associated with suicidal ideation, suicide attempts, and self-harm behaviours (Boden, Fergusson, & Horwood, 2007; Moran et al., 2012; O'Neil, Puleo, Benjamin, Podell, & Kendall, 2012), which can also have implications for treatment and require therapists to adapt manualized treatment program to the needs of the clients (Garber & Weersing, 2010; Micco & Ehrenreich, 2010).

Evidence that parenting strategies and parent characteristics influence the symptoms of anxiety in children has prompted a focus on parent involvement and the development of parent-centered programs (Barmish & Kendall, 2005; Barrett et al., 1996; Chorpita & Barlow, 1998; Dadds, Heard, & Rapee, 1992; Khanna & Kendall, 2009; Rapee, 1997; 2012). In parent-centered treatment programs, the therapist, acting as an expert consultant, assists the parent in the sustainable implementation of CBT skills in the home environment (Bodden et al., 2008; Ginsburg, Silverman, & Kurtines, 1995; Silverman, Ginsburg, & Kurtines, 1995). A number of articles discuss the overall role of parents in the treatment of childhood anxiety and the effectiveness of parent-centered programs (e.g., Barmish & Kendall, 2005; Bodden et al., 2008; Breinholst, Esbjørn, Reinholdt-Dunne, & Stallard, 2012; Cobham, Dadds, & Spence, 1998; Forehand, Jones, & Parent, 2013; Khanna & Kendall, 2009; Manassis et al., 2014; Taboas, McKay, Whiteside, & Storch, 2014). These studies however are founded on clinical experience and literature review and do not include input from the primary stakeholders in the process (i.e., parents). Parent involvement has been operationalized as number of sessions and do not address the systemic or procedural factors that could influence CBT implementation in the home (Manassis et al., 2014). They also do not take into consideration the complex clinical presentations and contextual factors that could influence the implementation of CBT by parents of anxious children.

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An examination of the implementation process that unfolds when parents of anxious children practice CBT with their child could uncover milestones and phases, challenges, as well as potential targets for intervention. The current research offers a qualitative examination of the process that mothers of anxious children undertake when implementing CBT at home with their child, after taking part in a group for parents of anxious children. This study proposes a theory regarding the process of change in actions, emotions, and meanings, for mothers of anxious children and the factors that influence this dynamic process. The study also explored how child factors such as the presence of suicidal ideation and self-harm behaviours can influence mothers' process when implementing CBT.

This literature review begins with an outline of the goals, nature, and content of parent-centered programs for parents of anxious children and youth. It will also summarize the existing literature on the process of parents who implement treatment programs with their child. Finally, it reviews child factors that influence treatment delivery for pediatric anxiety disorders and how certain clinical presentations could influence CBT implementation by parents. Additionally, it considers the presence of signs of suicidality such as threats of suicide and non-suicidal self-harm behaviours and their influence on mothers' implementation of CBT at home. The gaps in the literature regarding parents' process in the treatment of childhood anxiety will motivate the present program of study which ultimately aims to improve service delivery by understanding the process of therapeutic engagement and implementation for mothers of anxious children.

Parent-Centered Programs for Parents of Anxious Children

Family dysfunction, negative parent-child interactions, controlling or overprotective parenting strategies, parental anxiety, as well as parents' accommodations of the child's avoidant behaviours have been identified as possible contributors to pediatric anxiety disorders (McLeod et al., 2007; Rapee, 2012 for reviews). Given the reciprocal nature of parent-child relationships (e.g., Ballash, Leyfer, Buckley, & Woodruff-Borden, 2006; Chorpita & Barlow, 1998; Rapee, 1997), these factors may act as etiological or maintaining factors that may either cause or perpetuate anxiety disorders in children. These environmental

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and parenting strategies are malleable to treatment and have motivated the inclusion of parents in the treatment of childhood anxiety disorders.

In terms of content, parent-centered treatment programs address systemic factors that have been shown to maintain or perpetuate anxiety symptoms in children or that negatively influence treatment outcome (Cobham et al., 1998; Crawford & Manassis, 2001; McLeod et al., 2007; Rapee, 2012 for reviews). The programs typically include the core tenets of CBT interventions: psychoeducation, treatment rationale, relaxation strategies, reappraisal of cognitive distortions that perpetuate anxiety (i.e., cognitive restructuring), and behavioural exercises such as systematic desensitization that aim to decrease avoidance behaviours. In parent-centered programs, caregivers learn how to recognize and respond to their child's anxiety, reward the use of adaptive coping styles, and promote exposure as opposed to avoidance. Parents are encouraged to utilize adaptive "courageous" responses such as cognitive restructuring and exposure for their own, as well as their child's anxiety (Barnish & Kendall, 2005). It is also assumed that when parents are familiar with the treatment rationale, they can prompt the child in the use of methods and assist in cognitive reappraisal (Barrett, 1998; Ginsburg et al., 1995; Silverman, et al., 1995; Silverman & Kurtines, 1996; Stallard, 2006). Finally, when parent and child use adaptive coping strategies, it is expected that treatment gains will successfully generalize to new situation and be maintained over time (Barrett et al., 1996; Kendall, MacDonald, & Treadwell, 1995; Toren et al., 2000).

Transfer of control (Ginsburg et al., 1995; Silverman, et al., 1995; Silverman & Kurtines, 1996) is considered a fundamental component in building sustainable therapeutic change within the home environment in order to reduce and manage the child's symptoms of anxiety. With guidance from the therapist, the parent is expected to practice CBT techniques with the child, model appropriate coping strategies to encourage the development of their child's independent use of coping strategies. Parents learn about contingency management and exposure, and then apply this knowledge with their child in the home environment. The child is trained by the parent (and heavily supported by the parent) in the use of these strategies and self-management skills, and is then encouraged to apply these skills in anxiety provoking situations. The therapist's role in transfer of control is to assist parents' efforts, by answering

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questions and facilitating creative and adaptive problem solving (Silverman & Kurtines, 1996). The parents' role is to support their child in developing adaptive coping skills, by modelling the strategies themselves, creating structure in the practice of the strategies, and eventually promoting the independent use of these strategies. Once the treatment program is terminated, parents rely on therapy materials such as handouts to continue to support their work at home.

Nature of parent involvement. In examining the format of parent-centered CBT programs, parents' role has been categorized in many ways: consultant, facilitator/collaborator, co-therapist, or co-client (Barmish & Kendall, 2005; Forehand et al., 2013; Stallard, 2006). Parents act as consultants (e.g., Kendall et al., 2010) provide information regarding the child's symptoms and progress, which allows the therapist and child to focus and modify the intervention plan if necessary. As facilitators (or collaborators), parents may take part in two or three sessions that are parallel but separate from their child's therapy session. They are informed of the methods that their child will be learning, while the child remains the focus of the treatment. Examples of these models include the "Coping Cat" program for anxious children (Kendall, 1994) and "How I ran OCD out of my land" (March, Mulle, & Herbel, 1995). Parents as co-therapists are as involved in the treatment program as the child is, and take part in separate but similar interventions. Strategies in managing their child's anxiety are not directly addressed in all treatment programs (e.g., Mendlowitz et al., 1999; Toren et al., 2000). In other programs, parents as co-clients signifies that parental behaviours in response to their child's anxiety become the target of intervention as a way to elicit changes in the child's symptoms (e.g., Cobham et al., 1998). These groups, which are also referred to as family-centered CBT groups or CBT with a family component (Barrett et al., 1996; Bodden et al., 2008; Cobham et al., 1998; Ginsburg & Schlossberg, 2002; Wood et al., 2006) focus on assisting parents to manage the systemic factors that could perpetuate their child's anxiety, such as family dysfunction, negative parent-child interactions, and parent psychopathology. Barmish and Kendall (2005) conducted a review examining the impact of including parents as co-clients in the treatment of childhood psychopathology. Although effect sizes for clinician and children self-reports of anxiety symptoms ranged from medium to large, these were not significantly greater than the outcomes of child-

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focused CBT without parent involvement. Barmish and Kendall however, did not examine the change in parent functioning or parenting style when parents act as co-clients. Long-term benefits of targeting parenting factors in treatment and the involvement of parents as co-clients cannot be discounted given the known role of parenting style in child psychopathology (Cobham et al., 1998; Kendall & Panichelli-Mindel, 1995; Toren et al., 2000).

In summary, parent involvement in the treatment of pediatric anxiety targets systemic factors that have been shown to maintain and foster symptoms of anxiety in children and youth. A key anticipated outcome of parent-centered programs is that the CBT skills will be practiced at home and the treatment gains will be maintained by way of the implementation of skills in the home by the parent (Ginsburg et al., 1995; Kendall et al., 1995; Khanna & Kendall, 2009; Silverman & Kurtines, 1999). Despite the expectation of generalization, little is known about this process and the way in which parents incorporate the therapeutic knowledge into their parenting style and home environment. The literature does not address the way in which parents approach these treatment programs, nor does it speak to their engagement with the material or implementation of the methods in the long-term. Parents' process, engagement, and understanding of these responsibilities is not well understood. The current study aims to elucidate the process of at-home CBT implementation by mothers of anxious children. A qualitative approach to this question allows an examination of *how* parents implement CBT, as opposed to what they *should* be doing according to the treatment program. The study explored the implementation of CBT by mothers of anxious children up to 24 months after group termination, in an effort to explicate the contextual factors that influence the dynamic process of change in the long-term, as well their impact on the parent-child relationship, family dynamics, and parental strategies. Given that most studies include a 12-month follow-up (e.g., Barret et al., 1996; Kendall, 1994); the information obtained in this study may elucidate challenges faced by parents that may not have been identified in previous studies.

Caregiver Process in Parent-Centered Therapy Program

Though not specific to CBT for childhood anxiety, researchers have evaluated the acceptability, perceived effectiveness, and perception of parenting groups for other childhood disorders (e.g., Bavin-

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Hoffman, Jennings, & Landreth, 1996; Foley, Higdon, & White, 2006). Others have sought to elucidate the cognitive, emotional, and behavioural process that parents' undergo and understand the occurrence of change for parents of children with externalizing disorders (Holtrop, Parra-Cardona, & Forgatch, 2013).

This section reviews studies that have elucidated parents' process when caregivers are involved in treatment of children with behavioural or emotional adjustment difficulties. These studies place the parents' experience within the larger context of the therapeutic process and serve to identify ways to improve services through a deeper understanding of the role and impact of key stakeholders. This section also reviews constructs such as therapeutic engagement and parent responsibility, as they could influence the way in which parents implement therapeutic programs with their anxious child.

Parenting programs for childhood externalizing disorders. Parenting programs have been shown to be an effective intervention in the treatment of childhood externalizing disorders (e.g., Dretzke et al., 2009; Forgatch, Patterson, DeGarmo, & Beldavs, 2009; Kjøbli & Ogden, 2012; Sanders, Turner, & Markie-Dadds, 2002; Webster-Stratton, Reid, & Hammond, 2001). Kane, Wood, and Barlow (2007) conducted a systematic review of qualitative studies that examine the experience of parents after taking part in parent training for children and youth with externalizing disorders. Their goal was to identify components of parenting trainings deemed useful from the *users'* perspective, in order to promote engagement and acceptability of the programs. Their review suggests that parents take part in the programs after experiencing powerlessness, inadequacy, and stigma. Parents felt that they gained control and were able to cope when they developed new skills and felt supported by the therapist and other parents in the treatment group. They reported that this new understanding allowed them to express more empathy toward their child when he or she is experiencing difficulty. Mytton, Ingram, Manns, and Thomas (2014) conducted a review of qualitative studies that examined the facilitators and barriers to parents' engagement in parent training. The authors identified increased confidence and self-efficacy, skill acquisition, therapeutic rapport, and positive group experience as treatment facilitators. Furthermore,

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treatment engagement was reported as more successful when parents could tailor the contents of the program to their own experiences. In regards to barriers, parents indicated that changing their own practices, as opposed to focusing on their child's behaviour was most challenging. Mismatch between parents' expectation and program content, poor group dynamics, cultural insensitivity, training and credibility of the treatment provider, as well as parents' competing demands, such as work schedule and child care for the other children, were identified as barriers to engagement. Overall, their review identified discrepancies between process components that parents and researchers or clinicians view as important (Mytton et al., 2014). These two reviews emphasize the importance of considering parental process and external factors when involving caregivers in the treatment of externalizing disorders in children and youth.

Holtrop et al. (2013) pointed to a gap in the literature regarding the process of change that occurs because of parents' adaptation of the role of therapeutic agent with their child. Using the qualitative methodology of grounded theory, they interviewed 20 parents who took part in an evidence-based program for parents of children with externalizing disorders. Their findings indicate that the process of change is cyclical and consists of three primary stages: attempt, appraisal, and application. In the first stage, parents strived to practice the skills at home and struggle with the details or novelty of the approach. They subsequently engaged in an ongoing evaluation of the methods, and identified conditions that promote or hinder program delivery in their home. At this stage, parents struggled to implement the skills consistently. Finally, some parents continued to practice the skills at home, adapted strategies to fit the needs of their child and family, utilized the program as reinforcement during a crisis, or became complacent in the delivery of the program. As such, change occurred gradually, through experimentation, evaluation, and modification of approaches over time. Parents progressively altered their understanding and approach toward their child. Long-term implementation of interventions for parents of children with externalizing disorders is founded on parents' assessment of the child's needs and situational factors. (Holtrop et al., 2013).

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Therapeutic engagement and attitude. Environmental, therapist, task, and client factors influence and prevent successful practice of CBT outside the therapeutic environment (Kazantzis & Shinkfield, 2007). For instance, clients' belief in their aptitude to complete the task (i.e., self-efficacy) has been shown to determine whether they complete it (Bandura, 1989; Beck, 2005). Dunn, Morrison, and Bentall (2002) used qualitative methods to understand the factors influencing homework completion in the course of CBT for psychosis. They found that patients' perception of homework relevance was an influential factor in regards to homework completion. Concurrently, parents' understanding of the therapeutic exercises and belief in their ability to implement the tasks could influence the practice of CBT skills at home. In parent-centered programs, caregivers must manage negative emotions that can arise, such as anxiety, frustration, confusion, and guilt of putting their child in an uncomfortable situation. For instance, parents must manage their own discomfort or guilt when encouraging their child to engage in exposure exercises that require intentional approach of anxiety-provoking situations. On the other hand, parents may experience pride and empowerment in being able to contribute to their child's treatment. These experiences could interact with stressors in the home such as the presence of other children or their relationship with their spouse, to influence whether or not parents continue to implement CBT in the home over the long-term.

Increased responsibility. In parent-centered therapy, the program's effectiveness in reducing the child's anxiety symptoms relies partially on parents' willingness and ability to implement CBT skills successfully in the home. When the child does not participate in treatment sessions, the onus is on the caregivers to implement and practice the CBT techniques at home, not only during treatment, but also over the long-term (Kazdin, Siegel, & Bass, 1990; Ollendick & Russ, 1999). This requires significant commitment on the part of parents who may feel overwhelmed or confused by the new information and implies added responsibility for practicing CBT with the child despite other stressors in the home (e.g., other children, work). External factors such as disruption of daily routine and impact on relationships could also alter parents' implementation of CBT techniques in the home. Parents may experience frustration at their child's lack of progress or their own inability to enact the skills on a consistent basis

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(Foley, Higdon, & White, 2006). As such, when considering the parents' role in enacting CBT in the home, it is important to explore the external and internal factors that facilitate or complicate both the short and long-term implementation of these skills.

Summary of parental process. Overall, research on parental experience when implementing therapeutic strategies in the home suggests that parents undergo a gradual process initiated by increased awareness, knowledge, and acceptance for their child's experience (Holtrop et al., 2013). Parents gradually gain control, self-efficacy, and the skills necessary to cope with their child's problematic behaviours (Foley et al., 2006; Kane et al., 2007; Spitzer, Webster-Stratton, & Hollinsworth, 1991). Contextual factors and program characteristics influence parents' process of change, as well as their engagement in the treatment program (Holtrop et al., 2013; Kazantzis & Shinkfield, 2007; Mytton et al., 2014). The client's engagement with the task, belief in their perceived ability to complete the task, and time management abilities have also been shown to influence the practice of CBT skills (Dunn et al., 2002; Kazantzis & Shinkfield, 2007). Despite the increased responsibility these programs place on parents in their child's treatment, studies have not examined the process through which parents become agents of therapeutic change for their anxious child and how various environmental and contextual factors may potentially influence this process.

The abovementioned studies are based mainly on parenting programs for childhood externalizing disorders. Given the distinct family dynamics and parental strategies that have been linked to pediatric anxiety disorders compared to externalizing disorders, parents of children with anxiety disorders may undergo a different process and face unique challenges compared to parents of children with externalizing disorders (Forehand et al., 2013; McLeod et al., 2007). For instance, family dysfunction, nature of parent-child relationships and parenting styles, parent psychopathology, parents accommodations of the child's avoidant behaviours, as well as learned mechanisms have been identified as possible contributors to pediatric anxiety disorders (McLeod et al., 2007; Rapee, 2012 for a review). Further, anxiety disorders may also co-occur with other symptoms such as suicidal ideation and self-harm behaviours, which could

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present additional challenges for parents involved in treatment. The primary goal of the present study was to provide an understanding of these factors and elucidate procedural phases that mothers of *anxious* children undergo when implementing CBT, which in turn may identify contextual and personal challenges. The findings can inform service delivery by allowing clinicians to provide additional support for parents of anxious children. Additionally, findings can serve to address the gap in the literature pertaining to parent involvement in the treatment of childhood anxiety disorders, by offering an explanatory account of parental process.

Child Factors in Treatment Implementation and Outcome

Parent involvement in the treatment of childhood anxiety is founded on the notion that external factors, such as environment and parental strategies can contribute to the disorder. Child factors, such as the presence of other disorders and symptoms can also influence treatment implementation and outcome (Micco & Ehrenreich, 2010). For instance, Rapee (2003) examined how treatment outcome for children aged 7 to 16 diagnosed primarily with an anxiety disorder was influenced by the presence of a comorbid mood or externalizing disorder. He found that although post-treatment outcome measures were comparable, children without a comorbidity maintained their treatment gains better at a 12-month follow-up than those with a co-occurring disorder. As such, comorbidity may indicate the need for ongoing support in maintaining treatment gains and variations in presentation and symptoms may represent additional challenges for parents who are engaged in the treatment process.

The anxious child's presentation may interact with parental strategies to complicate treatment implementation and outcome. The literature indicates that parents of children who engage in non-suicidal self-harm report being particularly vigilant and careful around their child, in an effort to prevent another episode (Oldershaw, Richards, Simic, & Schmidt, 2008). Mothers were also reluctant to impose boundaries and reported experiencing helplessness and sadness in response to their child's behaviours (Raphael, Clarke, & Kumar, 2006). Consequently, the presence of suicidal thoughts (e.g., "I wish I was dead"), threats of suicide (e.g., "I am going to kill myself if this happens"), and non-suicidal self-injury (e.g., superficial cutting on forearms) may require modification to the CBT for anxiety protocol,

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especially if parents are placed at the center of the treatment protocol. That is, parents of children who make such threats may approach the implementation of CBT differently than when there are no concerns about safety. The findings from the present also elucidate how signs of suicidality such as thoughts of death, suicidal threats, and non-suicidal self-harm behaviours influences the mothers' process when implementing CBT with an anxious child.

Anxiety and suicidality. Pediatric anxiety disorders are associated with a higher risk of suicidality relative to the general population of children and youth (e.g., Boden, Fergusson, & Horwood, 2007; Foley, Goldston, Costello, & Angold, 2006; Moran et al., 2012; Nelson et al., 2000; Wunerlich, Bronisch, & Wittchen, 1998). For instance, Boden et al. (2007) followed anxious youth aged 16 to 25 and found that anxiety disorders were significantly associated with suicide attempts and suicidal ideation, even after controlling for comorbidity and occurrences of stressful life events. Similarly, in a community sample of adolescent females, social phobia was significantly associated with suicidal ideation, even after controlling for major depressive disorder (Nelson et al., 2000). Finally, O'Neil et al. (2012) reported that 41.3% of anxiety-disordered children and youth aged 7 to 17 were classified in a comorbid suicidal ideation group, with no difference found in the anxiety diagnoses.

Despite the link between anxiety disorders and signs of suicidality in children and youth with externalizing disorders, the literature not does address the treatment implications of this clinical presentation, especially when parents are involved in the treatment process. Suicidality, when occurring within the context of anxiety, is likely addressed in the same manner as within a treatment program for depression. That is, the suicidality symptoms are addressed first, evaluating risk and intent, then engaging in safety planning, psychoeducation, and developing reasons for living and hope (Stanley et al., 2009). The involvement of parents in this process remains unclear and few studies have examined the impact of parent involvement in the treatment of symptoms of suicide. Toumbourou & Gregg (2002) evaluated the effectiveness of a parent education program in reducing risk factors associated with suicide in adolescents. The program was associated with decrease in adolescent substance use, delinquency, as well as improvement in family functioning and maternal care compared to the matched control group. As such,

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parents could play a valuable role the improvement of wellbeing for children and youth with suicidal symptoms.

When a child has made threats of suicide or engaged in non-suicidal self-harm behaviours, mothers may respond to their distress differently, and undergo a different process when implementing CBT. For instance, the requirements of CBT for anxiety, such as active ignoring, could seem counterintuitive for parents who are concerned about their child's safety. Parents whose anxious child also presents with signs of suicidality may therefore face additional challenges when assuming a therapeutic role. Given the heterogeneous presentation of anxiety disorders and the co-occurrence of anxious symptoms and signs of suicidality, understanding this process makes a valuable contribution to clinical practice.

Definition of the Problem

Although the literature on parental involvement in the treatment of childhood anxiety is growing, a number of questions regarding the implementation process of CBT within the home remain. At present, the literature on childhood anxiety offers a plethora of information regarding the potential mechanisms through which anxiety is maintained over time. Key principles of treatment have been identified however; it is unclear which components (if any) are responsible for therapeutic gains (Barmish & Kendall, 2005; Barret et al., 1996; Forehand et al., 2013; Khanna & Kendall, 2009; Silverman & Kurtines, 1996). Data on treatment effectiveness are available, albeit inconclusive (Manassis et al., 2014). The existing description of behavioural and treatment principles does not explicate the ongoing process of parents who attempt to modify their own attitudes and practices, as well as those of their anxious child within the ongoing context of their everyday lives. Theories have been developed to explain the process of parents who take part in a program for parents of children with externalizing disorders (e.g., Holtrop et al., 2013; Spitzer et al., 1991), while others describe the experience of parents whose child presents with signs of suicidality (e.g., Raphael et al., 2006). The findings from these studies may not be generalizable to parents of anxious children given the differences in etiology, symptoms, and treatment needs. Parent-centered therapy, and the change it aims to elicit, begins once the parent leaves the therapeutic environment and initiates CBT implementation at home. An understanding of this process requires a deeper examination of

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parents' role and the complex process they undertake when they engage in various components of treatment, including homework assignments, exposure exercises, and cognitive restructuring. Such findings can serve to inform clinical practice in the form of program adaptation and modification and identify important therapeutic processes that influence outcome (Holtrop et al., 2013; Kazdin, 1997).

Quantitative studies have focused primarily on effectiveness in reducing the child's anxious symptoms and operationalized parental involvement as the number of parenting sessions in a program. This quantification of parent involvement does not take into consideration parents' engagement, attitude, or process, nor does it explain the way in which parents translate the group content in their home. It also fails to consider the possible influence of complex clinical presentations and symptoms such as signs of suicidality and/or non-suicidal self-harm behaviours on treatment implementation by caregivers that could result from parents' emotional and behavioural responses to the child's clinical presentation. Evidence-based practice should rely on more than randomized control trials and include qualitative findings that speak to the process and experience of participants (Dixon-Woods & Fitzpatrick, 2001). An examination of qualitative factors that influence implementation and treatment outcome could clarify parents' role and reveal the nature of parental involvement that have been obscured by a quantitative conceptualization (Manassis et al., 2014).

The Present Study

Qualitative studies offer an in-depth examination of the subjective processes associated with treatment engagement and implementation. They explain how strategies and attitudes are challenged, and what emotional, behavioural, cognitive, and environmental changes occur when implementing CBT at home with an anxious child. The present study sought to develop a grounded theory of the process that parents of anxious children undertake when adopting a therapeutic role with their children. It explored how internal factors such as parents' perceived ability or external factors such as the presence of other siblings or spousal support, impact the process of implementing CBT in the home while taking into account the complex presentation of anxiety disorders (i.e., presence of suicidal ideation and/or self-harm

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behaviours). As such, it explicates the process of change that parents of anxious children undergo when implementing CBT at home with their anxious child.

This qualitative examination of the delivery of CBT by mothers of anxious children serves to address gaps in the literature regarding the parents' process, therapeutic engagement, and program delivery. The findings may be valuable when adapting treatment manuals, engaging parents in therapy, and help to improve service delivery and potentially treatment outcome. From an applied clinical perspective, this theory can serve to improve how clinicians facilitate parent-centered groups, by utilizing methods that maximize engagement and providing supports in implementation and decision-making. Furthermore, this study takes a long-term perspective to the treatment of childhood anxiety by examining how CBT is implemented by parents up to 24 months after group termination, which is longer than most follow-up measures in the literature (e.g., Barrett et al., 1996; Kendall, 1994). Consequently, findings from this study may allow clinicians to foresee challenges that occur after group termination and plan for their clients' long-term needs. The study may also inform improvements in service delivery to support parents in conducting CBT in the home and by extension lend valuable insights into extending therapeutic maintenance for anxious children. The motivation for this study therefore supports clinical psychologists' professional obligation to deliver effective treatments and support their clients in the process (Kazdin & Kendall, 1998).

Research Questions

The specific aims of the study are to create an awareness of the process and conditions that impact mothers when attempting to carry out CBT in the home, explicate *how* certain conditions motivate and/or challenge mothers in their attempt to carry out CBT in the home, and to build an understanding of the process of change within a parenting program for mothers of anxious children. The central research questions for this study are:

- 1) What internal and external factors shape the implementation of CBT at home for mothers who participated in a group for parents of anxious children?

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2) What is the process of change for mothers in parenting when implementing CBT at home with an anxious child?

3) How is CBT implementation impacted when an anxious child also presents with signs of suicidality and/or non-suicidal self-harm behaviours?

In the present study, the qualitative approach of grounded theory was employed to examine patterns of action and interaction involved in the complex process of carrying out CBT with one's child in one's home. Grounded theory is a qualitative research method that serves to uncover patterns of action and interaction that occur in relation to internal and external changes that develop in response to a particular phenomenon (Glaser & Strauss, 1967; Strauss & Corbin, 1997; 1998). It goes beyond a general description of the process to offer an explanatory theory of how the phenomenon influences and shapes those who experience it and related conditions. It does this through a process of constant refinement of systematically generated information, using observations and narratives (Bryant & Charmaz, 2007). The resulting theory provides an understanding of the complexities and multi-factorial elements involved in the process that is undertaken when experiencing the phenomenon of interest. Further details about the choice of methodology and approach are provided in the Design and Theoretical Stance Chapter.

Organization of the Thesis

The Theoretical Stance Chapter explicates the choice of methodology and provides an in depth description of the nature and process of the qualitative method of grounded theory. The Methods Chapter provides a description of the data collection, analysis, and interpretation process. The Results Chapter presents the core categories and subcategories of the grounded theory, whereas the Synopsis Chapter presents the final theory, explicating links and interactions between each of its components. The Reflexivity Chapter aims to bring forward personal process, biases, and perceptions that influenced data collection, analysis, interpretation, and presentation. Finally, the Discussion Chapter situates the findings within the literature, presents the theoretical and clinical implications of the findings, and reviews the limitations of the study as well as avenues for future research.

Chapter 2

Design and Theoretical Stance

In the present study, I utilized the qualitative method of grounded theory to conduct an in-depth examination of the role and process taken on by parents when they implement cognitive behavioural therapy (CBT) with their anxious child in their home. This chapter provides a description of the methodology and the reasoning for my decision to conduct a grounded theory founded on the work of (Charmaz, 2010; 2014).

Qualitative methods can help to uncover actions, themes, and consequences of a phenomenon and can demonstrate how these components interact in a given context. Because qualitative methods examine phenomenon holistically (i.e., in a natural environment without controlling or manipulating variables, a comprehensive understanding of the phenomenon in all of its complexity is revealed (Creswell, 2013; Miles & Huberman, 1984; Packer, 2011) allowing for the identification and systematic exploration of reciprocal relationships and interactions. The result is a rich narrative, where change in terms of stressors, inter- and intrapersonal factors can be described and explained. This approach was ideal when examining a dynamic and multifaceted process such as the implementation of CBT by mothers of anxious children, because numerous perspectives, dimensions, and themes could be explored simultaneously.

Grounded Theory

Grounded theory is a qualitative research method that serves to uncover patterns of action and interaction that characterize a particular phenomenon and accounts for the internal and external responses in actors operating within the circumstances (Glaser & Strauss, 1967; Strauss & Corbin, 1990). It brings to the surface implied and taken-for-granted meanings and processes (Charmaz, 2014). The resulting “theory” provides an account of the system of ideas and concepts that organize and produce a social process. This theory is substantive in that it is transferable to other similar contexts and modifiable in the light of new information (Adelman, 2010). The grounded theory begins from the phenomenon of interest

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and generates explanatory theory that is subsequently verified through the data. That is, it is a bottom-up method of theory formulation.

In the present study, the qualitative approach of grounded theory was employed to understand the process of carrying out CBT with an anxious child in the home, after taking part in a CBT group for parents of an anxious child. A grounded theory is constructed through a process of constant refinement of systematically generated information, using observations and narratives obtained through interviews or focus groups (Bryant & Charmaz, 2007; Charmaz, 2014 for review). Since qualitative studies aim to understand a complex phenomenon as it naturally unfolds, data collection takes place in the setting where it occurs, through interviews and observations with individuals who have experienced it. Similarly, grounded theory incorporates the researcher's observations (i.e., field notes or memos) and in-depth interviews to develop theory. The development of a grounded theory takes place through a cyclical and iterative process, whereby the researcher alternates between data collection and analysis with a focus on the needs of the emerging theory rather than preconceived hypotheses. This results in a back and forth between data collection, data analysis, and theory formation that is unique to the grounded theory methodology (Creswell, 2013; Glaser & Strauss, 1967). Thus, emerging theory is directly "grounded" in the data rather than in a-priori assumptions and expectations that may or may not be reflective of actual experience. The bottom-up and investigative nature of a grounded theory allows for factors that are unforeseen by the researcher to emerge, which renders it ideal when the literature on the research question is scarce or when a small sample is available (Charmaz, 2014). Additionally, literature review prior to data collection in grounded theory is targeted and limited: the investigator utilizes the existing literature to build a research question, not to develop a hypothesis (Strauss & Corbin, 1998). The existing literature is used more extensively in the final interpretation and integration phase of the theory. Links are sought between the theory and related literature, thus expanding the scope and depth of the theory.

The Constructivist Grounded Theory

The grounded theory method was originally developed through the collaboration of Barney Glaser and Anselm Strauss (Glaser & Strauss 1965; 1968; Strauss & Glaser, 1970). The authors described the systematic methodological strategies used in their own research and proposed that these steps could be used when examining other social processes (Charmaz & Bryant, 2010; Heath & Cowley, 2004; Morse, Stern, Corbin, Bowers, & Charmaz, 2009). The original grounded theory comprised mainly of two processes (Walker & Myrick, 2006). The first process consisted of systematic and iterative data analysis, where the theory emerges through constant comparison of codes (i.e., labels to meaningful data). Second, the researcher generates abstract concepts, relationships from the data's properties, resulting in a theory that is founded in the data. It also emphasizes a symbolic interactionism stance as a framework for understanding social processes. Thus, the resulting grounded theory is but one take on the nature of the phenomenon; providing illumination from a particular stance (Baker, Wuest, & Stern, 1992; Strauss & Corbin, 1990; 1998).

The collection of techniques and guidelines of the original grounded theory included the following: 1) conducting data collection and analysis simultaneously in an iterative process; 2) analyzing actions and processes rather than themes and structure; 3) using comparative methods (i.e., comparative comparison); 4) drawing on data (e.g., narratives and descriptions) in service of developing new conceptual categories; 5) developing inductive abstract categories through systemic data analysis; 6) emphasizing theory construction rather than description or application of current theories; 7) engaging in theoretical sampling; 8) searching for variation in the studied categories or process; and 9) pursuing developing a category rather than covering a specific empirical point (Charmaz, 2010, p.11).

While it maintains the original grounded theory's pragmatic and methodological foundation, the constructivist grounded theory, pioneered by Charmaz (2000) and Bryant (2002) differs from Glaser (1992), as well as Strauss & Corbin's (1990) in its emphasis on social construction of reality and the use of reflexivity methods. According to Charmaz, the original grounded theory presumes the existence of a

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single reality, which was to be discovered through constant comparison methods (Charmaz & Bryant; 2010; Charmaz, 2014). Constructivist grounded theory rejects the positivist nature of the original method that suggests the discovery of a single “ultimate” reality, which would emerge from the data through iterative analysis. Instead, constructivist grounded theory proposes a dynamic analytical process whereby the researcher engages with the data to construct *a* reality. The relativist perspective of constructive grounded theory assumes that reality is constructive and can differ across individuals and change over time. When taking a constructivist approach to grounded theory, the researcher attempts to gain an insider’s perspective of the phenomenon under study and may interview participants on multiple occasions to obtain an intimate understanding of the process. This practice presumes that participants’ understanding and the *meaning* of a process is in flux, and that the researcher’s questioning (and all the biases, presumptions, intentions that it includes) can influence this meaning. The final theory is meant to reflect this dynamic process.

The constructivist grounded theory also accepts and explicitly acknowledges the researcher as part of the research process, not an outside objective observer. The act of inquiry itself can therefore influence the outcome. The constructivist grounded theory proposes that the researcher’s self-reflections about the process be incorporated into the analysis process (Bryant, 2002; Charmaz, 2000; 2014; Denzin & Lincoln, 2000). The researcher uses reflexivity methods, where the factors that influenced decision-making and interpretation are described, evaluated, and reflected upon. It includes self-examination of the assumptions that may have influenced data collection, analysis, interpretation, and theory construction. This information is incorporated into the final theory, which is ultimately an interpretation of the complexities contained within the social processes under study.

In her revision of the constructive grounded theory, which maintains the crucial role of iterative data analysis with inductive and deductive methods, Charmaz (2014) incorporates the use of abduction in data analysis. Abduction is an inferential leap made by the researcher to account for an unexpected or perplexing finding. It occurs during inductive analysis, where an inference made regarding a piece of data

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does not fit the general pattern or cannot be explained in the same way as the remaining findings. According to Charmaz (2014, p. 201) “Abductive inference entails considering all plausible theoretical explanations for the surprising data, forming hypotheses for each possible explanation, and checking these hypotheses empirically by examining data to arrive to the most plausible explanation”. This method requires the researcher to take notice of nuances and variations in the data in order to explain them, as opposed to speaking only to data that fit the general pattern of findings. Abductive inference may require further analysis, and interpretations, literature review, as well as additional data collection, which are all methods inherent to the grounded theory methodology (e.g., Lois, 2010). It serves to deepen and strengthen the analysis by accounting for multiple perspectives and outcomes. It is common for the grounded theory theorist to interview participants on more than one occasion, to obtain additional information about the development of a process, or changes in meaning that may have occurred since the first inquiry (Charmaz, 2014). Additional data collection and abduction ultimately facilitate the inclusion of variations of findings in the final theory and can generate further research (Charmaz, 2014).

Reasoning for Methodology Choice

Grounded theory was selected as the methodological approach for this study, as the goal was to develop a theoretical model to explain the complex process of CBT implementation by mothers of anxious children. The grounded theory methodology founded primarily on the work of Charmaz (2010; 2014) was selected due to the nature of the research question, my previous knowledge of the literature, the complex multi-factorial nature of the topic, as well the inherent methods of rigor and trustworthiness embedded in the method.

First, despite the plethora of research on the nature and treatment of anxiety disorders and the growing literature on the role of parents in its maintenance and treatment, no research has examined the *process* of CBT implementation in the home. A theoretical model of change relating to parental involvement in the treatment of childhood anxiety disorders is lacking. A grounded theory will shed light on the inner and material conditions that comprise the parental role, thus enabling identification of key

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enablers and tensions. Understanding the process of mothers who undertake this endeavor is important for clinicians who aim to support parents in the sustainable practice and implementation of the methods.

Since grounded theory utilizes the collected data to generate theory, it is ideal when the literature on the research question is scarce (Charmaz, 2014). Furthermore, it typically requires a sample size of approximately 25 participants (Creswell, 2013), which fits the sample available for this study.

Second, given that this research project is a continuation and expansion of another study examining the efficiency of a CBT group for parents of anxious children, a completely naive approach void of literature review was not realistic. Glaser's (1992) grounded theory model that considers literature review as hindering the emergence of the theory was not followed. When this project was initiated, I had been immersed in the literature regarding anxiety disorders in children and youth and the role of parents in their development, maintenance, and treatment for nearly four years. I had also gained knowledge of pediatric anxiety disorders through clinical practice and was familiar with etiology and intervention theories. This knowledge was crucial in crafting the research question, designing the study, and ensuring a baseline of knowledge that allowed me to capture seemingly relevant codes during the initial phases of data analysis (i.e., theoretical sensitivity). I did not conduct an exhaustive literature review with the purpose of extracting thematic hypotheses. In other words, my research and clinical experience with the topic of parental involvement in the treatment of childhood anxiety provided me with a framework and starting point for data analysis, not preconceived theories to be tested (Charmaz, 2010). In this way, my approach was very much in keeping with the constructivist grounded theory approach proposed by Charmaz.

Third, the theoretical orientation of symbolic interactionism, which is concerned with the dynamic construction of meaning, allowed for an in-depth and multi-faceted examination of the social process under study. Blumer (1969) emphasized the importance of interaction between individuals, place, and events to generate behaviour and meaning. Strauss and Corbin (1990) emphasized the importance of examining meaning and how it is derived, shaped, and acted upon. In the context of CBT implementation

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in the home, parents' understanding of their evolving role and the significance of their actions was essential to the research question. The study seeks to uncover the reciprocal relationship between parents' attitudes, understanding of their child, and CBT implementation, which may change over time and may occur within an equally dynamic context. Additionally, the constructive grounded theory emphasizes the researcher as the primary research tool. That is, his/her role, including preconception and reflections, are understood to be a part of theory construction (Charmaz, 2014). As such, the constructivist theory allows for the generation of a comprehensive theory that is truly reflective of the process under study as it was experienced by the participants and the researcher.

Finally, inherent in the process of collecting and analyzing narrative data is the possibility that the researcher's personal biases, previous knowledge, or expectations will confuse the analytical process, and influence the emergent theory. Compared to other qualitative research methods, the grounded theory methodology consists of clear guidelines (e.g., constant comparison, theoretical sampling) for data collection and analysis, as well as rigor and trustworthiness procedures that ensure the credibility of findings (e.g., Charmaz, 2014; Chiovitti & Piran, 2003; Cutcliffe; 2000). Given my training and experience in quantitative methods, I appreciate the explicit analytical methods of grounded theory. However, grounded theory remains flexible to the research question and dynamic development of the theory (Charmaz, 2014) and the onus is on the researcher to demonstrate the use of rigor and trustworthiness methods throughout data collection and analysis. As such, the balance between explicit methodology and flexibility in implementation was well matched to my background in quantitative research as well as the current research focus. An explication of the reflexive exercise I undertook is contained in the Reflexivity Chapter.

Taken together, the grounded theory method is an optimal approach for the present research study given the numerous factors that interact when mothers of anxious children implement CBT in the home. It is beneficial for unraveling the personal, environmental, and situational complexity involved in a process such the one investigated in the present study.

Chapter 3

Methods and Rigor

The grounded theory was employed as a methodology for understanding the process of carrying out CBT with an anxious child in the home, after taking part in a CBT group for parents of anxious children and youth. Grounded theory is a bottom-up qualitative research method that serves to explain patterns of action and interaction that characterize a particular phenomenon and accounts for internal and external responses in actors operating within the circumstances (Glaser & Strauss, 1967; Strauss & Corbin, 1990). As described in the previous chapter, this method is characterized by constant comparison and theoretical sampling, which drive iterative data collection and analysis. Each step of data collection and analysis informs the next. The constructivist grounded theory (Charmaz, 2010; 2014) was selected given the nature of the research question, my previous knowledge of the literature, the complex multi-factorial nature of the topic, as well the inherent methods of rigor and trustworthiness embedded in the method. This chapter presents the characteristics of the sample, the data collection procedure, and data analysis. In order to maximize transparency of the analysis and illustrate the process through which the theory was developed, I included a number of figures and tables that reflect the milestones in the development of the theory. These serve to reflect the stages of grounded theory analysis and interpretation and iterations of the final theory presented in the Results Chapter.

Participants

Mothers who were invited to take part in the study were drawn from those who participated in a CBT group for parents of anxious children and youth, to ensure that their experiences and process were in line with the research questions. The treatment group is a 6-session (over 7 weeks) CBT program, based on the book “Keys to Parenting your Anxious Child” (Manassis, 1996) and a psychoeducational group for parents of anxious youth by the same author. The book and the program are designed to assist parents in dealing with an anxious child by explaining the nature of anxiety, providing strategies to challenge negative thoughts and building exposure exercises, as well as communication and problem-solving skills.

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The primary source of data for this study consisted of interviews with 19 mothers who took part in the CBT group for parents of anxious children and youth at a tertiary outpatient child and adolescent psychiatry unit between September 2011 and June 2014. Although the original goal was to interview mothers and fathers, it was quickly evident that for the most part, mothers took part in the group alone, were more involved in the implementation of CBT in the home, and were more likely to be available and willing to take part in the interview. As such, it was determined that mothers only would be interviewed, as fathers' experiences might have been different, and beyond the scope of the present study.

Characteristic of the Sample

In the present study, 19 mothers were interviewed. This falls within the suggested benchmark of 25 participants when constructing a grounded theory (Creswell, 2013; Thomson, 2011). The mean age of the child when mothers took part in the group was 10.68 years ($SD = 1.7$ years). On average, mothers took part in the interview 1.12 years ($SD = 0.74$ years) after taking part in the parenting group. The mothers' reported their child's diagnosis at the time of the interview, which included a diverse range of diagnoses. Mothers reported the following diagnoses: Generalized Anxiety Disorder ($n = 8$), Social Anxiety Disorder ($n = 3$), Separation Anxiety Disorder ($n = 2$), Panic Disorder ($n = 1$), Selective Mutism ($n = 1$), Panic Disorder ($n = 2$), Specific Phobia ($n = 2$). Two mothers were unsure of their child's diagnoses. Children also presented with various comorbidities: Learning Disability ($n = 3$), ADHD ($n = 5$) and ASD ($n = 1$). Finally, of the 19 families, 7 children had a history of suicidal ideation and/or self-harm behaviours, as reported by the mothers. Mothers' marital status also proved to be important in the emerging theory. In the present sample, 15 of the 19 mothers took part in the group without their spouses and 5 were single. One mother had a single child and eighteen mothers lived in a home ranging from 3 to 5 children.

Purposive Sample

In purposive sampling, participants (and other sources of data) are selected based on whether they have experienced the phenomenon under study. In this study, all mothers had taken part in the CBT

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program for parents of anxious children. However, the issue of suicidality, suicidal threats, and self-harm behaviours arose during the initial interviews. Mothers whose anxious child also presented with signs of suicidality and/or self-harm expressed distinct emotional experiences and challenges compared to the remainder of the sample. These particular experiences were examined further with the use of purposive sampling and they were analyzed independently as well as with the remainder of the sample. This approach resulted in seven participants being strategically selected based on characteristics or experiences pertinent to the research question.

The use of purposive sampling allowed targeted data collection with the population of interest given the research questions and aims. The targeted nature of the sampling method results in a cohesive sample that represents the naturalistic group and allows for targeted and meaningful recommendations. In this study, I sought to recruit mothers whose child also made threats of suicide, had suicidal thoughts, or engaged in self-harm behaviours at some point during the treatment of an anxiety disorder. None of the mothers in the present sample indicated that their child had attempted suicide. They indicated that their child's symptoms consisted of thoughts of suicides ("I wish I was dead"), making threats of suicide in a specific event ("I'm going to kill myself if this happens"), and non-suicidal self-injury (e.g., superficial cuts). Despite this difference, the sample remained cohesive given that the primary reason for referral and treatment was the child's anxiety disorder, and that mothers were referred to a parenting group for this purpose. Purposive sample allows for a naturalistic sample as well, given the co-occurrence of pediatric anxiety disorders and suicidal ideation (O'Neil et al., 2012).

The preliminary analysis with this subsample suggested that mothers' concerns pertained primarily to the perception of safety. Consequently, the methodological decision was made to examine participants whose child made suicide threats, had suicidal thoughts, or engaged in self-harm behaviours together.

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Theoretical Sampling

The goal of a grounded theory is to develop a conceptual theory rather than a descriptive account of the phenomenon under study. Iterative data collection and analysis may result in modifications in the direction of the theory, hence the source of data. Theoretical sampling refers to the researcher's attempt to follow the direction of the theory in regards to participant selection and interview questions, in order to explicate variations and identify gaps in the theory (Glaser & Strauss, 1967). It is dynamic and malleable to the needs of the emerging theory. As a result, the researcher may adapt the interview schedule to inquire about particular experiences and processes in more depth. As such, theoretical sampling does not necessarily lead to recruitment of participants, but may instead serve to develop code and categories. For instance, theoretical sampling was used during the data collection to inquire about mothers' feelings of discomfort of "unnatural" as well as when mothers' felt manipulated by their child (i.e., "bluffing"). Theoretical sampling in the interview context was also used to explore sibling dynamics in the home. When pertinent codes emerged, I decided to inquire further about the underlying processes in subsequent interviews. This method allows for the development of a rich theory that takes into account nuances of participants' experiences.

Theoretical Saturation

Recruitment continued until theoretical saturation was achieved (i.e., when no more new themes emerge from the data) and theory was deemed complete (Strauss & Corbin, 1998). To achieve saturation and ensure multiple perspectives, processes, and actions were explored, data analysis and recruitment occurred in tandem. This process increased the likelihood that variations amongst themes would be identified, improving support for the emerging theory. Reaching for theoretical saturation also meant that additional participants were continuously recruited to develop the theory further.

In constructivist grounded theory, the data are said to be saturated when the analysis does not expose novel aspects of the experience or process, nor does it drive further theory development (Charmaz, 2014). After 19 participants, no new information was pulled from each transcript or memo. That is,

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analysis of individual interviews did not result in new codes or categories and the available data were deemed to encompass the participants' experience. As such, theoretical saturation was reached after 19 participants as no more new themes emerge from the data and variations within the sample were believed to be well accounted for (Strauss & Corbin, 1998).

Data Collection

Ethical approval for this study was sought through Queen's University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board. Potential participants were first contact by mail. The letter of information detailed the goal of the study, what it entailed, the study's theoretical stance, as well as the rights of a volunteer research participant. The letter advised potential participants that the primary investigator would call them within the next 2 to 3 weeks to formally invite them to take part in the study and to schedule an interview time. Parents were also asked to sign and return the consent portion of the form in a pre-paid envelope if they were interested in participating.

Interviews

Once mothers were contacted by telephone, they were given the option to complete the interview face-to-face in their home or over the telephone. The former was preferred, as optimal data collection in qualitative research is gathered "in the field": the context where the phenomenon takes place (e.g., Creswell, 2013). As such, whenever possible, interviews took place face-to-face, in the participants' home. Prior to interview, parents provided written informed consent, which included the agreement to be tape-recorded. The interviews typically lasted between 50 to 65 minutes.

In the present study, the original interview guide, (Appendix C) was modified on two occasions (Appendix D). Due to the evolving nature of theory construction, iteration of the interview guide is expected and desired in the grounded theory methodology. The first iteration occurred after the first six participants were interviewed. The second iteration occurred after 14 participants were interviewed. At this point in the analysis, it was clear that mothers did not distinguish between the role of therapist and

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parent, but they experienced an evolution in their role in regards to their child's anxiety disorder. I sought more information about important events or milestones, as well as the surprises that parents encountered (e.g., "What surprises, if any, did you experience while implementing CBT with your child?"). In the first interviews, mothers were eager to discuss new situations in which their child experienced anxiety. Given the direction of the theory, I directly inquired about new, potentially anxiety provoking situation they encountered with their child and how they responded to these (e.g., "Were there any new situations that you faced, where your child might have been anxious. If so, how did you respond?"). The last change was in regards to children who also presented with suicidal ideation and/or self-harm behaviours. Given the seemingly distinct experience of these parents, I sought to understand their unique process and inquired about this occurrence directly. The following interview questions were therefore added: Before, during, or after the group, did you child every express having thoughts of suicide, or did she/he engage in self-harm behaviours? How did you handle that? How did that impact your implementation of CBT?"

Transcription

All the interviews were recorded and transcribed, by either the primary researcher or one of two research assistants. Audio recordings were transcribed using transcription guidelines from Bailey (2008) and Flick (2002, p.171) who quote Strauss (1987) "In more psychological or sociological research [...] it seems more reasonable to transcribe only as much and only as exactly as is required by the research question". To maintain semantic validity, interviewees' words and grammar were not be altered, even if there were structural and grammatical errors. To avoid cluttered transcripts, features of verbal communication such as repetitions, coughs, and word confusions were omitted (Tilley, 2003). Characteristics of speech, such as intonations, pauses, and pace were recorded in field notes, as they can be important for interpretation (see Bailey, 2008 for transcription conventions). In the grounded theory methodology, data collection and analysis are shaped by the components of the emerging theory. When a particular theme, idea, or process is deemed important - based on the frequency in which it occurs, the emotional response of participants, or the researcher's interpretation of theoretical pull – further

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information is sought to examine it. This can result in new lines of inquiry in subsequent interviews (Charmaz, 2014). The modifications to the original interview guide seek to add clarity to the categories and further explicate the process under study.

Data Analysis

The interview transcripts were coded manually using a word processing software and the codes were then transferred to a spreadsheet for easier examination. All sources of data were analyzed using the iterative and inductive process of constructivist grounded theory (Charmaz & Bryant, 2010; Charmaz, 2014), originally developed by Glaser and Strauss (1967). The iterative process of grounded theory implies that each step of the process (data collection, analysis, and interpretation) informs the other and observations made during an interview session are utilized to select future participants, develop new interview questions, and identify new codes. The theory formulation and level of abstraction develops through each phase of analysis. In other words, the iterative process of grounded theory includes a constant back and forth between data collection, analysis, and interpretation.

The analytical process in grounded theory consists of four phases: Initial, Focused, Axial, and Theoretical coding phases, which are described in detail below. Table 1 presents a summary of the data analysis and interpretation process. The emerging theory is further refined and modified throughout the stages of analysis. Although this chapter includes major milestones of theory development in an effort to explicate the analysis process, the significant iterations of the final theory are presented in Appendix E. I have included these depictions and description of the early stages of the theory to increase transparency of data analysis and illustrate process, rather than the results of the theory itself.

Table 1

Steps of Grounded Theory Analysis

Step	Definition	Description
Initial coding	Line-by-line analysis is used to identify data relevant to the research question.	<p>Quotes and field notes (i.e., data) relevant to the process of transition from caregiver to CBT therapist will be extracted.</p> <p>Relevant data refers to observations and quotes that are pertinent to the research question.</p> <p>Code labels describe the process encapsulate by the code.</p>
Focused Coding	Frequent, meaningful, and codes with “theoretical reach” are selected.	<p>Codes from the open coding phase are organized, amalgamated, and interpreted into focused codes.</p> <p>Preliminary relationships between codes, emerging categories, and subcategories are outlined.</p> <p>Subsequent data collection is guided by the focused coding findings.</p>

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Axial Coding	Data is brought back into context as the foundation of the theory is outlined.	Codes, important quotes, and observations are reassembled in new ways in order to construct a coherent explanation of the process under study.
Theoretical Coding	Identification and elaboration of the core variable. Final integration of theoretical codes with the existing literature into a singular substantive theory (i.e., proposition).	The primary “story” is developed in this step, and the theoretical proposition is made. The proposition is founded on the core variable, codes, categories, and the relationships amongst them. The theory will also integrate current literature on the research topic. Codes (quotes) will be used to support the proposed theory.

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Theoretical sensitivity is a multifaceted construct that includes the researcher's previous knowledge, emerging codes, pertinent categories or ideas, as well as various theoretical directions founded in the nuances of the data (Charmaz, 2014; Strauss & Corbin, 1990). In constructivist grounded theory, it develops throughout data collection, coding, analysis, and theory formulation. Theoretical sensitivity allows the researcher to distinguish relevant data and follow theoretical directions that emerge from the data. Throughout coding, theoretical sensitivity was used to extract data that are relevant to the research question. Theoretical sensitivity requires some knowledge of the literature and existing theories, without permitting it to limit emerging codes, themes, or relationships amongst elements of the theory. Consequently, not all of the information collected will be part of the emerging theory. Sensitizing concepts can provide starting points for analysis and interpretation, without limiting further data collection and analysis (Charmaz, 2014). As data analysis advances, the researcher seeks more precise information in order to further develop and deepen the emerging theory. Subsequent coding and analysis continues in tandem with additional data collection, until saturation is achieved. Saturation is achieved when new data (e.g., new interviews) no longer add depth to the theory and no more novel codes or categories is extracted from data.

Throughout data collection, detailed memos were kept regarding the methodological process, as well as steps in the analysis and interpretation. Charmaz (2014) suggests that memoing is an intermediate step between data collection and theory construction, as it highlights items of interest and potential theoretical directions. Two types of memos were written. First, information regarding coding, organization of data, sampling, modification to the interview, and steps in the analysis process were carefully documented in methodological memos. Second, analysis and interpretation memos documented summary notes after each interviews, insights on theory direction, and interpretational hunches. These memos were often cumulative, as their content would built on each other, increasing in detail and depth.

Constant comparison enables the researcher to identify codes that are qualitatively distinct from each other, and to nest smaller codes together to form larger categories. The process of "constant

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comparison” occurs simultaneously with initial coding. Every new piece of relevant information is systematically compared to existing codes, to determine if it fits into it, whether an existing code needs to be modified, or whether a new code is necessary. The comparison process is repeated until no new codes emerge, and the data set is said to be saturated. This rigorous comparative analysis of information serves to delineate codes and categories, to specify what data are included and what are excluded. Comparative analysis also ensures that codes and categories are homogeneous and can lead to the identification of new codes. To increase transparency, specific examples (e.g., anecdotes) can be used as “exemplars” or ideal illustrations of a particular code or category.

Initial Coding

Initial coding of interview transcripts consisted of labeling, categorizing, and sorting the interview transcripts line-by-line. In the initial coding phase, information is classified into “codes”, which are the building blocks of the emerging theory. They include any valuable or pertinent information that conveys meaning. In other words, codes attempt to name “what is happening”. For instance, I developed the code “scaffolding relaxation” if a mother described herself assisting her child in the implementation of relaxation techniques. At this stage, every instance or event was labeled in regards to the process that it represented. For every instance, the researcher uses a code that seeks to answer: “what is happening here? What processes are at issue here – how can I define it? How do participants act while involved in this process? What are the consequences of the process?” (Charmaz, 2014). The goal of this process was to breakdown the data into manageable segments and identify the relevant data, which are the quotes or observations directly related to the research questions and emerging theory. *Figure 1* shows an example of a line-by-line analysis.

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I	Um, it, you mentioned something interesting, you said “in other parts of parenting it wasn’t like that”, can you?	
P	Right. So in other ways that I would parent so you know the kid would say can I do this can I not do this and I would have my answer and my practical reasons for the answer and you know they might get upset about that and I had no problems saying no, cause I had my reasons why and I’m confident in my, ah, in parenting. Um, but I did have a problem saying no before that, because I could see the <i>distress</i> it caused her, like it’s different when you just see a child that’s unhappy with your answer or you see one that’s in distress right, in a way that it’s causing them anx- (to watch someone be anxious and be worried and feel sick about something and be upset about something you know, it’s a bigger issue if their just, you know, upset cause you said no and having a tantrum, right?)	<p>Comment [R1]: Child asks for permission</p> <p>Comment [R2]: Parent has no issue with saying no to the child</p> <p>Comment [R3]: Parent felt confident in parenting (when not anxiety situation)</p> <p>Comment [R4]: Parent has a hard time saying no</p> <p>Comment [R5]: Parent sees distress in child</p> <p>Comment [R6]: Parent responds to unhappiness vs. distress</p>
I	Yea y-yea-	
P	You know what I mean, it’s just different. It was different, so.	
I	Yea, ah are there other ways that it was different- so it’s really interesting having someone be- your child be distressed versus be unhappy – anything else that made it, that made sort of anxiety interactions different from other parenting interactions?	<p>Comment [R7]: Watching child be anxious</p> <p>Comment [R8]: Watching child be upset/tantrum</p> <p>Comment [R9]: “it’s just different”</p>
P	(Pause). I guess it worried me a bit. So it, c-caused a reaction in me that I’m like “what is going on, this is not, this is a bit worrisome that she’s struggling so much in this area of separation and so, I guess, that then maybe made me worry and maybe that sort of bounced back and forth a bit, you know-	<p>Comment [R10]: Parent is worried about child’s anxiety</p> <p>Comment [R11]: Parent hesitates</p> <p>Comment [R12]: Vacillating between possible approaches</p>

Figure 1. Example of Line-by-line coding in the initial coding phase.

This figure illustrates how relevant information is labeled by codes in the line-by-line phase. “I” represents the interviewer and “P” the parent.

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The initial coding process resulted in a high number of codes per interview: a 50-minute interview resulted in 119 initial codes. Over the first four interviews, 995 codes were identified through the line-by-line analysis. The initial codes from the first four interviews were then clustered by collapsing, eliminating, and detailing the existing codes. Codes were eliminated when they occurred on one occasion in a single interview or a single time across four interviews. Codes that were unrelated to the research question were also eliminated. A code may also have been better encapsulated by another, so the original code was eliminated. For instance, when describing a parent who explains her new approach to the child, the initial code “Parent expresses desire to the child” was collapsed with and replaced by “Parent justifies behaviour to the child”. This process ensures homogenous language throughout the coding process, which facilitates comparative analysis. Codes were also eliminated if they were too abstract for this level of analysis. For instance, the initial code “Issue at systemic level” was relevant, as it described an enmeshed parent-child relationship before treatment, but it was too abstract for this stage of analysis. Its position in the theory and the information it contained were not clear. Hence, the code was eliminated, and replaced by “Enmeshed parent-child relationship”. Initial codes were also merged when different labels described the same process or experience. For instance, the initial codes “Parent does it alone” and “Parent is the only one implementing CBT” were merged with “One parent takes the lead” and was eventually encapsulated in the category of “Mother is main Implementer”. Finally, new codes were also created to better explicate codes that would otherwise be merged or eliminated. For instance, “Forcing child” and “Reminding child of authority” were re-categorized under the new initial code of “Authoritarian parenting”. In order to review the codes, the interview transcripts were reviewed, to ensure that the labels continued to represent the participants’ experience. From the 995 codes, 178 remained after the initial coding phase. Four more interviews were coded using these 178 initial codes.

Focused Coding

Focused coding is the second coding phase of a constructivist grounded theory (Charmaz, 2014). In this stage, using constant comparison methods, the researcher selects codes that more frequent,

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meaningful, and that serve to further development the theory. The information is then organized, amalgamated, and interpreted into focused codes that become the nucleus of the developing theory. Preliminarily relationships between codes are also outlined. Finally, the focused coding phase involves coding interviews using the new categories and subcategories generated.

The first step of focused coding started by reviewing and studying the 178 initial codes, and returning to the original transcripts and memos to fully appreciate their context. The resulting codes from the first 8 interviews were examined closely, to identify similarities, differences, relationships, as well as examples (i.e., quotes) for each emerging focused code. Following this iterative analysis, 14 focused codes were identified. To illustrate this process, Table 2 outlines these tentative focused codes and their descriptions in effort to demonstrate the content of the focused coding process.

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Table 2

Example of Tentative Focused Codes

<u>Tentative Focused Code</u>	<u>Description</u>
<u>(TFC)</u>	
(1) Parent worries/concerns	Parent's anxiety about the child's anxiety. The nature of these anxiety changes over time. Examples: worry about the child's future, not knowing what to do, worries about relapse.
(2) Parent seeks to know and understand the child	Over time, parent has new understanding of the child's triggers, functions of the behaviours, and abilities. This understanding is dynamic. Parent also shows an understanding of anxiety theory (e.g., avoidance, reinforcement, exposure, threat perception).
(3) Internal to the parent	Elements internal to the parent (personality, approach, attitude, context) that encourage or hinder the implementation of CBT in the home and/or increase the effectiveness of the methods used. Examples: anxiety; confidence; frustration; pride

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(4) External to the parent	Day to day situations or people that pose a challenge or facilitate the implementation of CBT to the home. Examples: home, work, other children, spouse, anxious child's response.
(5) Dilemmas for the parent	Issues that parent struggles with while implementing CBT. Example: other children in the home, issues around safety
(6) Context/ Conditions	Description of the context and conditions under which mothers of the anxious child implement CBT. Examples: impact on other children, relationship with spouse, stress.
(7) Parenting Strategies	Explicit and implicit strategies used by the parent while implementing CBT or when responding to the child's anxiety. Examples: using self as example; scaffolding; cueing, deep breathing.
(8) Things that change: a) child; b) parent; c) home	Mainly descriptive code about the changes that occur in the child, parent, and home after implementing CBT in the home.
(9) Implementation Process	Steps or important events in the process of implementing CBT at home. These are moments/actions/steps that are deemed significant for the parent and child.

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(10) Control	Any reference to the notion of “control”. Given the preliminary nature of this code, the person attempting to exert control, the object of control, and consequence should be clearly included. Examples: Parent’s control of the child’s future: child given control over rewards/consequences (increases compliance)
(11) Parent emotional experience	All of the emotional experience the parent labels. Include the context and consequence of this emotional response.
(12) Dealing with new (potential) trigger	Parent and child face an event that could be anxiety provoking for the child (e.g., camp). This situation may occur after the group and/or may not “fit” the examples discussed in the group. The parent is left to decide how to proceed.
(13) Parent goes against instincts (unnatural)	Parent describes CBT implementation as unnatural, or going against maternal instincts. Instead of intervening or protecting, the parent must detach.
(14) Child with other mental health diagnoses	Challenges unique to situations where the child has made threats of suicide or self-harm.

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Next, data from the first eight interviews, in addition to two new interviews were re-coded with the 14 above-mentioned categories. That is, quotes from these 10 interviews were categorized into the 14 tentative focused codes. During this iterative process, the categorization of quotes allowed themes, categories, processes, and links to emerge further. In order to keep the information organized and obtain an objective perspective of the importance of each tentative code, the frequency with which each code occurred in interviews was recorded. Appendix E includes a table that summarizes the frequency with which a particular tentative focused code occurred across 10 interviews. Examining frequencies as well as the content of each categories led to further modifications to this initial coding scheme. It also initiated theoretical sampling of mothers whose children have similar symptoms. This quantitative information also suggested that further examination of the codes was necessary. Specifically, although certain codes occurred frequently across the interviews, they included diverse information and required further tailoring and perhaps subcategories needed to be identified. Furthermore, the nature of the tentative focused codes were inherently descriptive, and did not reflect the dynamic and multifactorial process that mothers of anxious children underwent.

Through examination of the codes and supervision, it was determined that although these tentative codes reflect core components of the emerging theory, they did not represent a process. In the next step of the analysis, the goal was to bring these categories back into context, provide detail in regards to their content, emphasize the links amongst them, and focus on the process under study, as opposed to components of it.

Axial Coding

The aim of axial coding is to bring the data back into context and begin identifying links between different components of the theory (Strauss & Corbin, 1990). The tentative codes, important quotes, and observations are reassembled in new ways in order to construct a coherent explanation of the process under study (Charmaz, 2014; Creswell, 2013). Strauss and Corbin (1990) suggest that components of the

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theory can be organized as conditions, actions/interactions, and consequences, providing a framework for the researcher.

Charmaz (2010) describes this process as consisting “of unfolding temporal sequences that may have identifiable markers with clear beginnings and endings and benchmarks in between” (p. 10). Given this definition, the categories identified in the focused coding stage were re-examined with a temporal and interactive perspective. This approach allowed the organization of conditions, action/interactions, and consequences in way that highlighted the dynamic nature of the process, while maintaining a linear perspective. The focused codes were first re-organized into five procedural phases (included Appendix E) with an additional parallel category; specific to mothers of anxious children who also presented with suicidal ideation and/or self-harm behaviours was kept in parallel to these five phases, in order to account for the distinct variations of this group. Subsequent data from the remaining 9 interviews were coded with the coding scheme of the five procedural phases. At this phase, it was also determined that the categories were likely saturated and data collection was stopped, until the next phase of analysis.

At this stage, supervision with thesis supervisors and members of the research steering committee (further described below) facilitated further analysis. Although the content of the emerging theory resonated with supervisors, the primary concern was the linear presentation of data. The next phase of data analysis took the interactive approach into consideration to explicate the dynamic nature of the process of implementing CBT in the home. The final stage of analysis aimed to move away from description to explanation.

Theoretical Coding

In the theoretical coding phase, codes and the relationships amongst them were incorporated with existing knowledge (i.e., the literature). Theoretical codes are those drawn from prior theories or analytic schemes (Charmaz, 2014). Theoretical coding is not a distinct phase that occurs following focused and axial coding. Information from the relevant scientific literature can inform focused coding as well, but it

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should not be the *only* framework. In other words, previous theories should not be imposed onto the data (Glaser & Strauss, 1967; Glaser, 1992). Ultimately, theoretical coding, which includes methods such as constant comparison and theoretical sensitivity, facilitate the identification of a core category that explains the majority of variations within the data set. The core category consists of a process, continuum, range, theme, condition, or event that represents a stable pattern in the data. Strauss and Corbin (1990) identified three subcategories that can then be identified around the core category: causal, strategic, and contextual. These categories serve to respectively identify factors that are a cause of the core category, a response to the core category, or a situational characteristic of the core category.

Given the scarce literature on the implementation of CBT in the home, relevant literature in fields associated with the research questions were sought. Specifically, studies examining the implementation of other parenting interventions (e.g., Foley et al., 2006; Mah & Johnston, 2008; Spitzer et al., 1991), practical wisdom (Schwartz & Sharpe, 2006), stages of change and engagement (Eiser & Meidert, 2011; Norcross, Krebs, & Prochaska, 2011; Prochaska & Norcross, 2001) were sought to comprehend the data at hand and further develop the theory. Literature specific to suicidality in anxious children and youth, as well as parental involvement in prevention programs for suicidal youth were also consulted (e.g., Nelson et al., 2000; Toumbourou & Gregg, 2001). This literature review provided further depth and dimensions to the procedural phases identified in the focused coding phase.

Theory Formulation

At the integration phase, theoretical codes and themes, as well as memos, were conceptualized into a singular substantive theory. A number of analysis tools, including theoretical sorting of the data, diagramming and integrating were used to construct a cohesive explanation of the implementation of CBT in the home with anxious children. Re-engagement with the raw data, through audio recording or transcripts also occurred to ensure adequate integration of meaning and identification of salient and representative quotes. Tables and figures presented in this chapter reflect steps of the analysis process,

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and significant iterations of the theory are presented in Appendix E. The final proposition of the theory incorporates the core categories, subcategories, the relationships amongst them, as well as pertinent aspects of the existing literature. The final grounded theory is presented as narrative in the Synopsis Chapter, where the components of the theory, their interactions, and associations are depicted in relation to the research questions.

Rigor and Trustworthiness Procedures

Rigor and trustworthiness procedures in qualitative research refer to methods undertaken to ensure the quality, strength, and integrity of the findings (Lincoln & Guba, 1985). There are also specific methods specified for grounded theory proposed by Charmaz (2014). Details on the specific methods undertaken to ensure trustworthiness and rigor of the present findings are provided in this section.

Trustworthiness

Lincoln & Guba (1985) proposed four components of trustworthiness – credibility, transferability, dependability and confirmability –, which are parallel to characteristics of quantitative data: internal validity, external validity, reliability, and objectivity. Credibility, which is parallel to the concept of internal validity in quantitative research, seeks to ensure that the study assesses the intended phenomenon. Transferability refers to the applicability of the findings to other similar contexts. By providing detail regarding data collection, analysis, and formulation, the authors ensure generalizability of the findings. Finally, confirmability refers to the attempts made by the researchers to remain true to the data and that the final result is a representation of the experiences and ideas of the participants and phenomenon under study.

To ensure that the findings assess the intended phenomena (i.e., credibility), only mothers who had undergone the process of interest – participation in a CBT group for parents of anxious children and youth - were selected. As such, the mothers were considered reliable informants for describing the process of implementing CBT with an anxiety child in the home. Steps to ensure credibility were also undertaken

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throughout the data collection. The interview questions were also developed to elicit relevant information from the participants (e.g., How do you go about implementing CBT at home with your child? How did the home environment impact this implementation?). The interview questions were altered to address the emerging directions of the theory and to gain more information about parents' changing role as opposed to descriptions of CBT implementation. Information was also sought about parents' concerns or apprehensions in regards to implementing CBT, as well as changes in their self-perception and perception of their child. These changes to the interview guide ensured credibility because by maintaining the focus on the emerging theory and research question.

Finally, during the interviews, reflective interviewing methods were used to ensure that the researcher's understanding of parents' experience was accurate. The method of interviewing consists of reiterating the interviewee's statements, and confirming whether the interviewers' understanding represents the original intent. For instance, I paraphrased mothers' responses or asked them whether my understanding of their experience was accurate.

- [Interviewer] "How do you find that your role as a parent is different when you practice CBT at home with [child's name]?"

- [Mother] "Ugh ok, my role as a parent – hmmm, (pauses) well, I don't know I guess I kind of feel more like a parent because I'm putting those restrictions on things. (...) So I think it, it kind of just rounded us in again and went ok so, yeah we're tired, yeah but we can't let up kind of thing. And maybe that just made us cognisant of that, do you know what I mean?"

- [Interviewer] "Different level of awareness maybe?"

- [Mother] "Yeah definitely a new level of awareness for sure"

In regards to transferability, efforts were made to ensure that the sample was varied in regards to diagnosis, age, and gender of the children. Parents were also from different socioeconomic groups, in different home environments (single parent, married, blended families, presence of extended family members). Therefore, the subjects, content, and range of data available were considered appropriate given

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the research question. This allows transferability because the findings could potentially be applied to similar settings with other mothers of anxious children who took part in a parent CBT group.

Audit trail. An audit trail consists of organizing and documenting every step of data collection and analysis so that a third party could follow the steps that led the researcher to a given interpretation or conclusion (Hoepfl, 1997; Koch, 2006). The evolution of the codes, categories, and theory were rigorously documented. The content of the audit trail is meant to spell out how the researcher developed the theory from the concrete data. It is therefore a summary of the process and product of the grounded theory (Bowen, 2009). The audit trail serves to support dependability and confirmability by providing transparency to the researcher's analysis and findings (Lincoln & Guba, 1985).

A complete audit trail should include the following information: raw data, data reduction and analysis notes, data reconstruction and synthesis products, process notes, materials related to intentions and dispositions, drafts of interpretations, and preliminary development information (Bowen, 2009 for a review; Lincoln & Guba, 1985). This information can be incorporated in the final grounded theory with an integrative diagram that includes all the codes as well as data (i.e., quotes) to illustrate each code (O'Connell & Irurita, 2000).

In the present study, detailed methodological memos were kept, where any information regarding coding, organization of data, sampling, modification to the interview, and steps in the analysis process were carefully documented. A qualitative research supervisor reviewed the process and product of the study. She reviewed a trail of documentation assembled by the primary researcher that outlines the qualitative methodology and emergent theory development. She was provided with the raw data, coded data, steps of analysis, emerging versions of the theory, and drafts of the theory formulation. I met with the qualitative research supervisor frequently throughout the data analysis and interpretation process to discuss concerns and insight into the developing process.

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Literature review. The impact of an in-depth literature review prior to data collection and analysis is at the core of the divergence between Glaser and Strauss' approaches to grounded theory (Heath & Cowley, 2004). They originally agreed that a framework of concepts and general understanding of the phenomenon under study is beneficial (Cutcliffe, 2000). To minimize the likelihood that preconceived ideas and hypotheses alter the data analysis process, qualitative researchers – particularly Glaser (1992) - recommend that in-depth literature reviews should only occur during the final stage of data analysis and theory formulation. Strauss and Corbin (1990; 1998) recommend that a review of the relevant scientific research is necessary for the researcher to identify relevant information and guide theoretical sensitivity. Charmaz (2014) also rejects the notion of delving into the research process without any knowledge of the phenomenon under study when conducting a constructivist grounded theory.

According to Cutcliffe (2000), two factors determine the decision to review literature research pertaining to the area of study: whether the researcher has decided which qualitative research methodology will be used and the researcher's familiarity with the research topic. In the present study, a succinct literature review prior to data collection and analysis provided information regarding the terminology, procedures, existing theories, gaps in the literature, and ethics of a given topic. This information guided the choice in regards to methodology. Additionally, it is inconceivable – and perhaps unethical – to conduct research completely blind to the research topic. It is important for the researcher to be informed about the possible ethical dilemmas and considerations in order to prevent adverse events in research. Information regarding the existing dilemmas in the areas, leading theories, and ethics allow the researcher to develop meaningful research questions and identify information that is relevant to the topic. However, it is important to remain open and attuned to the data – as opposed to preconceived ideas and hypotheses – during the collection, analysis, and formulation phase. Ideas and hypotheses that are not supported through the analytic process should be dismissed in order to maintain credibility (Strauss & Corbin, 1990).

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Before conducting the present study, I had already been immersed in the relevant literature for nearly four years, thus a completely naive approach as recommended by Glaser (1992) was impossible. It is important to note however that the purpose of this literature review was to develop a research question and instill a theoretical framework to work from, not to develop theory or hypotheses (Charmaz, 2010). Additionally, given that this research was my first qualitative project, it was important to determine whether the research question fit the grounded theory method. This process entailed a review of the literature on the role of parents in the development, maintenance, and treatment of childhood anxiety disorders in order to refine the research questions and determine how a qualitative methodology could be used to mend this gap.

Throughout data collection and analysis, I continuously wrote memos about insights, ideas, and possible directions for the theory. Occasionally, I reached to the literature to scaffold these hunches. It was important to ensure that the information I gained, as well as my previous experience and knowledge of the topic, were kept “in-check” while I collected and analyzed data. To remain informed yet open-minded, I accumulated but did not read new research on the topic in detail. Articles of interest were flagged and only reviewed in detail once data analysis was underway. As such, I developed an annotated bibliography of pertinent studies that were used in the later stages of theory construction.

Triangulation. Dependability refers to the reliability of the conclusions reached by the investigator (Lincoln & Guba, 1985) and it is primarily achieved through triangulation. Triangulation promotes credibility, dependability, and conformability (Lincoln & Guba, 1985; Charmaz, 2014). It is a process whereby the primary researcher collaborates with other researchers to compare and contrast transcripts in relation to the research question (Curtin & Fossey, 2007). It can also consist of gathering diverse data such as interviews, document reviews, and observations. Although comparable findings from different sources of data increases confidence in the findings, differences do not necessarily provide grounds for rejection. Divergent findings from triangulation can be a result of different data collection methods,

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perspectives, and interpretation. Each source of data is seen as providing a partial picture of the entire phenomenon under study, and should be considered as complementary rather than competitive (Richardson, 1991).

Early in the research process, a portion of the transcripts was cross-coded by two experts in qualitative research, one of whom was a dissertation supervisor. Reliability was established through discussion and revision of the codes that emerge from the transcripts with supervisors. Additionally, at every step of data analysis I consulted with an expert in constructive grounded theory, to ensure that the method used and interpretations made were consistent with the approach. The research steering committee meetings acted as another source of triangulation, where stakeholders in the process under study discussed the findings, and expressed their agreements and disagreements with the emerging theory.

Memos. In contrast to the impartial role of the researcher in quantitative studies, the role of the researcher in qualitative research is far more involved, as he or she is the primary research instrument (Charmaz, 2014; Creswell, 2013). Given the researcher's central role in the data collection, analysis, and interpretation, his or her observations and reflections are discussed and examined (Marshall & Rossman, 1995). Thoughts, tentative interpretations, and hunches regarding the data were carefully recorded. The purpose of these memos is to record important insights that may contribute to the final theory. They also provide a detailed tracking of the study to enable replicability and transparency. Field notes, which were observations made during the interview were recorded, as they sometimes included insights regarding the theory. These reflections and field notes were documented as memos and included observations on parents' responses, reflections on their answers, and potential concepts, categories and/or propositions. These Analysis and Interpretation Memos were detailed and dated to facilitate their incorporation into the final theory.

Research-steering committee group (i.e., member-checking process). A research group, also referred to as a steering committee (RSC), is a method utilized to reduce the impact of personal biases and

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to ensure that the emerging theory is truly representative of the social phenomenon under study (Carlson, 2010; Chiovitti & Piran, 2003; Morse et al., 2002). Research groups consist of participants and fellow researchers who review results as the theory is being developed, in the view of increasing transferability and credibility (Lincoln & Guba, 1985). The purpose of the RSC is to create a forum in which members have the opportunity to reflect on the findings. This process is important in ensuring that the findings are relevant and reflective of the participants' process when they undergo the phenomenon under study. The question at the center of a steering-committee meeting is "According to those who have undergone the process and/or play an important role in it, to what extent are the researcher's findings representative of the process under study?" As such, the research group reviewed and discussed the data, preliminary findings, as well the contents of the researcher's field notes and reflexivity notes. The overall process is meant to reduce researcher bias and increase the credibility of findings through collaborative interaction (e.g., Cho & Trent, 2006; Creswell & Miller, 2000). Furthermore, the RSC commented and advised on the implication of the findings and effective transmission of knowledge.

The timing and correct approach to RSC meetings is loosely addressed in the literature (e.g., Carlson, 2010; Morse, Barrett, Mayan, Olson, & Spiers, 2002; Midgley, Danaher, & Baguley, 2013). This gap in the literature is surprising given the importance attributed to the process in establishing credibility (Creswell & Miller, 2000; Guba, 1981). While some researchers suggest that participants be involved at every level of data collection and analysis - even reviewing interview transcripts for accuracy (Carlson, 2010) - others suggest that only polished data be presented to primary stakeholders (Creswell, 2009). Lincoln and Guba (1981; 1985) cite member-checking while coding and categorizing as well as confirming results with participants as important steps in ensuring credibility of the findings. Others follow this approach, and share interpretations of data with participants to verify plausibility (Curtin & Fossey, 2007; Merriam, 1998). By engaging in conversation with participants after the initial interview and presenting the evolving analysis, findings are continuously reviewed, evaluated, and modified. Most

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importantly, ongoing engagement with methods that establish trustworthiness ensure that the researcher does not miss threats to reliability and validity of study and can respond to any issues as they arise. Continuous engagement with the participants can therefore be conceptualized as part of the iterative data analysis process, where the researcher vacillates between data collection, analysis, and interpretation.

The RSC for the present study consisted of two participants (i.e., parents who took part in the parenting group), a registered clinical psychologist who facilitated the parenting groups, and an expert researcher in qualitative research. Participants were invited to take part in the RSC meetings at the beginning of data collection (June 2014), when saturation was reached (October 2014), and when the final theory was formulated (January 2014). In the first steering committee meeting, information was provided regarding research question, methodology, and role of the committee. Discussion revolved around the codes that occurred frequently in the first six interviews. In the second meeting, the five procedural phases were presented. The focus of the discussion was the need for a dynamic formulation (as opposed to linear), that is representative of the interactional nature of the process under study. In the third RSC meeting, the final theory was presented, and the focus of discussion was on the implications and applications of the findings.

Reflexivity analysis. To maintain the integrity of the study and its findings, qualitative researchers must continuously monitor biases that could influence data analysis. Reflexivity (or self-reflection) is the researcher's self-monitoring through journaling of thoughts and responses to data (Charmaz, 2014), active attempts to avoid emotional involvement (Arber, 2006), as well as peer supervision (Rager, 2005). Reflexivity notes may include emotional responses to interviews, personal biases in regards to findings, or pre-conceived expectations that influenced decision-making and interpretation. The notes may include deliberate expressions of the researcher's preconceived ideas, which can then be contrasted or related the data and assist in the modification or rejection of themes and hypotheses that are not supported by the data. In other words, reflexivity includes self-examination of the assumptions that may have influenced

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data collection, analysis, interpretation, and theory construction. The researcher is meant to remain mindful of these biases and incorporate this information into the final formulation.

Failure to reflect on one's ideas and "hunches" can result in a theory that imitates the researcher's ideologies and knowledge of the research question, as opposed to the examination and explanation of the phenomenon under study. Reflexivity, in combination with iterative data analysis can serve to validate or discard ideas (Cutcliffe, 2000). By incorporating the idea in question into the participant interview, the researcher can determine if an interpretation or hypothesis is truly representative of the process under study or as belonging solely to the researcher. Ideas, hypotheses, and interpretations that are not supported by participants should be discarded (Strauss & Corbin, 1998). As such, the reflexivity analysis can serve to increase the credibility of findings and is typically incorporated into the grounded theory in the data analysis section.

In the present study, reflexivity notes were recoded as analysis and interpretation memos. When conducting analysis or interpretation, the content of these notes were available and incorporated when necessary or deemed appropriate. Early reflexivity notes refer to anxieties about engaging in a qualitative research project, the outcome of the study, and the pressure to produce new knowledge. As the data collection and analysis advanced, the reflexivity notes included reflections on interview style, pertinent questions, and responses from participants. Later reflexivity notes refer to organization of the theory, implications, and practicality of findings. Throughout data analysis, the reflexivity notes also include concerns about adherence to methodology, which were later addressed through supervision with research supervisors and mentors. The Reflexivity Chapter explicates this process in detail.

Rigor Criteria Specific to Grounded Theory

Charmaz (2005; 2014) identified credibility, originality, resonance, and usefulness as rigor criteria for the constructivist grounded theory, which are closely aligned to those proposed by Lincoln & Guba (1985) for trustworthiness of qualitative research.

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Credibility. Credibility is achieved when informants and important stakeholders recognize the process as it is presented by the researcher (Beck, 1993; Chiovitti & Piran, 2003). Chiovitti & Piran (2003) propose four methods to increase credibility in GT: 1) let participants guide the inquiry process; 2) check the theoretical construction generated against participants' meanings of the phenomenon; 3) use participants' actual words in the theory; 4) articulate the researcher's personal views and insights about the phenomenon through memoing and monitoring of the literature that was sought and used throughout data collection and analysis. To ensure the grounded theory's credibility I maintained a flexible interview guide, where semi-structured questions allowed participants to tell their story, without being restrained by the limits of my research question. The interview guide was also modified over time to fit the changing direction of the theory. A number of *in vivo* codes, or verbatim labels provided by participants were utilized. For instance, "floating", "unnatural", and "against my instincts", are all *in vivo* codes. Finally, after each interview, summary notes of the information provided by the participants, as well as my own reflections about the interview were documented in analysis and interpretation memos. These memos therefore document the data analysis and interpretation process of the emerging theory from its initial to final draft.

Originality. Originality refers to the contribution of the study to the existing literature. The research must clearly describe the novelty and significance of the findings within the existing research. The implication of the study are unique in that they provide a procedural description of the phases parents undergo when implementing CBT in the home with their anxious child. These implications are further described in the Discussion Chapter.

Resonance. Resonance refers to the scope of the study and whether the researcher sought variations in the codes, processes, and actions. This criterion can be met by utilizing comparative comparison methods, ensuring that categories are fully saturated and clearly defined, all the while representing the meaning of participants' experience. As described previously, iterative comparison

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methods were utilized from the initial coding stage to the theoretical coding and theory formulation stages. Second interviews and theoretical sampling methods were utilized to ensure that variations within the sample were well understood and accounted for.

Usefulness. Charmaz (2014) defines usefulness as the practicality and relevance of the final theory. A grounded theory is meant to contribute to the literature and be used by the stakeholders to improve service delivery or initiate future research. The usefulness criterion is met by ensuring the originality and credibility of the study. As will be further described in the Discussion Chapter, the present study contributes to the literature by delineating phases that mothers of anxious children undergo when implementing CBT at home. This information raises information regarding the challenges parents face. It allows clinicians to improve service delivery by putting in place steps that would prevent these challenges, or providing tools to circumvent them.

Chapter 4

Reflexivity

In qualitative research, it is recognised that all research carries bias, and that intentions and expectations can influence the results. The reflexivity analysis informs the audience of the researcher's process when conducting research, including examinations of the researcher's identity, background, and expectations (Charmaz, 2014; Robson, 2002). Through reflection, the researcher becomes self-aware of potential biases and can identify assumptions that may have influenced data collection, analysis, interpretation, and theory construction. The analysis synthesizes the qualitative researcher's theoretical, methodological, and interpretational notes made throughout data collection and analysis and serves to delineate the different ways in which the researcher may have influenced the research process.

Gentles, Jack, Nicholas, and McKibbin (2014) propose that the reflexivity analysis be presented as the reciprocal relationship between the research and participants, procedure, analysis, and findings. The aim is to expose bias to oneself and to the audience, in order to reduce its impact on the final theory. It ensures transparency in the research process and credibility of the results (Cohen & Crabtree, 2008; Lincoln & Guba, 1985; Tong, Sainsbury, & Craig, 2007). The present reflexivity analysis principally follows the critical approach of Gentles et al. (2014), explicating the choice of research topic, the interaction between researcher and participant, as well as the researcher's influence on data analysis and writing.

Choice of Research Topic

The present study grew out of a previous program evaluation for a cognitive behavioural therapy (CBT) group for parents of anxious children and youth. The recruitment for the initial study was low and attrition was high. The remaining participants however often chose to share their experience of the parenting group and implementation of CBT at home spontaneously with me during the appointments. Discussions with mothers about experiences initiated questions regarding their challenges and process,

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which became the foundation of the current study. In sum, my prior experience with the population of interest initiated the research question.

Researcher-Participant Interactional Influence during Data Collection

Constructive grounded theory posits that the process of theory formulation includes a back and forth between data collection and analysis, as well as between the researcher and research subject. Every interaction between the participants and myself played a role in mothers' perception of the research as well as the information they provided. For instance, the way the research was presented or that my questions were formulated could have influenced the way participants responded and ultimately the final theory. It was therefore important that I remain candid about the goals of my research, use reflective interview methods to ensure that I understood their intentions, and that I maintain the interview focused on the topic at hand.

Focus of the research and interview. A recurrent challenge during data collection was to maintain the focus of the interview on *mothers'* process, when mothers commonly focused and framed their answers from the perspective of their child. For instance, when asking about the overall impact of CBT, mothers discussed changes in their child's symptoms as opposed to changes in their own parenting approaches. In these instances, I redirected the mothers to their own experience and encouraged them to discuss events from their perspective. I occasionally reminded participants of my research questions. I made use of follow-up questions to encourage participants to discuss the event from their own perspective and express their meaning of the event in question.

Expectations. Given my knowledge of the literature, I was well informed about the parenting strategies that have been associated with the development and maintenance of anxiety disorders in children and youth (McLeod et al., 2007). This knowledge contributed to preconceived notions of how mothers initially interacted or engaged with their anxious child and how the CBT program may have influenced their parenting. I therefore had expectations of how mothers would answer my interview

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questions. While conducting the first few interviews, I attempted to extract these expected experiences from mothers, but I quickly found that their experiences and processes were more complex than I originally anticipated. This experience was frustrating and confusing, because I initially perceived it as a barrier to my analysis, rather than an avenue for further investigation. Early in the data collection process, I therefore became aware of my expectation that mothers' experiences and how their process "should" map onto the literature on pediatric anxiety disorders. The line-by-line analysis and coding allowed me to notice how my original codes did not correspond to my preconceived expectations, which forced me to cast them aside and focus on the information that participants actually provided. I therefore attempted to overcome this bias by allowing the codes that emerged from the line-by-line analysis to direct future interviews and modifying the interview questions to seek a wider range of experiences.

Finally, I had to be mindful of my personal judgement regarding mothers' strategies and choices. My interviews were not attempts to evaluate mothers' performance and determine how "successful" they were in implementing CBT; rather, my goal was to understand their process. I made this clear to participants at the beginning of the interviews and had to remind myself of this goal when mothers expressed negative experiences about the parenting group or appeared not to have integrated the group material. For instance, one mother revealed that her experience in the group was negative and she claimed that the material presented did not apply to her child. My initial reaction to her statements was to reiterate the content of the group, hoping that she would engage. Her response to my attempt was negative, as she told me that she could not take this approach with her child. I realized that I attempted to impose meaning onto her experience, took a step back, and instead attempted to understand why and how she felt that way. This changed the direction of the interview, bringing to the surface her thoughts and emotions regarding the process of CBT implementation (or lack thereof). Hence, withholding judgment and focusing on the purpose of my study was occasionally a challenge that I addressed by redirecting my attention to my research questions and seeking understanding. Nevertheless, this interaction gave me an insight into the

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process and experience of mothers who do not make links between CBT tenets and their parenting or who do not integrate the group material.

Being an outsider. When inviting mothers to take part in the study and while conducting the interviews, I was inherently an outsider to every facet of the phenomenon under study. I am not a parent, I did not take part or facilitate the treatment group in question, and I have not met their child. These contextual differences between researcher and participant were a barrier to fully understanding the situations of mothers throughout the research. However, being an observer of the process provided me with a better vantage point to examine multiple experiences and identify nuances, common themes, and patterns.

I addressed this challenge by taking an open-minded and curious approach to data collection and analysis. I began the interviews by explaining my role and interests as the researcher, and asked the mothers to focus on experiences that they deemed important. Being candid about my stance as the researcher and outsider allowed mothers to “let me in” and truly describe their process. My hope was that mothers provided more detail knowing that I was not familiar with their particular experience. Additionally, if an answer was unclear or I was unsure of the intent, I asked for clarification or reformulated the answer. Overall, mothers were forthcoming and cooperative and seemed engaged with the interview process despite my stance as the researcher.

As data collection progressed, I became more comfortable with the interview process and gained a better understanding of mothers’ expectations of the interview. With this increased confidence and understanding, I felt more comfortable asking targeted questions and probing deeper into mothers’ experiences. Chesney (2001) refers to this as the evolution of the “researcher persona”, which can influence data collection. I drew upon data from previous interviews and the evolving theory to relate to mothers’ experiences. This allowed me to test the direction of the theory and to connect with mothers by

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showing understanding and compassion. One example of my increased understanding and the benefits of iterative data analysis and collection was my use of the term “unnatural” to describe the challenge of withholding attention or comfort from a child in distress. When asked if they “felt unnatural” at any point, mothers were responsive and related to the experience. This served to strengthen the rapport between the researcher and the participant, and ultimately resulted in better data collection.

Researcher Influence on the Analysis

The method of grounded theory acknowledges that the researcher is a research tool, and that his or her background can influence the theory (Charmaz, 2014; Hall & Callery, 2001). As suggested by Corbin and Strauss (2008) I drew on my personal experiences and knowledge to identify the nuances of the process under study as well as the ways in which these perceptions could be influenced by my background.

Engaging with the data. I initially approached coding and analysis analytically, attempting to maintain an objective stance in the process. Although it allowed me to generate a large number of codes and categories from the data, it resulted in preliminary theory iterations that were linear, flat, and ultimately unrepresentative of the multifaceted nature of the process under study. During research steering committee meetings and supervision, it was clear that my attempts to present a clear and concise theory compromised the complexity of participants’ process. I had to allow myself to engage with the data in a meaningful manner to notice what mothers were actually expressing. To do this, I returned to the original codes and listened to the audiotapes of the interviews, asking myself “what is the problem here?” “What is she doing about it?” “What does this mean?” I obliged myself to examine the data from new angles to ensure that all variations and nuances were taken into consideration. This method resulted in modifications to the coding scheme and further iterations of the theory. I was able to capture participants’ entire experience by taking a step back in the analysis, halting data collection for a period time, seeking supervision, and returning to the original data.

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Theoretical sensitivity. My previous knowledge of the literature was one component of theoretical sensitivity, where the researcher's previous knowledge and background can be used as one (of many) analysis frameworks (Charmaz, 2014; Hall & Callery, 2001). In an attempt to overcome this challenge, I recorded instances where the data supported or contradicted preconceptions or expectations in the analysis and interpretation memos. On occasion, these records led to important developments in the analysis, and served to guide further analysis or data collection. For instance, I initially expected that mothers' choice to comfort their anxious child to appease their own anxiety, however the data did not fully support this, and suggested multiple motivations for their strategy. After this discovery, I shifted the interview questions to focus on mothers' perception of their role, as opposed to their actions.

Another example of the role of theoretical sensitivity is the use of the literature to scaffold coding and theory formulation. During the focused coding stage, I read the article by Spitzer et al. (1991) who developed a grounded theory of parents' process when implementing a behavioural program for children with conduct disorders. This article provided me with one approach to interpretation. I was initially worried about trying to impose Spitzer et al.'s model onto my findings and had to step away from data analysis for some time. Taking time away from the data, and revisiting the coding scheme with a fresh perspective allowed me to remain grounded in the transcripts as opposed to the findings of another study. However, I continued to struggle with *how* to use the information I learned by reading Spitzer's study. After seeking supervision, I determined that Spitzer et al.'s study should be a reminder to examine *process* in the data and subsequently shifted my analysis from a descriptive and linear format to an explanatory and dynamic model. I also utilized the article in the Discussion Chapter to situate my finding in the existing literature.

Research steering committee. Decisions regarding the role and level of involvement of the RSC were challenging because the literature does not provide clear guidelines on the correct use of RSC meetings in grounded theory (Carlson, 2010; Doyle, 2007; Midgley, Danaher, & Baguley, 2013; Morse et al., 2002). I sought supervision through various sources in regards to the inclusion of a research steering

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committee, and I found a balance between Carlson's (2010) suggestion to involve participants at every level of the research process (even transcription) and Creswell's (2009) proposition that only polished should be data be presented to primary stakeholders.

My original intention was to make use of the RSC as part of the rigor process; to reduce the impact of personal bias and ensure resonance of the theory with primary stakeholders (Carlson, 2010; Chiovitti & Piran, 2003; Morse et al., 2002). The contributions made by members of the RSC however often exceeded my expectations, as they willingly and spontaneously contributed avenues for further investigation or made interesting suggestions regarding analysis. As described in detail later in this chapter, suggestions made by members of the RSC also became the foundation of an abduction analysis. Given the ethics clearance obtained and consent provided by the members of the RSC, it was important that I remain loyal to my original intention for the research group, and that I do not utilize their contributions as data per say (i.e., by labeling them and using them as codes). Rather, their contribution were conceptualized as memos and avenues for explorations. Overall, my continuous engagement with the participants became part of the rigor process and helped shape data analysis, ongoing collection, interpretation, and theory formulation.

Abduction analysis. The model of mothers' decision-making process when faced with a novel anxiety-provoking situation is an example of abduction, which is an inferential leap made by the researcher to account for an unexpected or perplexing finding (Charmaz, 2014). After proposing an initial model of mothers' decision-making, a member of the RSC suggested that I should not overlook mothers' decision to take their child to anxiety-provoking events that are "non-negotiable", such as medical appointments. These discussions initiated a deeper examination of the transcripts, novel interview questions, as well as a modification of the model to represent the nuances in mothers' experiences.

Supervision. Supervision was sought regarding every stage of data collection, analysis, and formulation. The most significant impact of supervision took place in the initial coding phase of analysis, after I shared the line-by-line analysis with another grounded theory researcher. He recommended that my

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initial codes be concise descriptions of the data, and that I avoid abstract codes. For instance, the initial code “issue at systemic level” was relevant, as it described an enmeshed parent-child relationship before treatment, but it was too abstract for this stage of analysis. I therefore restarted the line-by-line analysis of the first four transcripts. Seeking supervision regularly ensured that I followed the fundamental tenants of grounded theory methodology.

Supervision regarding theory formulation and writing of qualitative research was a valuable part of the process. This process helped me shape my ideas, solidify the theory, and take into considerations nuances in the data. In regards to writing, a back and forth between writing and supervision facilitated the development of my writing style. It was challenging to maintain a writing style typical of qualitative findings and to adopt a conservative stance regarding the implications of my findings. Supervision helped me keep my analysis founded on the data and make realistic recommendations for practice based on these findings.

Researcher Influence on the Writing Process

Charmaz (2014) describes the writing phase of a grounded theory as a stage of the analytic process. Ideas are detailed, linked, and summarized, and gaps in the theory can be identified. It follows that the reflexivity analysis should include an examination of the writing process, because personal qualms about the value of the analysis (Charmaz, 2014) and concerns for one’s audience (Mruck & Mey, 2007) could lead to self-censorship or distortion of the findings. Reflections on the influence of researcher on the writing process may bring to light concerns such as catering to supervisors, meeting publication requirements or apprehensions for participants’ responses to findings (Gentles et al., 2014). These concerns can distort the final product and should be addressed in the reflexivity analysis (Mruck & Mey, 2007).

Understanding qualitative inquiry. It is my impression that my difficulty engaging with the data meaningfully was rooted in my lack of understanding of the methodology and significance of qualitative inquiry. My research training prior to this project had been quantitative; hence, it was difficult for me to

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frame my findings in a qualitative manner. This prejudice slowed down the theory formulation and writing process, because I attempted to theorize and write based on quantitative concepts (e.g., prediction, mediation), rather than from a qualitative perspective of complex lived experience. This method resulted in several iterations of the results and constant reappraisal of the stance from which I was writing. I initially wrote from a therapist's perspective, describing mothers' experiences, and actions; I struggled to frame my findings from the *mothers'* stance. I addressed this issue through supervision and by reading qualitative research studies, immersing myself in the writing style and theoretical stance of constructivist grounded theory. This process allowed me to understand how and why qualitative research is presented. With practice and revisions, I was able to adopt a qualitative voice, writing from the mothers' perspective.

Contribution of the findings. My most salient apprehension in the writing process was in regards to the contribution of the findings to the literature and practice of psychology. My training in quantitative research initially prevented me from appreciating the value of qualitative research and the difference in the type of information that each research modality provides. At first, my apprehensions led me to make inferences and links that were beyond the data, as I attempted to justify and prove the importance of the results. I found myself making conclusions and recommendations that were beyond my data. This problem was significant and required reflection, study of the qualitative method, and supervision. I also conducted a thorough literature review, which served to highlight the gaps in the literature that my study could address. Additionally, I drew on the contributions of RSC members, whose valuable input reminded me of the importance of my research. Maintaining awareness of the gap in the literature and taking into consideration the response of primary stakeholders to the findings solidified my confidence in the value of my research. This confidence allowed me to draw conclusions and make recommendations that are truly founded in the data and the theory.

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Chapter 5

Results

The purpose of this study was to understand the process that mothers of anxious children undertake when introducing CBT in the home and to explicate the accompanying changes that occur for mothers in their role and family interactions. The study also sought to elucidate the distinctive process that mothers of anxious children undergo when their child also presents with symptoms of suicidality and/or self-harm. The scope of the findings enable us to understand the emotional, cognitive, and behavioural processes that mothers go through while implementing CBT methods in the home, as well as the environmental and personal factors that influence these processes.

Two primary categories, evolving over four phases, emerged from the analysis. In this chapter, the progression of the two core categories (*Mothers' Perception of the Child* and *Mothers' Perception of her Role*) are explicated within each phase (*Recognizing the Crisis*, *Making Links*, *Integrating*, and *Sustaining Gains*). Explaining the evolution of the core themes within each phase allows the integration of these experiences with the emotions, thoughts, and actions that elicit change or result from the two core categories.

During data collection, it became apparent that mothers whose child also made threats of suicide or engaged in non-suicidal self-harm behaviours had distinct experiences while implementing CBT. Through theoretical coding, seven mothers from this group were interviewed. Two experiences, *Establishing Safety* and *Questioning the Child's Intentions*, are unique to this subsample. These two phases occur prior to *Making Links* (phase II), and as part of *Integrating* (phase III) respectively.

Figure 2 illustrates the core categories as they occur within each phase, as well the associated process factors. As any theory seeking to explicate a phenomenon, the present theory reflect a general process and may not represent the specific experience of *all* mothers of anxious children. This theory represent the overall process of mothers in the present sample. Furthermore, the progression through each

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phase or evolution of the core themes is not linear, as mothers could vacillate between stages given particular challenges.

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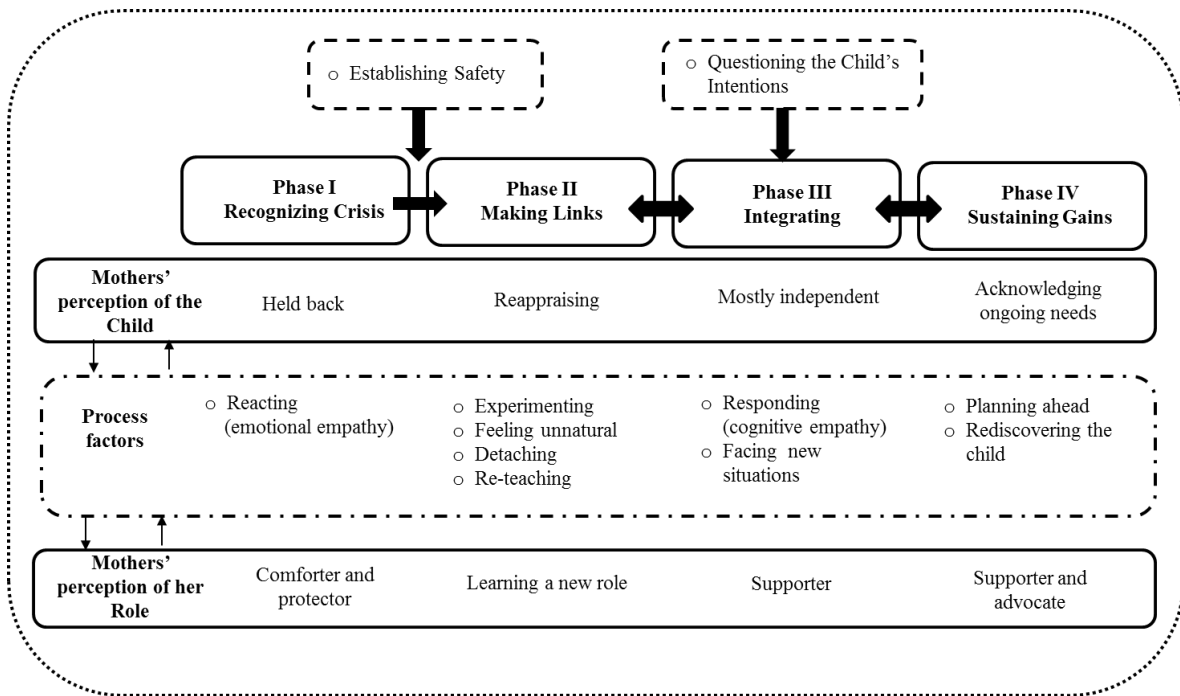


Figure 2. Grounded theory of mothers' process when implementing CBT at home with an anxious child.

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Phase I: Recognizing the Crisis

Recognizing the Crisis represents how mothers noticed and responded to the mounting difficulties of their child as well as the impact of the child's symptoms on the functioning of the home. The crisis prompted mothers to seek external help and preceded the implementation of CBT in the home, as many children had not been seen by a mental health professional or received a diagnosis. Mothers lived in a household where daily routines revolved around the anxious child's symptoms. The family was in an alert mode and prepared to react immediately to the anxious child's needs to ensure his or her emotional and behavioural stability. Mothers strived to manage the anxious child's behaviours and to maintain a precarious balance, while caregivers and other siblings attempted to go through their day without setting off the anxious child.

[Mother BY] "We used to do that, cause when we, we would never put as much expectation on her as the other kids, when we ask her to do something, we always addressed it softer [...] Cause we didn't want a blow. We didn't want her upset. So we would tippy toe around her."

[Mother BW] "if you're a mom but when you're running a household with three kids and you've got a really busy job and you're husband's working and you don't have a lot of supports around, and you just sort of get into this role at times (...) and he's my oldest so, um, so I would just get frustrated by him not being able to do certain things and adapt to certain things"

The quotes above illustrate how mothers and other family members feel compelled to modify their approach with the anxious child, to prevent a tantrum or distress. Some mothers tended to give the anxious child more attention and leeway compared to other children in the home (i.e., siblings, stepsiblings, and/or half-siblings) to prevent further intensification of crisis. Although this lifestyle was routine for mothers and their families, it was also experienced as tiresome and demanding.

Mothers Perceive the Child as Held Back

Prior to CBT implementation, mothers often perceived their child as *held back* and different from other children of the same age. Perceiving the anxious child as *held back* insinuates that the child requires

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more support, attention, and affection than other children his or her age, and that he or she is unable to relieve or manage his or her own negative emotional experiences. A *held back* child's behaviour was perceived by mothers as out-of-control and volatile, and the child is ultimately caught in a negative and distressing pattern of behaviours and emotions. Some mothers worried about their child missing out on important life experiences.

Mothers experienced their child's behaviours as exceeding their current abilities and felt that they had no control in managing his or her tantrums and distress. In response, mothers became more involved and exerted more control over their child's activities and behaviours. Despite expressing a perceived lack of control over the child's emotions and behaviours, mothers increasingly regulated their child's environment by eliminating stressors before they occurred. For instance, some mothers explained how they allowed the child not to go to a birthday party or to try out for a sports team to prevent the occurrence of negative emotions and tantrums and to facilitate daily routines such as preparing for school or running errands.

[Mother CB] "He was afraid that he was gonna have a panic attack. Because when he goes to these meetings, they're one hour long and the parents aren't there. So it's just a bunch of strange kids, not even kids that necessarily go to his school! [Short laugh] So a whole different situation and it happens that way every week, it's a new situation for them. So he was afraid that this would happen and I said: "well you know what, maybe this year we won't do that then. You know maybe we're reaching a little too far this year, why don't you go ahead and join baseball with sissy?"

As such, mothers who perceived their child as *held back* believed that he or she was unable to cope with otherwise age-appropriate activities. Their perceptions maybe in line with their child's experience, who may attempt to avoid anxiety provoking situations as well. Together, the anxious child's tendency to avoid anxiety-provoking situations and mothers' perception of the child as being fragile and unable to cope, can promote further avoidance or over-involvement by mothers.

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Mothers' Perception of their Role as Comforter and Protector

While the crisis builds in the home, mothers responded by emphasizing their empathy for the child, and becoming more nurturing, loving, and involved. The *comforter/protector* aimed to mitigate the anxious child's experience of anxiety, through various types of accommodations. To manage the child's symptoms, mothers may have prevented exposure to potential triggers, controlled the child's environment, and provided reassurance in order to manage their child's emotions.

[Mother BY] "I always thought when she asked for reassurance it was my job to reassure her. It was my job to make her feel better in her environment, try to make her feel more regulated or prepared for situations that I knew would make her uncomfortable."

Mothers gradually realized that the complexity of the child's environment and experiences were beyond their ability to manage and that their current strategies were not viable in the long-term. They worried about the child's experience of important events and opportunities, and the concern that the child might not grow into a successful or independent adult became salient. They were no longer hopeful that their child will outgrow this anxiety and began to perceive it as a lifelong debilitating illness.

[Mother AR] "I don't want him to give up certain things or not do certain things because of um, of nerves and anxiety so, I'm sad and (...) and I just, I worry, you know, what if he doesn't do this or doesn't do that and, it's just a, you know, it's a pain in the chest."

Mothers were mindful of the unstable nature of their child's emotionality, knowing that the child's anxiety can be catalyzed by new triggers each day. If the anxious child had trouble at school, the mother was typically contacted to intervene. This could result in day-to-day anxiety for mothers who anticipated negative events to occur during the day. In response to this unpredictability, some mothers re-shaped their everyday routine to accommodate their child's needs. For instance, they made themselves available and fostered a relationship with their employer that allowed them to leave work when necessary. This constant state of alert influenced mothers' wellbeing as well as their personal time and career.

[Mother CB] "And it was like if I'm going to survive, I need to start doing this. Because otherwise I'm gonna wind up with a son who

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continues to grow larger, he's almost as tall as I am now, so how am I gonna deal with this then, like I'm not always gonna be able to forcibly place him somewhere. He's going to become stronger than I am."

Overall, the perception of one's role as *comforter/protector* self-imposed responsibility to alleviate the child's anxiety and prevented further escalation of negative emotions, at the expense of mothers' own wellness. Mothers typically did this by exerting control over the child's actions and environment as well as adjusting other aspects of their life to accommodate the child's needs.

Reacting

When mothers' perceived their child as *held back* and construed their role as *comforter/protector*, they vicariously shared the child's emotional experience and attempted to alleviate their child's anxiety and their own distress. Some mothers also anticipated that their child would have trouble before an upcoming stressful situation such as an exam, and they shared their child's distress pre-emptively. Some mothers indicated that they had also been diagnosed with an anxiety disorder, which they believed intensified their emotional reaction to the child's distress. Mothers' over-identification with the child's distress could increase understanding and empathy, leading them to provide reassurance and comfort. It could also lead the parent to lose objectivity and complicate decision-making. *Reacting* therefore captures how mothers experienced their child's distress as their own and lost objectivity in the process of attempting to manage their child's anxiety. Mothers' reaction to their child's anxiety was driven by a feeling of not having control, and became guided by their own distress, confusion, frustration, or sorrow for the child who is in distress.

At this stage, some mothers became frustrated with their inability to successfully manage their child's anxiety, and felt a sense of lack of control over child rearing. They felt helpless as their empathetic comforting and reassurance of the child did not reduce his or her anxiety and distress successfully. External pressures intensified this frustration and distress. For instance, the child's school may have pressured the parent to remove the child from the classroom, the mothers' employer may have been unable to accommodate her need to leave work to attend to her child, or the mother may have felt that

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family and friends judged her as being a bad parent. In response to this experience, some mothers reacted more intensely, further comforting and soothing the anxious child. They may have exerted more control on the child's environment and actions, by restricting the activities that the child partakes in for instance. Alternatively, some mothers took a dismissive approach, where they brushed off the child's symptoms with a vague statement or solution that did not address the source of the child's fear and the thoughts that underlie it. Mothers' intention when taking this approach was to communicate the benign nature of the child's fear from their perspective.

[Mother BO] "She was like "mom, I feel – I've got asthma. I've got asthma, I can't breathe." And I'm like "no, of course you don't have asthma, you don't, you can breathe." And she's like "I can't catch my breath" and I'm like "ok, so just open up the window."

Mothers felt that they used different parenting strategies with their anxious child than with their other children. They felt that this differential approach initiated conflict between the children, as the anxious child's siblings felt shortchanged in terms of attention or leeway. Further conflict and tension arose if the spouse (if in a two-parent family) had either a different parenting approach, chose not to engage behavioural management, or was absent for long periods of times (e.g., military deployment). Mothers self-ascribed a management and leading role in the behavioural management responsibilities, and felt that the crisis intensified along with their sense of frustration, confusion, self-doubt, and helplessness. The quote below reflects how a mother experiences the intensifying crisis as *floating*. *Floating* is an *in vivo* code that encapsulates worries about the child's future and wellbeing, self-doubt about parenting skills, as well as shame, as mothers acknowledged that their current methods are inadequate.

[Mother E] "You kinda get thrown a curveball, and you're left feeling like you're floating, and you're not quite sure what to do. And honestly during that, there was a period there where I was like I don't even know if I'm the right person to be her mom. And then I mean, I did a lot of reading and trying to get her help, and going from one organization [to the next] that I didn't feel was helping us."

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The accumulating stressors within the home as well as the potential long-term impact of the child's behaviours built towards a state of crisis in the home. All the members of the family were impacted by the additional needs of the anxious child. Conflicts also arose because of differential treatment of the child or differing approaches to parenting. Mothers felt that they were caught in the center of this snowballing crisis, which they felt that they could not manage or control effectively.

Phase II: Making Links

The process of *Making Links* involves making conceptual linkages between the theoretical constructs of CBT, the anxious child's symptoms, and day-to-day parenting strategies. This process allowed mothers to reappraise their child's experiences and shapes mothers' self-perception of her role. At this point, many mothers (and occasionally their spouse) opted to engage in a CBT program with the intention of understanding their child and changing aspects of their parenting and family context that would benefit their child. Mothers were therefore open to change and were hopeful about gaining control of the increasing crisis in the home.

[Mother Z] "I used to think that that was nurturing and that I was actually doing something good for her. Once I got in the group I quickly learned that that was enabling a lot of anxiety for her, it actually potentially making it, probably, likely making it worse, because it wasn't giving her the tools to deal with it on her own. So our approach is always different where we just sort of examine the issue and say, you know, this is what we have to look at, it's gonna feel like this, is- that's okay, what do we do to get through it."

[Mother CF] "I think I have a better understanding of how he works, which I didn't before, I have a better understanding of the anxiety part of it, I have a better [inhales] understanding of myself I think"

When mothers understood the group content and applied it to their parenting approach and their child's behaviours, they felt able to modify the way they addressed their child's needs. Many mothers perceived their ability to make these links as a sign of their increased capacity to manage the situation and make life better for their child. As illustrated by the quote below, if and when mothers perceived

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themselves as making links between CBT theory and their daily practices, they experienced a sense of control, accountability, and hope.

[Mother BO] “So, the onus was on us [to practice], and I’m glad they set it up that way where they help teach the parents, versus do with the kids and then the parents. I said that was the best thing you can do, because you need the parents on board”

If mothers do not make links between the CBT rationale, their parenting methods, and their child’s symptoms, they might have reverted to their old parenting strategies. A few mothers continued to experience the feeling of unnaturalness (i.e., feeling unnatural) after taking part in the group, suggesting that they had not made sustainable links between CBT and their parenting practices. These mothers continued to express frustration when attempting to manage their child’s anxiety, seemingly remaining in the *recognizing the crisis* phase.

Mothers’ Perception of the Child: Reappraising the Child’s Experiences

A growing understanding of CBT theory and linking group content to the day-to-day parent-child interactions could foster a process of reappraisal, whereby mothers’ gained a new awareness of their child’s experience and needs. Reappraising represented a new awareness of what anxiety looks like for the child and elicited a new understanding of the function of their child’s symptoms. Mothers began to reassess the consequences of failure, and deemed it less catastrophic as previously assumed or as a valuable learning experience for the child.

[Mothers CE] “Having this book, by having the right language to use, um, benefits everyone, so then I would be able to address, what the anxiety is, with regards to is it about thoughts, body reactions, labelling, modelling, then I would be able to remind, you know, my husband and other children and even myself, um, when something happens what are we gonna do about it.”

The group material provided mothers with a new lens through which they understand and engage with their child. At this stage, mothers’ perception of their child is in flux: it widened from that of a child who is *held back* to that of a child who could learn a new, more effective way to experience and engage

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with his or her environment. Mothers who reappraised their child's symptoms based on the CBT framework could begin to engage with their child in a manner that seeks understanding, rather than intervening or solving the problem for the child (i.e., *reacting*). With a new understanding of their child's behaviours, mothers practiced the various CBT methods at home, witnessed how their child learned from this practice, and gained independence in anxiety management.

Mothers' Perception of their Role: Learning a New Role

The process of *Making Links* between the theory of anxiety, the child's behaviours, and parenting practices contributed to the evolution of mothers' perception of their role in the therapeutic process. Reappraising the child's symptoms de-emphasized the extent to which mothers perceived their role as a *comforter/protector* and in turn elucidated a new role option, that of *supporter*. This shift occurred as mothers discovered more effective alternatives to reactive parenting strategies, and began to assist their child in managing anxiety instead of attempting to control the situation entirely. This new role allowed mothers to ease their tendency to engage or leap in to solve their child's difficulties, and instead start to observe and assess the child's needs. It also alleviated some of the shame and confusion experienced by mothers with respect to their child's actions and emotions. Taking on the role of *supporter* could be counterintuitive to the traditional maternal role, which aims to comfort and reassure the child. Many mothers experienced a sense of increased control as they learn to approach their child's symptoms strategically and pragmatically. This shift in role provided open space for mothers to further step back, observe their child, and encourage him or her to find their own "tools" to deal with the situation at hand.

[Mother F] "And so when we took the parent program, it gave me an understanding about anxiety...and how what I was doing was actually contributing to his anxiety, as opposed to helping him. I had to completely switch the way I was thinking, so that my job as a parent, even though it goes against your instinct, not to protect your child and get them out of the situation that makes them uncomfortable. My job was to prepare for the real world...and give him the tools to manage this when it happened."

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[Mother Z] “you have an anxious child and you’re trying to accommodate that, then you have to factor in that maybe your own anxiety about them being anxious plays a role in how you respond to [her] (...) You know what I mean? If you have an anxious child and then you worry about them being anxious or worry about them missing stuff, that in a sense, that in itself is anxiety, so you worry like “does that influence your ability to help your child get through that, cause you worry about it and it’s an uncomfortable place to go, for the parent”

This new role option could be both challenging and welcoming. At times, letting go of the need to make things “right” for their child challenged aspects of the traditional parenting role and generated apprehension, as it involves changing ingrained emotional and behavioural responses to the child’s anxiety. Equally, shifting away from the role *comforter/protector* to that of *supporter* was accompanied by a sense of relief and hope. Mothers vacillated between these experiences and roles as they begin CBT implementation with their child. As such, they felt that their initial practice and implementation was not entirely consistent as they shifted back and both between new and old roles.

Experimenting

Mothers initially engaged in a process of trial-and-error where they experimented with various CBT methods and evaluated their effectiveness and feasibility. With caution and intention, they attempted to gradually translate the therapeutic approaches from the therapist to determine whether each method was a good fit for their child and home. In this exploratory phase, mothers experienced increased responsibility, accountability, and sense of control of their child’s anxiety disorder.

[Family Z] “I just actively listen to her anxiety and her worries and um just help talk her through the right way to manage it, I guess, or the, a way that works for her or works for us to manage it, incorporating things that I’ve learned in the group and things that she learned in her group and things that we’ve just discovered that will work for us.”

Contextual factors could make it more difficult for mothers to experiment with new CBT skills. For instance, mothers found it difficult to practice active ignoring when they were in a public space, or believed that it was impractical to engage in a conversation about thoughts and emotions when there was

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a time constraint. Mothers made rapid decisions about their approach when felt that the contextual factors were challenging. They made these decisions on an individual basis, evaluating whether the time and place permits the practice of a new approach. Most mothers indicated that they were sometimes inconsistent in their approach, and occasionally chose to avoid situations and events that were anxiety provoking for their child in order to prevent conflict or challenging interactions with their child. They referred to this as “choosing your battles”, when they felt unable to implement CBT skills such as cognitive restructuring, gradual exposure, or relaxation strategies, and perceived the consequences of missing the event as negligible. Mothers reported experiencing guilt when they resorted to old parenting strategies, acknowledging that in retrospect, other approaches founded on CBT strategies could have been plausible and effective. The *making links* phase and the process of *experimenting* is therefore characterized by inconsistency, as mothers vacillated between new and old perceptions of their child and of their role.

[Mother BW] “I usually say: this is what I expect, and this is what happens if you don’t do it” and then I can walk away, and he’ll matter and push and pull and do all this stuff and I’m better at walking away. I’m not great at it I’m not perfect at it (...) the [CBT] course really helped”

During this phase, mothers experienced moments of “enlightenment”, when they realized the effectiveness of the new methods. These moments of enlightenment occurred when mothers experienced unexpected success. From the mothers’ perspective, these moments served to lend credibility to the CBT approach. Moments of enlightenment also occurred when mothers connected the symptoms and behaviours described in the program to their own child’s presentations. For instance, mothers suddenly recognised that their child is experiencing a panic attack or that a tantrum is the manifestation of anxiety. Experimenting allowed mothers to modify their strategies to manage their child’s anxiety. They began to discover successful alternatives to protecting and comforting when responding to their child, which reflects the development of their role as *supporter*.

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Balancing. *Balancing* typically occurred during the *experimenting* process, and reflects how mothers found it difficult to balance the difficulty of the exercises with their perception of the child's ability. Their apprehensions about the child's ability to complete a task or consequences of possible failure could hold them back from implementing CBT methods. Balancing therefore influenced which methods were attempted and in what context.

The process of balancing involves mothers asking themselves (and the therapist) "how much can I push my child?" Embedded in the notion of balancing are worries about the consequences of failure, which are related to thoughts regarding the child's ability as well as mothers' perception of her role in this process. Mothers who perceived their child as able to cope in a certain situation remained consistent and pushed their child to engage in new situations or to use other adaptive coping skills. Alternatively, those who focused on the potential and consequences of failure were more likely to rely on old parenting strategies and not attempt new methods. In this experience, mothers' perception of their role vacillated between that of *comforter/protector* and *supporter*, and until an enlightening moment of success occurred, the perception of the child remained as *held back*. Mothers also vacillated between the use of old and new parenting strategies if they maintained a perception of the child as unable to cope with anxiety and a perception of the self as *comforter/supporter*.

[Mother AM] "You try to push it to a certain extent but you can't – there's only so far you can go, like you don't want him to, like, you know, have a breakdown and things, right, you have to know when to stop pushing that thing and realize that's not gonna work for him."

In sum, *balancing* reflects the mothers' experience in coordinating the difficulty of the exercises presented to the child and their perception of the child's ability to complete the exercise. These apprehensions could discourage mothers from practicing novel methods. As illustrated in the quote below, mothers may have continued to shift back and forth between approaches in the initial stages of CBT implementation, although they have discovered that one method may be more effective in the long term.

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[Mother BV] “If you engage, it’s dreadful, because she’s not in a place to engage, right? But yea I engage sometimes (laughs). It’s a bad, bad decision to engage. When the kid is tired and you know you’re not gonna win!”

Feeling Unnatural

The most significant challenge to *Making Links* is the discomfort experienced by mothers while implementing behavioural approaches that require ignoring their child’s distress or exposing their child to anxiety-provoking situations intentionally. Detaching from their child, not engaging, and ignoring symptoms of anxiety could go “against [the] instincts” of many mothers and could contribute to feeling that they are “withholding something from the child”.

[Mother E] “Um, I think in some ways there is, um, because some of it you have to fight a little bit of that mom instinct of “come here and just let me hold you and we’re gonna make it all, that will make it all better”. Um, and there is a little more of fighting that motherly instinct at times when things are really, really bad for them – like I said, all you wanna do as their mom is make it better, but knowing that you kind of have to step outta that role and step into, “well this is what we need to do to”, like you know “I know this is hard for you and I know this is- but you have to do it.”

This experience could be associated with self-perceptions of being “the mean parent” and guilt, because it was difficult for mothers to reconcile the notion that strategies such as active ignoring and exposure were beneficial for their child. Feeling unnatural highlights a tension between the practice of CBT and mothers’ perceptions of their role as a parent, and their perception of their child’s needs. This experience captures dissonance between what mothers ought to do based on the tenets of CBT and what instinctively felt “right”.

Detaching

Overcoming the experience of feeling unnatural occurred when mothers began to prioritize, understand, and became attuned to their child’s experience and set aside their own distress and worry. When this occurs, mothers separated their own apprehension and discomfort from the child’s distress and

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anxiety, which allowed them to examine the situation objectively and support the child in the use of adaptive coping strategies.

[Mother BW] “I’m a bit more directed, I’m not so worried about things” (...). If I don’t have confidence in him, who’s gonna have confidence in him? (...) And now I’m much more “you can do this [Child’s name], it’s not a big deal” and I’m able to say to him too like “you’re gonna fail sometimes. There are things that you’re gonna try that are not gonna work out.” (...) Learning that you know, that you fail sometimes makes you learn things and pushes you, so.

[Mother F] “I had to completely switch the way I was thinking, so that my job as a parent, even though it goes against your instinct, not to protect your child and get them out of the situation that makes them uncomfortable.”

When mothers allowed themselves to push their child, their apprehensions about the negative consequences of CBT implementation alleviated, and the links between theory and practice were strengthened. Perceiving their child’s distress as distinct from their own response may have contributed to mothers feeling relieved and in control of the situation when they allowed themselves to put difficult CBT methods into practice.

[Family CD] “I guess the great thing about the group was that we were given permission to, push, and to say no, and to, do you know what I mean, without feeling like we’re bad parents and you know feeling guilty about it.”

As exemplified by the abovementioned quote, distancing oneself from the emotional experience of parenting an anxious child and accepting the permission to push can serve to relieve the guilt (or *feeling unnatural*) associated with parenting strategies that were otherwise perceived as harsh. *Detaching* from their apprehensions reflects a distinctive shift in the parenting style of mothers that is founded on a new understanding of the anxious child’s needs. It represents the transition from a reactive parenting approach to an informed or pragmatic parenting approach. Mothers’ perception of her role as *supporter* was further strengthened in this process, as mothers reported experiencing less discomfort and guilt, and instead began to focus on the child’s needs in a given situation.

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Re-teaching

Re-teaching refers to mothers' attempts to transfer new knowledge and skills to their spouse primarily, but also to their extended family members and later to school personnel. These individuals may not have attended the CBT program or may otherwise have been disengaged from the management of the anxious child's symptoms. Mothers, who learned the methods and rationale from the therapist, attempted to extend their knowledge to another person with the goal of mitigating conflict in parenting approaches and generalizing the practice of CBT skills. These intensive instruction sessions typically took place during a crisis, when the anxious child exhibited severe symptoms, or when faced with a decision regarding avoidance or exposure of a trigger. When re-teaching, mothers told the spouse what to do, but the circumstances did not allow them to explain *why* and *how* a new approach is effective and preferable. Mothers experienced re-teaching as a frustrating additional step that slowed down the process, and they responded by taking charge of the situation. That is, instead of transferring their new skills and knowledge, some mothers attempted to circumvent potential conflicts and tension by taking full responsibility for CBT implementation in the home. They consequently felt that they are the sole implementer of CBT in the home.

[Mother AR] "I'll sometimes I'll argue with him [spouse], but I try to say, you know, just be quiet and back off then I prefer you not being here talking to him like that than, and making him get more worked up than he needs to, so just please, I prefer you be quiet, if you're not gonna be the same way as I am."

A mutual agreement could occur between caregivers to modify their parenting approach together, in order to incorporate notions of CBT. Re-teaching that occurred in the context of "getting on the same page" aimed to decrease the divergence between parents' strategies to manage anxiety in the home. When the spouse was present but not engaged in the process, or when parents were not in the process of getting on the same page, mothers felt that they were the main implementer and self-imposed full responsibility for the practice of CBT.

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[Mother BC] “That did cause a problem in our parenting....for the kids, cause, we weren’t on the same page at all. So I had to step it up and he (spouse) had to learn to kinda tone it down.”

As such, although the initial intent was to translate therapeutic skills to the anxious child, mothers sometimes found themselves extending the new skills to other caregivers, primarily their spouse. This challenging process could hinder the implementation of CBT skills and intensified their sense of being fully responsible for the practice.

Phase III: Integrating

With ongoing practice of CBT methods, mothers came to identify the therapeutic methods that were effective for their child and they *integrated* the tenets of CBT practice in their everyday parenting. They reported feeling more comfortable and confident in their ability to implement strategies that helped their child manage his or her anxiety. They began to utilize these strategies without experiencing guilt or discomfort. In other words, mothers ceased to differentiate between “practicing CBT” and parenting an anxious child as tenets of CBT become integrated into all their interaction with their child. Some mothers also chose to expand their use of the CBT strategies and implemented the methods with other children in the home who may or may not have an anxiety disorder.

[Mother CA] “I found that [active ignoring] actually helped with both children, not just him”

[Mother F] “Well I don’t know, when we first started to do that, it was I guess....those two things [CBT and parenting] were clearly separate things, and I would choose to use it for situations or not. Over time, it became the norm, and now I don’t differentiate.”

At this stage, mothers shifted their approach from reacting to their child’s distress to an informed and pragmatic approach. After evaluating the needs of the situation and taking the time to understand their child’s experience, mothers responded with a calm and thoughtful stance. Mothers felt that they were more attuned to their child’s symptoms and needs, to which they respond with control.

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Mother's Perception of the Child as Mostly Independent

At this stage, mothers felt that they had a solid understanding of their child's triggers and symptoms, as well as the methods that were most useful in alleviating his or her anxiety. With this new understanding, mothers felt that they could moderate their involvement. They knew that the child could use CBT methods automatically and independently, but he or she may occasionally require support and reminders in the use of adaptive strategies.

[Mother BH] "So part of it is refreshing because I don't feel like I'm having to... "Uh! I'm having this conversation again!" because now that the expectation has been set and she gets to see the whole process start to finish...it's not as big of an issue...she just kinda recognizes it on her own."

Despite perceiving that their child is more independent, mothers typically chose to remain involved in the practice through cueing and supporting. For instance, they reminded the child of "tools" that were successful in the past or continued to practice the deep breathing exercises with the child. When the anxious child was successful in managing his or her own anxiety, it contributed to mothers' perception of the child as independent and capable to cope.

Mothers' Perception of their Role as a Supporter

Mothers' redefinition of their role was dependent on the abovementioned perception of their child and their understanding of their child's behaviours. Mothers who perceived themselves as a *supporter* were able to emotionally distance themselves from the child and focus on the problem at hand, as opposed to the emotion that it elicited. Over time, the perception of oneself as being the supporter was solidified as mothers did less and less to assist their child who had now gained independence. Eventually, mothers "cued" the child to use strategies or asked simple questions that elicited self-reflection, understanding, and action from the child and mother. Mothers felt that they had the knowledge and skills necessary to assist their child.

[Mother CC] "Before the group I would say: "ugh, it's nothing, nothing bad is gonna happen, so stop it." You know, and I almost get angry (...)

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whereas now it's like "let's go through our (deep breathing), let's do our thing, let's, talk about what could happen and what happened last time"

[Mother CE] "One of the things we learned is what's the worst thing that happens if you're late for hockey? You know, is it nothing?"

The quotes above demonstrate the shift in the mother's intention when interacting with the anxious child using a more practical and solution-focused approach. Mothers did not experience guilt and do not worry about the negative consequences of being pragmatic and firm. At this stage, mothers described their demeanor around their child and anxiety-provoking situations as calm and in control, without worries of hurting the child or the parent-child relationship.

Pragmatic Parenting

Mothers' new knowledge and experiences culminated into an understanding of the child and of their role, which in turn encouraged continued use of the new parenting strategies. This parenting approach was informed and pragmatic, and in line with what has been described as cognitive empathy (Smith, 2006). It begins with attunement and understanding of the child and situation, and it is fostered by a calm and patient demeanor. This parenting strategy founded on cognitive empathy reflects how mothers noticed the child's distress, asked effective questions to understand the experience, and utilized methods that have been effective in the past. When mothers perceived their child as being able to cope with anxiety independently and perceive themselves as supporters, they were more likely to choose a course of action that was tailored to the needs of the particular situation as opposed to emotionality.

[Mother T] "I think because you learn to understand the behaviour that you're seeing in your child and you kinda start to understand what's driving it and so then there's things that you can do to try and help and when you actually see that it is helping and then you also get cued to the signs and the symptoms before it gets as escalated as it can, right? So you kinda see it coming before, whereas before we didn't think until it exploded."

At this stage, mothers attempted to understand the child's experience in order to respond more effectively. For instance, they began to ask questions that allowed them to re-evaluate thoughts and situations (e.g., What do you think is going to happen? What can you do if it does?). Mothers also felt that

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these questions allowed their child to gain a better understanding their own experience. These parent-child conversations became part of the problem-solving process used by mothers in their attempt to promote independence in the child.

[Mother CD] “You know, and we’ve learned, there’s a reason for this, there’s a reason why you’re feeling this way, right. Sometimes with her I even say, she’s quite intuitive, both kids are, and I say ”sometimes you just have to – when you start feeling it you just have to kinda look around and go what’s happening right now? What’s happening, am I in imminent danger?” Am I? Because maybe something is happening and maybe you do need to kind of walk away from whatever is going on. There is a reason for that but, for us, um, we can’t let that become all controlling either. So just being aware of your surroundings, because I say to her, when she was having a panic attack “so what’s happening right now” and just getting them out of their brain talking about it? Um, you know and then she would say it and I would say “So, are you in danger? No. Am I in danger? No. “Right.”

As the child gradually gains more control and independence over his or her own anxiety management, mothers began to feel as though they could take a step back in terms of direct implementation of methods. Instead, they remind their child to use coping strategies that have been successful in the past. This approach was a way for mothers to decrease their involvement and support independence.

[Mother CF] “Just trying to tell him, you know and remind him that you know, you’ve done this once already and what did you, and we get him to write down coping cards and, or he writes them down so his coping cards you know, what did you say about it the last time? Well I wrote down it wasn’t that really that bad.”

In sum, *Integrating* signifies that mothers took a pragmatic rather than emotional approach to managing their child’s anxiety. They responded to their child’s distress by evaluating the needs of the situation and did not act immediately based on their initial emotional response. In other words, their parenting strategy was founded on cognitive empathy, as they sought to understand their child’s experience with targeted questions, and cued him or her to the use of adaptive strategies.

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Facing a New Situation

A challenge for mothers who practiced CBT was to generalize their knowledge and skills to new situations. When facing a new situation that could initiate an anxiety response from the child, mothers could revert to old thinking patterns and continue to hesitate despite the child being adamant to take part in these activities. According to this grounded theory, mothers' hesitation reflects expectations about the child's ability to succeed or to cope with anxiety, as well as mothers' anxiety about possible failure. This experience is akin to *feeling unnatural* that occurs in the *making links* phase. Mothers had to overcome the distress associated with the initial implementation of CBT once again.

In this decision making process, mothers considered the child's (perceived) ability and risk of failure, their own emotional response and willingness, as well as the importance of the event. In evaluating the child's ability, mothers considered past experience (i.e., successes and failures) and compared their child to other same-aged children. Mothers who remained uncertain about their child's ability to cope or who catastrophized the consequences of failure for their child and for themselves, might have been unable to overcome their apprehensions and consequently prevented their child from taking part in the activity. In this case, mothers' experience resembles that of *feeling unnatural*, when they struggled to overcome their apprehensions in order to implement CBT. Mothers who had built a perception of their child as having the skills to cope with stress or who were able to overcome their own anxiety, typically took a detached and pragmatic approach, which allowed them to let the child lead, inhibit their own apprehensions, and consequently promote exposure to new situations. In some specific situations such as doctor's appointments, mothers judged that the event is significant enough and that it should not be missed, despite their own anxiety and their prediction of failure. In these cases, mothers' evaluation of the event's importance superseded their own apprehensions as well as their perception of the child's ability to overcome their anxiety.

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The quote below illustrates how a mother allowed her child to take the lead when faced with a potentially anxiety provoking opportunity. She repressed her own feelings about an overnight camp, and let her child respond first. She initially doubted the child's ability, but inhibited her own apprehensive response and was surprised at the child's willingness to engage. In other words, she approached the novel situation pragmatically (with cognitive empathy), eliminating the debilitating impact of emotions, and evaluating risk realistically.

[Mother F] "I got the notice and that's the first time it happened a few months ago, and it was the first time in a long time, where I said to myself "oh no, overnight trip to Toronto, on his own...that's never gonna happen", and I had to stop myself to say to him, to start off in the negative way by saying to him "oh I know it's gonna be hard for you, but I really think you should go", which is kinda how I was thinking...I didn't say anything...I said "oh I see you got a school trip notice" and he said "yeah isn't that great!", and I was just like [sound of amazement, mouth wide open] and so we just kept going."

While taking part in the CBT group, or after termination, most mothers faced new situations that were anxiety provoking for their child. For instance, the child may have had the opportunity to attend summer camp, required surgery, or be invited to sleepovers. These events required generalization and application of CBT tenets in novel situations, which could be challenging for some mothers. Some mothers returned to reactive parenting strategies that aimed to prevent negative emotions, thereby preventing the child to take part in an activity that would be age-appropriate but anxiety provoking. Others were more comfortable allowing their child to take a leap of faith in the face of new anxiety-provoking situations. These mothers were able to inhibit their own apprehensions and discomfort about the situation, and appraised their role as *supporter*.

Phase IV: Sustaining Gains

When the child had gained independence in the management of anxiety symptoms, mothers experienced a shift of focus, from the child's present symptoms to preventing relapse and planning for natural life transitions. *Sustaining Gains* refers to this shift in mothers' goal that follows from mothers'

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perception of their child as being able to cope with anxiety independently and their perception of their role as being that of *supporter*. Having experienced success, mothers now strived to maintain these gains, prevent relapse, and generalize the practice of CBT to novel situations.

[Mother BC] “I don’t feel like so sad and sorry, I know she can do it, and because I’ve seen her do it, so it’s like I’m almost believing in her, and believing that, um, you can cope with anxiety.”

Mothers sustained gains and prepared for the future when they were satisfied with their child’s improvement and their own changes in parenting style. They also recognized that anxiety disorders were chronic in nature and that symptoms may occasionally reappear. Accepting this progress and chronic nature of anxiety disorders allowed mothers to tolerate instances in which they “slip” into previous parenting styles without frustration or guilt, while remaining generally consistent in their practice.

[Mother CD] “That’s fantastic, and that’s such a huge improvement that sometimes like we need [pause] “let’s just... this is ok right now”.

In other words, *sustaining gains* reflects dissipation of crisis as well as mothers’ perception that they have regained control over the functioning of their home, including their child’s anxiety symptoms. Mothers who sought to sustain gains also sensed that at some level, the family had settled into a “new normal” where functioning is no longer centered on the anxious child.

Mothers’ Perception of the Child as Having Ongoing Needs

Over time, mothers came to perceive their child as being empowered and as having the tools to cope with negative emotionality. However, they were cognizant that anxiety disorders are chronic in nature and were concerned about the possibility of relapse. They worried that natural transitions such as adolescence and attending high school would be too much for their child to manage independently, and were unsure of *how* their child could face these life experiences successfully. They worried that their child’s current skills were not sufficient to cope with the distinct challenges posed by adolescence, relationships, or employment.

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[Mother BH] “Well yeah...in the teenage years things are completely different. Now separating puberty and different anxieties and stuff, and different social skills are coming up right?”

When mothers acknowledged their child’s ongoing needs, they understood that anxiety ebbs and flows and that it could be set off by seemingly small events, without expectation or warning. Despite their perception of their child as being able to cope, mothers acknowledged the challenges of life transitions, and worried about how these new challenges would influence their child in the future. They believed that anxiety would remain a part of their child’s life and that its management will be an ongoing process.

Mothers’ Perception of their Role as Advocate

Mothers’ effort to ensure that their child did not experience a relapse and their attempts to generalize the practice of CBT to new situations reflects their perception of their role as *advocate*. As advocates, mothers aimed to extend their knowledge and new understanding to other important adults in the child’s life. They attempted to re-teach methods of CBT to extended family members or educational personnel without explaining the rationale of the treatment. As such, *re-teaching* continued and expanded beyond the spouse.

[Mother T] “School is the big challenge. Its other adults. (...) I think, what the struggle for us has been, is trying to get the school on board, and educating the teacher each year, so that he gets to understand that what they’re seeing, [the anxious child’s] behaviour is driven by something, it’s not just bad behaviour. And it’s really, really hard. That’s probably the most frustrating piece we have.”

As illustrated by the quote above, mothers who advocate for their child experienced frustration, apprehension, and sometimes confusion. Adapting the role of *advocate* is ongoing and did not replace mothers’ role as *supporter* in relation to their anxious child.

Planning Ahead

To better support their child in future situations, mothers attempted to remain aware of changes that could trigger anxiety in their child’s environment and plan accordingly. For instance, mothers paid attention to substitute teachers and exam periods, which were both identified as stressful events for

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anxious child. Mothers' planning for potentially anxiety-provoking situations could be concrete, such as having an understanding with the employer to leave work if their child is in crisis, or covert, such as having a "mental plan" of how to respond to a child who calls during a sleepover.

[Mother Z] "It's just constantly trying to be ahead of, what you, might just be a reaction to be ahead of it and have a bit of a plan and think about the outcomes, like it's not something that I normally do all the time, like think "okay, if I do this, the outcome will be this and this will be- like always and so, you have to be more careful around this, if you, so I don't just sort of fall back into enabling things and making it worse so that's the hardest part. Is that it's a lot of work just to stay on track."

Mothers were concerned that failing to notice triggers and being unprepared will lead to a relapse, which motivated them to plan ahead. They were in a state of alert and consistently searched for signs of the next crisis or difficulty, hoping that they could prevent a relapse and prepare their child for the challenge. Mothers' attempt to prepare for new challenges and remaining aware of changes in the child's environment was described as time-consuming and tiring, yet crucial.

Rediscovering Qualities of the Child

When CBT became a natural part of parenting and symptoms of anxiety were managed, mothers experienced parent-child interactions as less stressful and more pleasant compared to the *Recognizing Crisis* phase. Now that their child required less consistent attention and could manage his or her own anxiety, mothers were able to reallocate their energy to enjoying their child's company. They experienced a closer and more positive relationship with their child, where they engaged in meaningful conversation and share leisure time together.

[Mother CC] "We talk a little more maturely, we can actually have a more, um, more mature conversation, more, you know, compared to her just-because it was just constant before. It was constant anxiety, constant behaviours and it was just me being a parent, you know, dealing with a child and whereas now we can actually joke around, she's pretty funny! [Laughs]"

Mothers came to describe their child as being more mature and acknowledged that some of the improvements in anxiety management and behaviours maybe a consequence of maturity. They once again

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appreciated qualities of their child that were previously obscured by anxiety, and that re-emerged now that symptoms of anxiety had dissipated.

Mothers of Children who present with Signs of Suicidality or Self-Harm Behaviours

Mothers' whose anxious child also made threats of suicide, expressed thoughts of suicide or who engaged in non-suicidal self-harm behaviours underwent two distinct experiences in addition to the four phases described above (refer to *Figure 2*). *Establishing Safety* allowed mothers to engage in therapy and therefore occurred prior to *Making Links* between their parenting strategies and CBT theory. *Questioning the Child's Intentions* is part of the *Integrating* phase.

As reflected in the quote below, mothers in this subsample felt as though their child was "crawling in her skin" and "out-of-control" as they witnessed the intense distress and vulnerability experienced by him or her. Mothers worried about the child's impulsive tendencies, and responded by increasing supervision and control on the child's behaviours and activities. Their wish to relieve their child's distress, but lack of knowledge and skills to do so, left them feeling helpless and confused. In all but one case, the child's threat of committing suicide or self-harm behaviours was the instigating factor to seek assistance from mental health professionals.

[Mother BO] "No, this is horrible, sorry, it's horrible (crying) cause once again you feel guilty cause (crying) you wish you could help your kid and you want to make things all better for them and you can't"

[Mother BY] "Like to me that's what it feels like with her, it's just highs are highs, lows are lows, and sometimes she just seems like she's crawling in her own skin, so you just wanna protect her from all that. I just want her to be, just be healthy, be happy, relax."

Mothers in this subsample faced unique challenges in regards to consequences of CBT implementation. Their need to feel safe for their child and to understand these behaviours influence their engagement with the group content and ultimately, the practice of CBT skills. Many indicated that they sought further assistance from the therapist in this process, in order to better understand their child's experience and ensure that they approached future incidences appropriately.

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Establishing Safety

When their anxious child made a threat of suicide or engaged in self-harm behaviours, mothers' instinct was to ensure the child's safety and to alleviate the child's distress. Feeling helpless, mothers sought to prevent the re-occurrence of another episode. Working with the therapist, mothers' gradually gained an understanding of the risk of suicide or self-harm and the function of the child's statements or behaviours, which contributed to them feeling that their anxious child is safe. Their primary goal was to be assured that their child would not seriously harm him or herself.

The quote below reflects how establishing safety is challenging because mothers believed that the stakes are high and they worried that detaching or pushing would cause their child to attempt suicide. Mothers who did not feel that their child was safe were reluctant to engage in therapy, had difficulty establishing boundaries, and consequently did not make links between their parenting strategies and the CBT group content. Mothers were also concerned that detaching and pushing would negatively affect their relationship with their child, as they anticipated resentment and opposition from the child. These anticipations further challenged the process of *establishing safety* and *making links*, sometimes resulting in guilt and further helplessness. Finally, this apprehension could lead to early termination of parent-centered treatment program. In fact, one mother reported terminating the group early, because she did not feel that her child was safe enough to practice the methods presented in the group.

[Mother BV] "So it's like sometimes you just gotta let her grow, but it's, like what if we get that wrong? And then she tries to kill herself or something like that. Like the consequences feel very big, so as a parent it gets very scary."

[Mother BC] "I think ultimately, I feared that (pause) if I was firm, too firm, that the separation would be too hard, that she would separate from me. And, (pause) that she would no longer love me as her mom."

Fundamentally, establishing safety is about the mother and therapist collaboratively building a shared understanding of the meaning of "safety" for the child. Mothers develop an intellectual understanding of the child through this process, which occurs by coming to a mutual understanding of the

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child's condition and risk of harm. Mothers worked collaboratively with the therapist, who assisted them to understand whether their child has suicidal intent or a serious risk to harm him or herself. Mothers who eventually established safety expressed confidence and control, which they believed allowed them to engage productively in the therapeutic process.

Questioning the Child's Intentions

Questioning the Child's Intentions occurs during the *Integrating* phase (refer to Figure 2) and typically results from mothers' attempt to better understand their child's experiences. Mothers who sensed that their child was safe and who had made links between anxiety theory, their child's behaviours, and their own parenting practices began to ask *why* their child engages in such behaviours. This process seemed to occur when mothers believed their child had developed some coping skills. Some mothers felt that their child might be "bluffing", perhaps in an attempt to avoid an anxiety-provoking situation or to gain attention and sympathy. Mothers experienced embarrassment, guilt, and anger when thinking that their child might be manipulating them. They were reluctant to express these thoughts, as they felt that it reflected poorly on their mothering skills. Although they momentarily felt as if they were denying their child sympathy or being harsh, mothers who felt that CBT approaches were ingrained in their parenting style took a pragmatic approach to these thoughts and questioned their child further. They responded to these subsequent threats based on the specifics of the situation, rather than the distress it elicits.

[Mother BW] "What I did notice though is that he was after a while, I was really busy at the office around that time, he would call me and then mention something like that just to get me to go back home and that got me frightened. (...) I went home one day and I said "look, that is not something you scare people with, and that is not something you use to control mom to come home or not, like if I have to work I have to work. If you are seriously in trouble you call me I come, but you can't be calling me with this every second day and thinking you're gonna make me hop, cause that's not gonna work"

In sum, when mothers questioned their child's intention, they might think that the child was attempting to manipulate them and they felt guilty about this appraisal. Some mothers perceived subsequent threats as learning opportunities, where the child takes responsibility for their actions and

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learns the impact of making such statements. Some mothers were practical, firm, and confident in their approach. These mothers discussed the meaning and consequences of making statements that suggest suicidal intent with their child, while other mothers reverted to old parenting strategies, as they worried about the consequences of taking a detached and objective stance.

Chapter 6

Synthesis of the Theory

The synthesis of the theory integrates the primary findings and further delineates the relationships and interactions between the core categories and process factors. It is an interpretive level of analysis concerned with the inferred and implied meanings derived from the results. In other words, the synthesis is the final stage of analysis, and represents the final theory that has emerged from the data analysis.

This grounded theory proposes that mothers' process is characterized by the evolution of their perception of their child and of their role, which allowed for a strategic shift for the caregiver, from reacting to the child with the goal of alleviating the distress (i.e., emotional empathy) to responding with a pragmatic approach that aimed to address the particular stressor (i.e., cognitive empathy). Mothers utilized their new knowledge and skills when facing situations that could be anxiety provoking for the child. Despite these procedural phases of CBT implementation, mothers' process was not linear. They continuously shifted back and forth between perceptions of their child and of their role, particularly when they experienced discomfort regarding the methods (e.g., *balancing* and *feeling unnatural*) and when facing new situations. Figure 3 illustrates this process and reflects how mothers vacillated between different phases of implementation and parenting strategies when they are faced with new situations and challenges.

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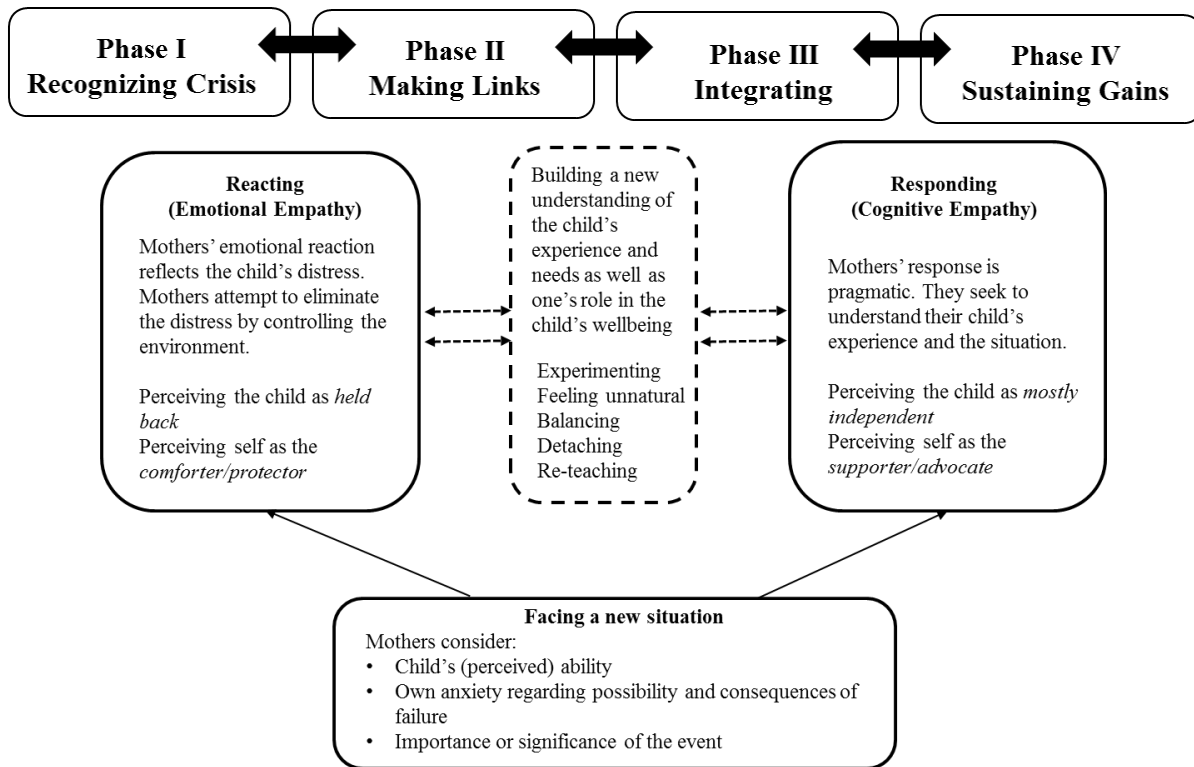


Figure 3. Synthesis of the Grounded Theory.

Mothers' process is characterized by a shift in parental strategy from reacting (emotional empathy) to responding (cognitive empathy) to the child's anxiety. Mothers may shift back and forth between these approaches.

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Shift in Parental Strategy

In the early stages of parenting an anxious child, mothers reacted to their child's symptoms with distress, helplessness, and confusion, which are reactions reflective of their child's experience and mothers' sense of lack of control. The emotional empathy initially experienced by mothers is an automatic reaction that occurs when the perception of distress or need in one's child activates similar behavioural and physiological responses in the mother (de Waal, 2007; Preston & de Waal, 2002; Smith, 2006). Mothers experienced the child's helplessness and distress as their own, and attempted to alleviate it. Mothers also had a perception of their child as being *held back*, and as being unable to cope with anxiety. They perceived themselves as the *comforter/protector* who must alleviate the child's distress and attempted to reassure and protect the child by controlling his or her environment and actions. Meanwhile, they did not address the underlying cause of distress and instead focused on alleviating the negative emotion. When mothers vicariously shared their child's negative emotions, they lost objectivity in the process of attempting to manage their child's anxiety. Mothers may have utilized strategies such as excessive reassurance and permitting avoidance that also served to alleviate their own apprehension and discomfort. They responded to their feeling of lacking control by imposing more restrictions on their child and his or her environment. Given that these approaches typically provided a short-term solution, mothers experienced further frustration, confusion, and feelings of lack of control when they realized that their strategies were not effective.

When mothers *made links* between the tenets of CBT and the child's symptoms, they developed a new awareness of the child's experiences and behaviours, which allowed them to change the perception of their role as well as their parenting strategies. For instance, mothers realized that the child's tantrum may be his or her way to express fear or that seeking reassurance only appeases the child's anxieties for a short period of time. Mothers therefore gradually *reappraised* the child's experience, abilities, and needs, which in turn allowed them to change their parenting strategies with the child. They *learned a new role* when they used the knowledge and strategies from the parent anxiety group, such as active ignoring or

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cognitive restructuring methods, as means to engage with the child differently. The new strategies provided mothers with control and assertiveness in situations that were previously experienced with helplessness, confusion, and frustration. Mothers who did not make links between theory and their own parenting spoke about the theory of detachment and rewards with frustration, but they did not describe their own engagement in the practice.

Mothers first began to practice CBT methods in the home with intentionality and rigidity, as they aimed to identify the methods that were effective for their child (i.e., *experimenting*). Those who were learning a new role may have experienced dissonance between what felt “right” as a *comforter/protector* and the directions of the CBT program (i.e., *feeling unnatural*). In these situations, mothers experienced guilt and apprehension about the consequences of using new parenting strategies. They may have reverted to old parenting habits (such as avoidance of anxiety provoking situations) as a way of decreasing their own discomfort caused by witnessing their child in distress. Mothers who took an informed and solution-based approach and who allowed themselves to push the child into more challenging situations began to perceive themselves as the *supporter*, who aims to understand and promote the independent use of CBT strategies. These mothers began to experience their child’s distress as distinct from their own, which facilitated the practice of new parenting strategies (i.e., *detaching*). Many struggled to balance the difficulty of the therapeutic methods with their perception of the child’s ability (i.e., *balancing*). During this stage, mothers worried about the potentially negative consequences of exposure exercises or active ignoring on their child, themselves, as well as their relationship with their child. For instance, mothers who continued to perceive their child as *held back* may worry that their child will not be able to regulate his or her anxiety and be “out-of-control”. They also anticipated discomfort when witnessing their child in distress or worried that implementation of CBT methods will deteriorate their relationship with their child, resulting in loss of trust or love. The theory proposes that worries about the consequences of CBT implementation for the child, self, and parent-child relationship, may underlie mothers’ tendency to waver between perceptions of the self as the *protector/comforter* and *supporter*, and the associated parenting

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strategies (i.e., reactive vs. pragmatic). As such, throughout the process of CBT implementation, mothers may shift in and out of various phases (*making links, Integrating*) and they face new challenges and worries.

The implementation of CBT was also challenged when mothers struggled to extend their knowledge and skills to another caregiver in the home, who may have had a diverging parenting strategy or be less open to change (i.e., *re-teaching*). If the spouse was unavailable, unable, or unwilling to implement the CBT strategies, mothers self-imposed the responsibility to single-handedly practice the new skills with the child. Their frustrations drove them to increase their efforts and to remain consistent and firm. Mothers who felt supported by their spouse however, were relieved when their partner agreed to develop a united strategy in regards to the child's anxiety. In these situations, caregivers approached the situation jointly and were less likely to experience conflict.

Mothers whose anxious child also made threats of suicide, expressed a wish to die, or who engaged in self-harm behaviours underwent additional challenges while they attempted to implement CBT at home. None of the mothers in the present sample indicated that their child had attempted suicide, and indicated that their child's symptoms consisted of thoughts of suicides ("I wish I was dead"), making threats of suicide in a specific event ("I'm going to kill myself if this happens"), and non-suicidal self-harm (e.g., deliberate cuts). In these situations, mothers experienced fear and confusion and they reached for the help of a mental health professional. Their primary goal was to prevent another incident. To protect their child, mothers may have utilized intrusive parenting strategies or accommodations that were counter-productive to the methods taught in the parent CBT program. That is, they may have been reluctant to ignore unwanted behaviour or establish boundaries, fearing the repercussions of their actions. Their concerns about the child's safety may have made it more difficult for them to make links between the contents of the parenting group, their child, and their parenting strategies, because they held on to their role as *protector/comforter* and contemplated the perceived risks of implementing these new strategies. Some mothers worked collaboratively with the therapist to understand the child's experience

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and needs, which allowed them to *establish a feeling of safety* for their child. When mothers felt that their child's symptoms of anxiety had dissipated or that he or she was *mostly independent* in coping with their negative emotions, some became concerned that their child was "bluffing" and felt manipulated by their child. Their impression was that their child occasionally made threats of suicide or engaged in self-harm behaviours as a way to get attention or to evade expectations and responsibilities, rather than having a true intention to harm him or herself. Although mothers expressed anger and frustration toward their child in these situations, they also expressed embarrassment and guilt about having such thoughts about their child. They felt that having such thoughts reflected poorly on them as a parent. When mothers *questioned the child's intentions*, they felt torn between the new strategies proposed by the CBT program and risking the child's safety. Some mothers were able to address these issues pragmatically, using subsequent threats as learning opportunities about the impact of making such statements, while others reverted to their old parenting strategies, further reassuring the child.

When mothers experienced success with the therapeutic methods, they began to perceive their child as *mostly independent*, as he or she demonstrated the ability to manage symptoms of anxiety independently and may have re-engaged with activities and people that had been previously avoided. This perception of the child allowed mothers to reduce their own involvement. As a *supporter*, mothers remained objective and calm when their child became anxious. Their involvement consisted of reminding the child of the "tools" that have been useful in the past. When mothers had *integrated* the tenets of CBT into their everyday parenting, they attempted to understand the child's experience and the particular needs of the situation, which allowed them to take a pragmatic approach to managing their child's behaviours and emotions. Mothers felt that detaching from the child's emotional experience and releasing control actually increased their sense of control over the situation, because they could approach it from an informed stance without experiencing discomfort or guilt. This reflects cognitive empathy in parenting, meaning that mothers took on the perspective of their child in an effort to understand the experience and the contextual factors that influence it (Smith, 2006). Parenting strategies guided by cognitive empathy

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suggest that the caregiver takes a problem- and situation-specific approach founded on the tenets of CBT, without letting her own or the child's emotions paralyze his or her decisions. Mothers felt in control of the situation, maintained a calm stance, and began to ask questions that increased their own and their child's understanding of the distressing situation. When guided by cognitive empathy, mothers no longer attempted to eliminate their child's distress, rather, they attempted to understand the child and promote the independent use of coping skills. Mothers gradually gained confidence in their ability to implement this approach consistently and perceive themselves as having control in their home as a caregiver.

When mothers felt comfortable with the improvements in the child's symptoms and their own strategies, they shifted their focus to the future because they were cognizant of the chronic nature of anxiety disorders and the potential challenges that the child might face. In response to this two-fold perception of their child (i.e., as independent yet needing ongoing support), mothers took on the role of *advocate* in addition to that of *supporter*. The *advocate* remains alert to changes in the child's life and signs of relapse, and she attempts to prepare for future challenges that may occur through natural life transitions. For instance, mothers anticipated that their child would be anxious when there is a substitute teacher, or that he or she will have difficulty adapting to life in high school. In anticipation of these difficulties, mothers may have contacted the school and requested that supports be put in place. Mothers' proactive and pragmatic approach reflects subtle insecurities about the child's and their own ability to cope with new challenges in the future. It may also reflect mothers' determination not to return to the pre-treatment conditions (i.e., *recognizing the crisis*).

Facing New Situations

Mothers used their new knowledge and skills when faced with new situations that could be anxiety provoking for the child, such as attending summer camp or a visit to the dentist. The present theory suggests that mothers' decisions were influenced by their personal assessment of the child's ability, by their own worries regarding the possibility and consequences of failure, as well as their subjective

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evaluation of the event's importance. These three factors interacted with each other and the particular context to influence mothers' decision-making process. Mothers' perception of their child and of their role may have influenced how they evaluated each of these factors, and consequently, whether they chose to proceed with an approach founded on emotional or cognitive empathy.

Although mothers experienced anxiety in the decision-making moment, they were primarily influenced by anticipated factors, that is, expectations of emotions that will be experienced in the future because of the decision (Loewenstein, Weber, Hssee, & Welch, 2001). Mothers focused on the consequences if their child failed and was unable to take part in the activity or event. For their child, failure may have resulted in embarrassment, loss of confidence, and sadness. Mothers were also concerned about the consequences of their child's failure for themselves, such as having to pick up the child from the event, making arrangements at work, damaging the parent-child relationship, or experiencing guilt. These thoughts and emotions were experienced despite knowing that the "preferable" decision according to CBT theory was to encourage exposure and prevent avoidance. As a result, mothers often hesitated to expose their child to these new situations, sometimes despite their child being excited or adamant to do so. Even mothers who had integrated the tenets of CBT and who identified as a *supporter* might have regressed to earlier phases of implementation, if they anticipated negative outcomes. Those who continued to perceive their child as *held back* or oneself as *comforter/protector* may have avoided the new situations, and adopted parenting strategies founded on emotional empathy. Mothers may therefore have attempted to prevent the experience of distress for their child and for themselves. Mothers who perceived their child as capable to cope with anxiety however, and who perceived the consequences of failure as manageable may have been more likely to engage with new situations with confidence. They might have taken a pragmatic approach founded on cognitive empathy and appraised the new situation as an opportunity to practice and develop adaptive coping skills.

In situations that involve "non-negotiables" such as doctors' appointments, mothers' perception of the event's importance superseded their child's and their own apprehensions in influencing their decision-

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making process. Mothers evaluated the risk of the decision (e.g., going to a dentist appointment or birthday party) as well as the social norms associated with each decision (Dore, Stone, & Buchanan, 2014). Given the socially valued factor of risk aversion for physical safety (Stone, Choi, Bruine de Bruin, & Mandel, 2013), mothers were unlikely to avoid a doctors' appointment but considered avoiding a social event. Consequently, in situations involving safety and health, mothers likely opted for exposure, because they evaluated it as being imperative to their child's wellbeing. However, they may have chosen to miss the birthday party if they did not value the experience of attending such an event, and instead gave emphasis to the consequences of failure for the child and for themselves.

Finally, for some mothers, occasionally avoiding situations that were not essential to the child's wellbeing was a way to avoid conflict or difficult interactions with their child (i.e., choosing your battles). Mothers may have anticipated a tedious conversation or defiance from their child, or they may have felt that they did not have the time and energy to expend on implementing CBT methods in this particular situation. Ultimately, they "chose their battles" when they felt that the consequences of missing a particular event were negligible compared to the tedious process of promoting exposure through the use of cognitive restructuring, gradual exposure, or relaxation strategies. When new situations that could generate anxiety for the child arose, the present theory suggests that mothers' perceptions, predictions, and contextual factors interact in this complex process to influence mother's course of action.

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Chapter 7

Discussion

The current study examined the process that mothers undergo when implementing CBT at home with an anxious child after participating in a parenting group. The qualitative approach of grounded theory was employed to answer the following research questions: 1) what internal and external factors shape the implementation of CBT at home for mothers who participate in a group for parents of an anxious child? 2) What is the process of change in parenting when implementing CBT at home with an anxious child? 3) How is CBT implementation impacted when a child, in addition to their anxiety, presents with signs of suicidality and/or self-harm behaviours? The key finding is a theory of change in mothers' perception of their child and of their role that allows for a shift in caregiving strategies from reacting with emotional empathy to responding with cognitive empathy. The resulting theory lends insight into parental involvement and adds to the existing literature by explicating change in parental perceptions and actions, highlighting nuances in at-home CBT implementation, and extending existing theories. The findings have potential implications in regards to targets of intervention in parent-centered treatments for childhood anxiety, as well as means for therapists to engage and support mothers in this process.

This chapter discusses study findings and situates them within the larger context of parental process and perceptions as well as parent involvement in the treatment of their child. The findings are presented in terms of mothers' process and experiences, the role of mothers' cognitions, the challenges they face while implementing CBT, as well as mothers' decision-making process. Finally, the distinct experiences of mothers whose anxious child also made threats of suicide, has thoughts of suicide, or who engaged in non-suicidal self-harm behaviours are discussed in the context of relevant literature. The findings' implications are used to make recommendation for practice and for future research directions. The chapter concludes with a discussion of the study's limitations.

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Mothers' Process and Experience

The current theory that emerged from the analysis maps onto the work of researchers who examined the process of caregivers who participated in intervention programs for parents of children with externalizing disorders such as conduct disorder and oppositional defiant disorder (Holtrop et al., 2014; Spitzer et al., 1991). Holtrop et al. (2014) found that the gradual process of change occurs as parents attempted a method, appraised its effectiveness, and continued to apply it when deemed necessary. Spitzer et al. (1991) described the process as a gradual increase in parents' perception of control, knowledge, and competence. The parental experiences and process described by Holtrop et al. (2014) and Spitzer et al. (1991) are comparable to those that have emerged in the present study. Mothers in the present study expressed apprehension regarding loss of control, similar to Spitzer et al.'s findings (1991). Parents of children with externalizing disorders and mothers in this study found it challenging to adopt new parenting strategies and to have trust in their effectiveness. They also worried about being unable to control their child if his or her behaviours and emotions escalated. The issues of perceived control is therefore prominent in parental involvement in both childhood anxiety and externalizing disorders. Mothers in the present study also acknowledged the ongoing nature of their child's needs and expressed the importance of preparing and planning for future challenges (i.e., being an *advocate*). Similarly, Spitzer et al. (1991) propose that parents of children with externalizing disorders re-evaluated their expectations of their child and prepared themselves for future challenges. Overall, parent-centered programs for childhood psychopathology may elicit a similar process and experience in parents regardless of the targeted disorder, particularly in regards to perceived control.

Unlike theories proposed for parents of children with externalizing disorders, mothers of anxious children also worried about adequately *balancing* the use of CBT strategies with the child's ability. The current theory proposes that this apprehension is rooted in mothers' perceptions of their anxious child. That is, mothers in the present study appeared to have engaged in the parenting program perceiving their

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child as *held back* and unable to cope, which is concurrent with findings that mothers of anxious children are less confident in their offspring's abilities and expect more negative emotionality from them compared to mothers of non-anxious children (Kortlander, Kendall, & Panichelli-Mindel, 1997).

Kortlander et al. (1997) compared the attributions of mothers of anxious children and mothers of non-anxious children regarding a stressful task. They found that mothers of anxious children rated their child as being more upset, as having poorer coping abilities, and were less confident in their child's ability to perform on a public speaking task compared to mothers of non-anxious children. Coordinating the difficulty of the exercises with the perceptions of the child's ability (i.e., "how much do I push?") is therefore an additional challenge for mothers of anxious children to overcome. Mothers may consequently be more prone to expect failure and to worry about the consequences of CBT implementation, which could deter consistent implementation of CBT strategies. These challenges reflect the importance of exploring and understanding mothers' perceptions of their child when they are involved in the implementation of CBT.

Mothers' Perceptions of the Anxious Child and Their Role

The current theory proposes that the perception of the child as being *held back* and unable to cope, coupled with perceptions of the self as being *comforter/protector* underlie parenting strategies guided by emotional empathy as well as maternal behaviours that have been characterized as intrusive and over-controlling (e.g., Hudson, Comer, & Kendall, 2008; Krohne & Hock, 1991; Rubin, Burgess, & Hastings, 2002). Parents who were less confident in their child's ability to complete a task (e.g., Kortlander et al., 1997), expected negative outcomes from the child's behaviour (Francis & Chorpita, 2009), or predicted that the child would become anxious or upset (Wheatcraft & Creswell, 2000), may have been more likely to intervene in a difficult situation. This theory adds to the literature by proposing that mothers of anxious children also empathized with the child's actual or anticipated emotional distress, which can result in self-focused distress, discomfort, and apprehension (Batson, 1991). Although

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mothers' emotional empathy initially allowed them to direct their attention to their child's needs (Hoffman, 2000), vicariously experiencing their child's negative emotion also caused them to lose objectivity in the process of attempting to manage their child's anxiety. Although focusing on attenuating their child's and their own distress provided a short-term solution, over-empathizing with the child's distress may have led mothers to intervene pre-emptively, thereby preventing the child from developing coping skills.

According to the present theory, the evolution of mothers' perceptions, which is facilitated by a new awareness of the child's experiences and needs, underlies the shift in parenting strategies from reacting with emotional empathy to responding pragmatically with cognitive empathy. Responding with cognitive empathy implies that mothers sought to understand the mental state of their child, beyond his or her emotional reaction (Preston & de Waal, 2002). They did this by asking questions that elicited exploration of the child's emotional, behavioural, and cognitive experience (e.g., "What do you think is going to happen?"). Gaining an understanding of the child's experience was not only an opportunity for the child to gain awareness in his or her own experience, it also allowed mothers to distance themselves from the emotional valence of their child's experience and utilize more effective coping strategies. Mothers therefore ceased to react to their child's distress with mirrored emotion. For this reason, mothers' reappraisal of their child's experiences and of their own role was a fundamental step in the process of CBT implementation.

This theory also serves to elucidate the relationship between perception of control over childrearing and parenting strategies. The process of CBT implementation reflect a gradual increase in mothers' sense of perceived control over their parenting skills and their ability to manage their child's symptoms. Concurrently, they discovered that their child's maladaptive behaviours could be managed by detaching and releasing control. Research suggests that parental cognitive processing such as perception of control over childrearing impacts parenting and parent-child interactions (Bugental & Johnston, 2000;

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Wheatcraft & Creswell, 2007). Wheatcraft and Creswell (2007) found that mothers who perceived their child as more anxious also perceived themselves as being less able to control their child's negative emotional experience compared to mothers who perceived their child as less anxious. Perceptions of lack of control over caregiving were also associated with predictions of failure in regards to one's parenting strategies, as well as the use of parenting strategies characterized by control (Bögels & Brechman-Toussaint, 2005). The findings from the current study support hypotheses that parental beliefs about their childrearing ability and attributions of their child's behaviours contribute to the use of parenting strategies that have been linked with the maintenance of childhood anxiety disorders (Bögels & Brechman-Toussaint, 2005; Bugental & Johnston, 2000). The findings extend the current literature beyond a behavioural conceptualization of parental strategies by integrating a conceptualization of mothers' perceptions in the process. In CBT, biased thoughts and perceptions, which underlie avoidant behaviours that maintain anxiety, are examined, and reappraised (Beck, 1995; Kendall & Suveg, 2006). Hence, from a CBT perspective, an examination of caregivers' cognitions is a prerequisite to understanding parental strategies (Kortlander et al., 1997) and can serve to develop parent or family-focused interventions (Kendall et al., 1992).

In summary, understanding parent-centered CBT implementation through the caregivers' perception of their child and of themselves could imply targets of intervention in parenting programs, where cognitions regarding the child, the role of the parent, and perceived control could be reappraised and replaced with more adaptive and representative perceptions. These findings therefore motivate the inclusion of parental cognitions about their child and about their role into parent-centered interventions, with the expectation that targeting parental cognitive biases related to their child's ability and their own role could generate change in parental strategies.

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Challenges Faced by Mothers while Implementing CBT

The findings from the current study bring to the forefront the challenges faced by mothers of anxious children in the process of implementing CBT. This new understanding complements and extends the transfer of control model (ToC) (Silverman et al., 1995; Silverman & Kurtines, 1996), which is a prominent model of parental involvement in the treatment of childhood anxiety disorders proposing that therapeutic knowledge and skills are transferred from the therapist to the parent and from the parent to the child. This section summarizes the challenges faced by mothers while implementing CBT at home with their anxious child and highlights three ways in which the findings serve to expand the ToC model in regards to mothers' experiences, responsibilities, and long-term needs.

The data indicate that a prominent challenge faced by mothers is the experience of *feeling unnatural* while ignoring maladaptive behaviours (e.g., tantrums or reassurance seeking), or “pushing” their child to engage in anxiety-provoking situations. Mothers experienced dissonance between the rationale of CBT that required them not to engage emotionally with the child and their perception of their role as *comforter/protector*. The ToC model refers to a similar experience as the “protection trap”, where parents' own feelings of anxiety prevents consistent implementation of contingency management and exposure exercises (Silverman et al., 1995; Silverman & Kurtines, 1996). Silverman et al. (1995) suggest overcoming the protection trap by encouraging parents to focus on the counterproductive impact or potential secondary gains associated with these parenting strategies. According to the present findings, reappraisal of mothers' perceptions of their role in the child's wellbeing could also address these apprehensions. Mothers could examine and re-evaluate cognitive distortions such as “I'm withholding something from my child” or “this is going to hurt my child”. A focus on the mothers' personal thoughts and experiences, as opposed to the unwanted consequences of parenting strategies, may serve to engage mothers in the therapeutic process, integrate the tenets of CBT, and generate change in regards to her perception of her role.

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Mothers in the current study found it challenging to disseminate their new knowledge and skills to others, particularly their spouse, in addition to the child, who was the original target. They indicated that this approach was often associated with conflict rather than enthusiasm, especially if parents did not make an agreement to “get on the same page” regarding their approach to the anxious child’s behaviours. This finding is novel when mapped onto the model proposed by Silverman and colleagues, which suggests that the transfer of knowledge and therapeutic skills is primarily linear, occurring from therapist to the parent, and from the parent to the child (Silverman et al., 1995; Silverman & Kurtines, 1996). The current theory therefore builds on the ToC model, incorporating how mothers extend their knowledge in multiple directions, beyond the anxious child. These findings not only suggest that mothers could benefit from additional support and skills when faced with the need to re-teach therapeutic skills, but also imply that parent-centered groups could do more to involve spouses in this process. For instance, caregivers could be trained to explain the primary tenets of CBT and the rationale for treatment, and encourage caregivers to share this knowledge with their significant other when there is no imminent crisis. Caregivers who participate in the group could also be encouraged to involve their significant other in the assigned homework.

Finally, in the present study, mothers expressed concerns regarding natural transitions such as adolescence and attending high school. As an *advocate*, mothers were uncertain of how to proceed when they realized that their child might require ongoing supports and accommodations. This finding points to a gap in the structure of existing parenting programs and highlights the potential benefit of booster sessions to facilitate transitions and maintain practice in the long-term. Booster sessions in CBT for anxiety allow time for clients to implement the CBT skills, and return to the treatment setting with questions, challenges, or success stories. The therapist can then assist with problem solving, troubleshooting, and generalization of the skills learnt in previous sessions (e.g., Shortt, Barrett, & Fox, 2001). Existing parenting programs do not include booster sessions, despite the fact that they are considered a core maintenance strategy in child-focused CBT programs (Eyberg, Edwards, Boggs, &

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Foote, 1998; Kendall, Safford, Flannery-Schroeder, & Webb, 2004; Whisman, 1990). Given the challenges faced by mothers in the current study after termination of the group, pre-scheduled booster sessions with mothers of anxious children at crucial developmental periods could relieve the anxiety associated with being an advocate and possibly improve long-term implementation.

The current theory brings to forefront challenges faced by mothers when implementing CBT with their anxious child. Although their overall process is largely akin to the ToC model (Silverman et al., 1995; Silverman & Kurtines, 1996), the present theory provides a deeper understanding of the process undergone by mothers as they attempt to transfer CBT practices into the home environment. The theory also accounts for the internal and external processes that influence therapeutic engagement as well as the long-term implementation of CBT skills, implying novel ways to overcome these challenges.

Facing New Situations

When faced with a new situation that could generate anxiety for the child, mothers chose to either engage with the event as an exposure exercise or avoid it. This theory suggests that when faced with a novel dilemma, mothers' decisions was influenced by their personal assessment of the child's ability, by their perceptions of the possibility and consequences of failure, as well as their subjective evaluation of the event's importance. The stage at which they faced these new situations and the role with which they identify would therefore influence their decision making process. Mothers who perceived their child as capable of coping with the anxiety-provoking situation, and who were capable of inhibiting their own negative emotions would have been more likely to propose exposure over avoidance compared to mothers who expected failure or who perceived themselves as needing to protect their child. For this reason, a realistic appraisal of the child's capacity and consequences of failure are important in ensuring that mothers make decisions congruent with the CBT model when faced with novel situations. This finding further emphasizes the importance of evaluating caregivers' cognitions when they become involved in the CBT implementation process.

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When faced with “non-negotiable” situations that could influence the child’s health and safety, mothers may overlook the consequences of failure and the distress that may result for the child and for themselves. Parents tend to avoid risk when making health and safety decisions (Dore et al., 2014) and consider the social norms associated with the decision or event (Stone et al., 2013). From the mothers’ perspective, missing a doctor’s appointment implied more risk and was less socially acceptable than missing a birthday party (i.e., a “negotiable” event). Mothers may have conceded to their child avoiding a birthday party because it is not directly related to his or her health and safety, but they would not allow the child to miss a doctor’s appointment. If mothers perceived the value of attending a “negotiable” social event differently, they might have been more likely to promote exposure rather than avoidance. This theory offers a new grasp of mothers’ decision-making process when faced with new potentially anxiety-provoking situations, which may allow clinicians to better support and guide them through this process. For instance, clinicians can encourage caregivers to examine their own perceptions of their role, of their child, and of the event’s significance in order to identify potential cognitive biases that influence their decision making process. This approach sets the stage for the incorporation and practice of cognitive restructuring methods.

The Importance of Establishing Safety

The composition of the sample in the present study allows the examination of the influence of signs of suicidality on the understanding of parental process and CBT implementation. In this sample, the anxious child’s suicidality and self-injurious behaviours included thoughts of suicide (“I wish I was dead”), making threats of suicide (“I’m going to kill myself if this happens”), or self-injurious behaviours that did not cause life-threatening injury. Mothers had a tendency to react their child with helplessness and sadness and subsequently increased their supervision as well as their tendency to comfort and accommodate the child. Their experience is consistent with research showing that parents of children who engaged in non-suicidal self-harm report “walking on eggshells” around their adolescent, for worry of

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instigating an episode (Oldershaw et al., 2008). Mothers in the present study, similar to parents of children whose self-harm behaviour instigated a visit to the emergency room, reported confusion, as well as a sense of self-blame and guilt (Raphael et al., 2006). Caregivers experienced anger, helplessness, and sadness and they attempted to make sense of the child's behaviours while preventing another incident by controlling their child's environment (Raphael et al., 2006). For mothers in the current study, these emotions and apprehensions prevented them from engaging in the therapeutic process (i.e., *making links*) until they had established their child's safety. This process is consistent with research indicating that parents of children and youth with a history of self-harm are worried about implementing boundaries that may be perceived as severe (Oldershaw et al., 2008).

The scope of the data only speaks to mothers' experience of their child's statements and actions, and cannot determine the child's intention and experience when threats of suicide were made or when he or she engaged in self-injurious behaviours. Mothers in the present sample worked collaboratively with mental health professionals to understand the nature of their child's symptoms and establish a place of safety for him or her. When mothers felt that their child's symptoms of anxiety had dissipated and that he or she was able to cope with anxiety effectively, some began to question their child's intention when subsequent threats of suicide or self-injurious behaviours occurred. With reluctance and embarrassment, some mothers in the current study expressed concerns that their child was "bluffing" and felt manipulated by their child when he or she made threats of suicide or expressed thoughts of suicide. Despite these feelings, they were worried about the consequences of utilizing certain CBT methods such as ignoring unwanted behaviours. This finding corroborates with those of Raphael et al. (2006), who interviewed parents of children who had engaged in deliberate non-suicidal self-harm. After discovering their child's non-suicidal self-injuries, parents experienced guilt when compromising their typical parenting approach to accommodate the child's perceived sensitivity. Parents felt that their child had power over their childrearing and discipline practices while experiencing fear of another attempt. They found themselves

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tor between compromising their fundamental parenting values and the potential impact of returning to previous parenting strategies (Raphael et al., 2006).

Pediatric anxiety disorders, particularly generalized anxiety disorder, have been linked with thoughts of suicide and suicide attempts, even after controlling for symptoms of depression and stressful life events (Boden et al., 2007; Gould et al., 1998; Nelson et al., 2000; O'Neil et al., 2012; Sapyta et al., 2012; Wunerlich et al., 1998). Threats of suicide and non-suicidal self-harm have been conceptualized in the literature as being associated with suicidal intent (which may involve planning) as well as suicide attempts (Hamza, Stewart, & Willoughby, 2012; Haw, Bergen, Casey, & Hawton, 2007). They are also often indicators of a depressive disorder (Portzky & van Heeringen, 2007, for a review). Mothers' concerns for their child's safety are therefore comprehensible and warranted, as the child may require additional support and a different treatment plan. Self-harm behaviours have also been shown to serve the purpose of self-regulation of negative affect, allowing the individual to express and temporarily relieve self-directed feelings of disgust or anger (Klonsky, 2007). In adult clinical populations, threats of suicide have been found to have an interpersonal component, including manipulative intentions (Wedig, Frankenburg, Bradford, Fitzmaurice, & Zanarini, 2013). The literature suggests that interpersonal influence – seeking help or manipulating another - is one of seven motivations for self-injurious supported by the literature (Klonsky, 2007). That is, in some contexts, making a threat of suicide (e.g., "I'm going to kill myself if this does not go away") or engaging in non-suicidal self-harm behaviours may not reflect an intent to attempt to kill oneself. Nevertheless, for parents who aimed to protect their child, discerning their child's intentions was a difficult and complicated distinction to make. It is the clinician's responsibility to conduct a thorough suicide risk assessment in order to determine intent and risk, which will ultimately influence the treatment plan. Mothers who questioned their child's intention recognized a pattern in their child's behaviours, which alerted them that he or she might be resorting to threats of suicide or non-suicidal self-injury to express a need for help, not to express a suicidal intent. However,

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they felt embarrassment and guilt in expressing these observations. Some mothers – who felt that their child was safe - trusted this hunch; they chose to approach these threats pragmatically and distanced themselves from the emotions elicited by the situation. Doing so allowed them to ask questions about the child's experience in an attempt to understand and respond adequately.

The current theory therefore brings to awareness an important experience for mothers whose child made threats of suicide or engaged in non-suicidal self-harm behaviours, as well as the stigma that accompanied experiences of anger and frustration directed toward the child. The findings provide a better understanding of mothers' experiences, thereby promoting and facilitating tackling of these topics by clinicians. These findings highlight the importance of a collaborative relationship between parent and therapist that begins with a shared understanding "safety" and of functions of the child's symptoms. When an anxious child also made threats of suicide or engaged in self-harm behaviours, mothers may require additional support and preparation to ensure therapeutic engagement and adequate implementation of CBT skills.

Practice Recommendations

The theoretical process and constructs that results from the present study suggest practice implications as well as avenues for future research. The current theory suggests that the process of CBT implementation by mothers of anxious children is characterized by the evolution of mothers' perception of their child and of their themselves. This finding suggests that practitioners working with mothers of anxious children could be mindful of these parental cognitions and incorporate these emotional, behavioural, and cognitive patterns in their practice. This recommendation is congruent with those made by Wheatcraft and Creswell (2007) who proposed that mothers' perceptions may be important targets of intervention in the parent-centered CBT program for childhood anxiety.

In the context of parent-centered programs for childhood anxiety, therapists could encourage parents to make links between the psychoeducational content and parents' own life circumstances. This

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practice may promote therapeutic engagement, which is particularly important when working with parents because they are the gatekeepers to consent, access, and ongoing involvement (Nock & Ferriter, 2005). Furthermore, when introducing CBT skills such as cognitive restructuring, parents could be encouraged to apply this knowledge to their child, self, and their home. Therapists could support parents' exploration of their own as well as their child's experience, particularly in regards to their role in their child's wellbeing and their child's perceived ability to overcome his or her anxiety. The focus on mothers' perception could help mothers overcome the challenges of *feeling unnatural* when they implement methods such as active ignoring. Exploring and re-evaluating thoughts such as "I'm a bad mother if I ignore my child's need for reassurance" or "She will lose control if I don't intervene" may allow mothers to approach crises pragmatically without engaging in an overly emotional matter that may perpetuate symptoms. The present theory therefore highlights the potential importance of incorporating mothers' cognitions throughout the therapeutic process and future research could examine whether parent-centered programs influence these cognitions and whether altering mothers' cognitive biases may generate changes in their parental strategies.

The proposed theoretical model exposes challenges that mothers of anxious children experience, which is valuable to therapists working with this population as well as mothers who become involved in implementing CBT with their anxious child. Mothers who attempted to implement CBT in the home experienced frustration and confusion during specific situations and periods. For instance, therapists may expect to support mothers who find themselves in the process of *re-teaching*, where they struggle to extend their new parenting strategies to the other caregivers in the home or extended family members. Mothers may require additional assistance with communication skills and problem solving when extending their knowledge and skills to other caregivers in the child's life. Furthermore, therapists could also encourage parents, whenever possible, to attend the parenting program together, in order to develop a unified approach to the management of their child's symptoms (i.e., *getting on the same page*). Therapists

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could also be cognizant that mothers may require support when their anxious child reaches natural transitions such as adolescence. Furthermore, future research could examine whether booster sessions, which are considered a core maintenance strategy in child-focused CBT programs (Eyberg, Edwards, Boggs, & Foote, 1998; Kendall, Safford, Flannery-Schroeder, & Webb, 2004; Whisman, 1990) would be a valuable addition to parent-centered programs. Supporting this recommendation is research demonstrating that the expectation of booster sessions alone may have a pre-emptive beneficial impact before termination of treatment in anticipation of the scheduled sessions (Gearing, Schwalbe, Lee, & Hoagwood, 2013). In a parent-centered program, booster sessions could describe how anxiety can manifest itself and impact youth during life events that were seemingly most stressful for mothers in the current sample, such as transition into high school, increased academic workload and social pressures, and puberty. It may also give mothers strategies to communicate and work collaboratively with external stakeholders in their child's life, such as school personnel. Such an approach would presumably help facilitate transitions and maintain ongoing implementation of CBT skills.

The theory proposed in this study explicates mothers' decision-making process when faced with a new anxiety-provoking situation for the child. These events can occur at any point during CBT implementation; hence, mothers may or may not have made links, integrated the practice, or be sustaining gains. Future research could therefore examine how mothers' perception of the child, their concern about failure, and their evaluation of the event's significance interact and influence decision making by the caregiver. Therapists may assist mothers with the reappraisal of anxiogenic cognitions regarding the child's ability, as well as the possibility and consequences of failure, with the aim of promoting exposure rather than avoidance when faced with these decisions. Therapists could also help mothers reappraise the value of events that are perceived as "negotiable", because increasing the social value associated with these would presumably promote exposure.

Future Research Directions

The present theory proposes that in parent-centered CBT for childhood anxiety, mothers shift their cognitions of their child and of themselves, and begin to approach anxiety-provoking situations with cognitive empathy – founded on understanding and evaluation of the situation – rather than emotional empathy aimed at mitigating negative affect. The theory therefore introduces lines of research that could further explicate the role of parental cognitions in the treatment of childhood anxiety disorders.

The literature on the cognitions of parents of anxious children has examined their expectations of their anxious child's ability to cope, perceptions of threat, as well as their beliefs about anxiety (Creswell & O'Connor, 2006; Francis & Chorpita, 2011; Kortlander et al., 1997). Positive correlations have been identified between mothers' expectations of their child's distress and the child's anxious cognitions (Creswell, O'Connor, & Brewin, 2006) as well as between parents' beliefs about the harmful nature of anxiety and the child's anxiety (Kortlander et al., 1997). Mothers' perception of control over childrearing has also been shown to be associated with their own anxiety, rather than their child's anxiety (Wheatcraft & Creswell, 2007). Perception of lack of control - which is an experience reported by mothers in the present study - has also been associated with use of controlling parenting strategies (Bögels & Brechman-Toussaint, 2005). Nevertheless, the relationship between mothers of anxious children's cognitions and their actual parenting strategies remains unclear. This relationship could be tested by examining whether mothers' perceptions of their anxious child as well as perceptions of their role, are predictive of the use of controlling and over-involved parenting strategies. Future research could also examine whether parent-centered program are associated with changes in parental cognitions, and as suggested by others, (Forehand et al., 2013; Kendall et al., 2012), determine whether changes parental strategies accompany participation as well.

The parenting shift from emotional empathy to cognitive empathy could be examined by exploring both mothers' perceptions as well as their parenting strategies when they undergo the process of CBT implementation with their anxious child. Emotional empathy would be characterized by high

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parental distress or helplessness, use of overprotective and controlling parenting strategies, and perceptions of lack of control. Cognitive empathy would be characterized by parental confidence, use of effective strategies founded on tenets of CBT (e.g., seeking to understand, promoting exposure, cognitive restructuring), and perceptions of control over childrearing. Parental outcome measures should also be assessed by examining parents accommodations of the child's symptoms (e.g., changing routine to prevent a tantrum, provide reassurance, permitting avoidance), parent psychopathology, family dysfunction or stress, parental attributions of the child's behaviours, as well assessment of cognitions relating to the child and to the parent's role. Such an approach may improve effectiveness of interventions by determining which parental factors are impacted by parent-centered programs and whether these lead to the desired clinical outcomes.

The current theory suggests that before participating in the program, mothers' perceptions drive the use of parenting strategies aimed at mitigating negative affect in the child and in themselves, and at removing the source of anxiety through avoidance of anxiety provoking situations. Through the implementation of CBT methods, mothers began to engage with their anxious child with the intention of addressing the underlying cause of their anxiety through discussion and problem solving. Consequently, before treatment, mothers' interactions with their child served to alleviate negative affect (e.g., "why don't you stay home instead of going to the birthday party?"). Post-treatment interactions however, focused on understanding, problem-solving, promoting use of CBT strategies, as well as re-appraisal (e.g. "what do you think is going to happen; what helped you last time you felt this way?"). Future studies could examine changes in the nature of parent-child interactions before and after treatment at varying time intervals, in relation to mothers' perception of their child (i.e. as *held back* vs. *independent*) and of their role (i.e., *protector/comforter* vs. *supporter/advocate*). Such lines of study would serve to identify mechanisms of change and clarify links between parent perceptions and parenting strategies.

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The present study also sheds light on processes, relationships, and events that may require further inquiry. For instance, the involvement and process of fathers in the implementation of CBT remains unclear, particularly when they do not take part in the parenting group. These fathers may find themselves receiving new information and may be required to modify their own parenting approaches. Future research could examine how they navigate this process and the internal and external factors that influence it. Similarly, the theoretical subsample in this study is unlikely to be saturated. Future studies could continue the exploration of parents' process when they undertake a therapeutic role with a child who has shown signs of suicidality.

Limitations

The current project lends insight into the process that mothers of anxious children undergo when implementing CBT. However, several limitations related to design and qualitative methodology should be considered when interpreting the findings from this project.

Sample

The present study only included interviews from mothers of anxious children, thereby omitting the valuable role of fathers in the implementation of CBT. Early in the data collection process, it was evident that mothers generally took part in the parenting group alone. Given that taking part in the parenting group was a prerequisite for participation, the small number of fathers who took part in the group, and difficulties with scheduling appointments with both parents, it was decided to focus solely on mothers' process. Mothers in this study also self-ascribed a management and primary implementer role in regards to CBT. Nevertheless, participants from two-parent households acknowledged the importance of their spouse in the process. Given the findings regarding the process of *re-teaching*, future research should examine fathers' role when learning from mothers who take part in a parenting-group, as well as the way they translate and implement CBT with their anxious child.

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All but one participant in the present study expressed positive opinions regarding the group content and delivery, which may reflect self-selection bias. The choice to take part in a particular study may reflect inherent bias in participants and could have influenced the final theory. It was difficult to gauge mothers' opinions of the parenting group before the interview, but during recruitment, mothers were encouraged to participate regardless of whether their experience had been positive or negative. As such, mothers who agreed to volunteer their time were likely committed and willing to provide more insight into their experiences. Mothers who were unhappy with the program may have been more likely to terminate prematurely or choose not to take part in the study when invited. Nevertheless, participants who were not entirely satisfied or had negative experiences could have provided valuable insight into their process, perhaps allowing improvement of the content or delivery.

Method and Researcher Limitations

Another potential limitation of this study is related to researcher bias, because all of the interviews, analysis, and interpretation of the data were conducted by one researcher. As described in the Methods and Rigor Chapter and the Reflexivity Chapter, a number of strategies to limit this bias were undertaken, such as seeking supervision at every stage of data collection, analysis, and interpretation and presenting the data to a research steering committee. This served to ensure the transparency of approach and credibility of the findings (Lincoln & Guba, 1985). However, in qualitative research and particularly constructive grounded theory, the researcher is perceived as a research instrument (Charmaz, 2014) and his or her perspective are part of theory development. As such, having a single individual collect data also presents an advantage in regards to consistency of approach and content, as it ensured that new possible lines of inquiry were followed spontaneously during interviews and that subsequent interviews built on previous findings. This allowed the researcher to uncover nuances in the data that could have been lost if multiple individuals collected data and ultimately adds depth to the findings.

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In this study, mothers were asked to recall their experiences and process before, during, and after taking part in a parent-centered group. Their recollection of events and affective states at the time of data collection may or may not have been different from their experience when the events originally transpired. Their present vantage point may therefore have been influenced by current contextual factors (e.g., life stress, child's present symptoms) and perception of the interview questions. Furthermore, despite efforts to build a therapeutic relationship, mothers may have censored their experiences due to embarrassment or discomfort. These limitations are inherent in retrospective studies, but are important to consider in a constructivist grounded theory, where meaning is co-created by the researcher and participant. A longitudinal approach to data collection, where interviews are conducted at various points in the process of CBT implementation may provide a developmental and interactional perspective on this process.

Conclusion

The lack of consistent evidence that parental involvement in the treatment of childhood anxiety can provide additional benefits beyond child-centered interventions has been attributed to the lack of a theory of change and model of parental involvement (Breinholst et al., 2012; Taboas et al., 2014). The current study uncovered a theory of mothers' implementation of CBT founded on mothers' perception of their child and of their role and a shift from emotional to cognitive empathy. The theory provides a novel lens and deeper understanding of the process and nature of parent involvement, which has otherwise been operationalized as a quantitative measure, such as number of sessions or time spent in therapy. These findings widen our understanding of parent involvement in the treatment of childhood anxiety disorders and bring to light continuous environmental challenges and experiences that shape CBT implementation in the home in the long-term. The theory explicates mothers' decision-making process when faced with novel anxiety-provoking situations and elucidates mothers' experiences when the child presents with signs of suicidality. Finally, the theory allows clinicians working with mothers of anxious children to

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provide better support, anticipate difficulties, and respond accordingly. It also opens new lines of inquiry, generating hypotheses regarding parent involvement in the treatment of pediatric anxiety disorders, and proposes novel research avenues that aim to improve clinical outcomes.

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Appendix A Ethics Clearance

Ethical approval for this study was granted by the Queen's University Health Sciences Research Ethics Board. Access to potential research participants was gained through the tertiary mental health setting where the CBT group for parent of anxious youth was offered. The letter of information sent by mail (Appendix B) outlined participants' rights regarding participation, the theoretical orientation of the study, the research question, as well as relevant contact information. Parents were informed that choosing not to participate or withdrawing their consent would not result in negative consequences regarding their relationship with Hotel Dieu Hospital or Queen's University. They were notified that they can choose not to answer any questions. In terms of informed consent, the research questions (under what conditions do parents attempt to carry out CBT in the home; how do these conditions shape the implementation of CBT in the home; how does the transition from parent to "at-home-therapist" take place?) were clearly outlined on the letter of information and consent form. By consenting to take part in the study, parents also agreed to be audio-taped during the interview. Informed consent included the manner in which the data were to be analyzed and published. Parents were informed that data, once transcribed and anonymized, were reviewed by the primary researcher as well as a steering committee comprised of other parents, clinicians, and researchers. They were also informed that anonymized quotes might be used in the publication of the study, which is expected to take place in the form of academic posters and research papers.

To ensure confidentiality, parents and their child were be given family ID letters. Their children and spouse were only be referred to by their gender and role. Furthermore, the audiotapes of the interviews and transcripts were be stored electronically and encrypted using the TrueCrypt software (<http://www.truecrypt.org/>).

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Ethical Issues Specific to the Research Steering Committee

Due to the nature of the method, anonymity is not possible during research-steering committee meetings. Since the researcher has no control over information sharing after the meeting (Stewart & Shamdasani 1990), members of the research steering committee were not guaranteed confidentiality (Appendix B). However, they were asked to sign a consent form that included a confidentiality agreement. In addition to the typical information regarding research participation (i.e., methods, goals, rights of the participants, research ethics board's contact information) it asked that participants to do not discuss or share any information, including the identity of other members of the research-steering committee, outside of the meeting. Participants signed the consent form at the first meeting and were reminded of its contents at the beginning of subsequent meetings.

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Amendment Acknowledgment/Approval Letter

October 04, 2013

Miss Rana Pishva
Department of Psychology
Queen's University

RE: File #6006037 PSYC-119-11 Parent-centered cognitive behavioural therapy group for parents of children with anxiety

Dear Miss Pishva:

I am writing to acknowledge receipt of the following:

- Request to review the Psychology files of all the children whose parents took part in the group for parents of children with anxiety at Hotel Dieu Hospital between September 2011 and May 2013
- Request to conduct a telephone interview with the all parents
- Provision of a copy of the revised script for parent recruitment
- Provision of a copy of the revised letter of invitation/information for parents
- Provision of a copy of the parent exit interview questions

I have reviewed these amendments and hereby give my approval. Receipt of these amendments will be reported to the Queen's University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board.

Yours sincerely,

A handwritten signature in cursive script that reads "Albert F. Clark".

Albert Clark, Ph.D.
Chair
Health Sciences Research Ethics Board

Appendix B

Letter of Information and Consent Forms

Participant Letter of Information and Consent Form

Becoming at-home Therapists

Please keep this form for your records

Dear Parent/Guardian,

My name is Rana Pishva, I am a doctoral student in psychology. In collaboration with my supervisors, Dr. Khalid-Khan M.D., Dr. Harkness C. Psych., from the department of Psychiatry and Psychology at Queen's University, as well as Dr. Salinda Horgan, **I am conducting a study to examine parents' transition from caregiver to at-home therapists after taking part in a group for parents of anxious youth.** You are being asked to take part in this interview because in the past 24 months you took part in the cognitive behavioural therapy group for parents of anxious youth at Hotel Dieu Hospital. The group took place on Thursdays and was facilitated by Dr. Julies Blais and Ms Danielle Proconier.

This letter is to notify that you that in approximately 2-3 weeks, you will receive a phone call from me (Rana Pishva) inviting you to participate in an interview as part of this study.

The Present Study

Research has demonstrated that parents can play a role in the treatment of their child's anxiety. As part of children's treatment, parents are often asked to complete tasks and activities with their child. Clinicians rely on parents to take on the responsibility of assisting their child in anxiety management. However, we do not know how parents experience these demands, what challenges they face, and what resources they need to succeed. I would like to learn about how you transitioned from "parent of an anxious child" to being an "at home therapist". **This information will help us understand the factors that facilitate or hinder parent involvement in youth therapy, and identify ways that clinicians can assist parents better.**

I will utilize a qualitative research method called "grounded theory" to understand parents' transition from caregiver to at-home therapist. **Qualitative research methods seek to understand a phenomenon at a deeper level, using interview as the main source of information.** Qualitative methods such as grounded theory (GT) are useful when existing theories developed through quantitative methods are insufficient, incomplete, or missing.

My research questions are:

- i) Under what conditions do parents attempt to carry out CBT in the home?
- ii) How do these conditions shape the implementation of CBT in the home?
- iii) How does the transition from parent to "at-home-therapist" take place?

Components of the Study

The study consists of an interview that can **take place over the phone or at your home.** The interview will take approximately 60 minutes, on a day and time that is convenient for you. The primary researcher, Rana Pishva, who is a doctoral candidate in clinical psychology at Queen's University will conduct the interview. The interview consists of open-ended questions. The interview will be audio-recorded for transcription and analysis.

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Finally, you might be asked to be part of a research group (or steering committee). Members of the research group help the primary researcher in the data analysis phase, by ensuring that the results are representative of participants' experiences. If you are invited and agree to be part of the research group, you would be asked meet with clinicians and researchers on at least 3 occasions between April 2014 and December 2014. You have no obligation to take part in the research group.

Your Rights as a Research Participant

It is important that you understand that you are not required to participate in the study. You are able to withdraw from this interview whenever you wish to withdraw. If you choose not to participate in the study (or part of the study) there will be no negative impact on your relationship with Hotel Dieu Hospital or Queen's University. There are no known risks to your involvement in this study and all your answers are confidential to the researchers only. Your name will not be included in any publications, and your confidentiality will be protected at all costs. **By participating in the research program, you and your child will contribute to the understanding and improvement of treatment programs for childhood anxiety.**

If you have any questions about your participation in this project at any time, please feel free to contact the main investigator, Rana Pishva at rana.pishva@queensu.ca or supervisor Dr. Sarosh Khalid-Khan M.D. at 613-544-3400 ext 2508. If you have concerns about your rights as a research participant please contact Dr. Albert Clark, Chair of the Queen's University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board at [\(613\) 533-6081](tel:6135336081).

I look forward to speaking with you and thank you in advance,

Rana Pishva MSc.
Doctoral Candidate in Clinical Psychology

Parent Consent Form

Please complete this consent form, which indicates that you are willing to participate in the "Becoming at-home Therapists" research project.

I _____ (print name), consent to the above mentioned terms and agree to take part in the "Becoming at-home Therapists" research project.

I understand:

- that my participation is entirely voluntary
- that I can withdrawal at any time
- that my information will be kept private and confidential

Signature

Date (YY/MM/DD)

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You can return this consent form the following ways:

- Scanning and emailing it to the primary investigator at rana.pishva@queensu.ca, with “Study Consent” in the subject box
- Mailing it in the envelope provided
- Returning it at the interview, if you choose to meet in person for it.

Thank you again for your time,

Rana Pishva MSc.
Doctoral Candidate in Clinical Psychology
Queen’s University

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Letter of Information & Confidentiality Agreement Research-steering Committee

Please keep this form for your records

Dear Research-steering committee Member,

My name is Rana Pishva, I am a doctoral student in Clinical Psychology at Queen's University. In collaboration with my supervisors - Dr. Khalid-Khan M.D., Dr. Harkness C. Psych., from the department of Psychiatry and Psychology at Queen's University, as well as Dr. Salinda Horgan, from the department of Rehabilitation Science - **I am conducting a study to examine parents' transition from caregiver to at-home therapists after taking part in a group for parents of anxious youth.**

You are being asked to take part in the research-steering committee group. Members of the research group help the primary researcher in the data analysis phase, by ensuring that the results are representative of participants' experiences. You would be asked meet with clinicians and researchers on at least 3 occasions between April 2014 and January 2015.

The Present Study

Research has demonstrated that parents can play a role in the treatment of their child's anxiety. As part of children's treatment, parents are often asked to complete tasks and activities with their child. Clinicians rely on parents to take on the responsibility of assisting their child in anxiety management. However, we do not know how parents experience these demands, what challenges they face, and what resources they need to succeed. **This information will help us understand the factors that facilitate or hinder parent involvement in youth therapy, and identify ways that clinicians can assist parents better.**

I will utilize a qualitative research method called "grounded theory" to understand parents' transition from caregiver to at-home therapist. **Qualitative research methods seek to understand a phenomenon at a deeper level, using interview as the main source of information.** Qualitative methods such as grounded theory (GT) are useful when existing theories developed through quantitative methods are insufficient, incomplete, or missing.

My research questions are:

- i) Under what conditions do parents attempt to carry out CBT in the home?
- ii) How do these conditions shape the implementation of CBT in the home?
- iii) How does the transition from parent to "at-home-therapist" take place?

Components of the Study

The first component of the study consisted of interviews with parents who took part in a Cognitive Behavioural Therapy group for parents of anxious youth. The primary researcher, Rana Pishva, who is a doctoral candidate in clinical psychology at Queen's University, conducted the interviews, which consisted of open-ended questions. The interviews were audio-recorded for transcription and analysis.

The second component of the study consists of meetings with the research-steering committee, which is comprised of the primary stakeholders in the phenomenon under study. The group will consist of at least two participants, a psychologist who is familiar the implementation of CBT with parents of anxious youth, the primary research and a research supervisor. The role of the committee is to reduce the impact of the researcher's personal biases and to ensure that the developing theory (i.e., results of the study) is truly representative of the social phenomenon under study. The primary research (Rana Pishva) will present preliminary findings and the group will discuss the findings to ensure that the developing theory is "grounded" in the data and to identify or clarify factors that could be influencing the data analysis. As

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such, the research group will review and discuss the data, preliminary findings, as well the contents of the researcher's field notes and reflexivity notes.

Your Rights as a Research-steering Committee Member

It is important that you understand that you are not required to participate in the study. You are able to withdraw from this committee whenever you wish to withdraw. If you choose not to participate in the study (or part of the study) there will be no negative impact on your relationship with Hotel Dieu Hospital or Queen's University. There are no known risks to your involvement in this study and all your answers are confidential to the researchers only. Your name will not be included in any publications, and your confidentiality will be protected at all costs. **By participating in the research program, you will contribute to the understanding and improvement of treatment programs for childhood anxiety.**

Your Responsibilities as a Research-steering Committee Member

The role of the committee is to reduce the impact of the researcher's personal biases and to ensure that the developing theory (i.e., results of the study) is truly representative of the social phenomenon under study. As such you will be asked to be honest and open about your ideas and opinions regarding the findings. As a research-steering committee member, you will be privy to findings from a research project that has not been published. **As such, you will be asked not to discuss or share any of the findings presented in the meetings with individuals who are not members of the research-steering committee.** You will be asked to keep any findings discussed in research-steering committee meetings private. Additionally, given that personal information may be shared during the meeting, **you will be asked to respect the privacy and confidentiality of the other group members**, by not sharing their identity or disclosures with individuals outside the committee.

If you have any questions about your participation in this project at any time, please feel free to contact the main investigator, Rana Pishva at rana.pishva@queensu.ca or supervisor Dr. Sarosh Khalid-Khan M.D. at 613-544-3400 ext 2508. If you have concerns about your rights as a research participant please contact Dr. Albert Clark, Chair of the Queen's University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board at [\(613\) 533-6081](tel:6135336081).

I look forward to speaking with you and thank you in advance,

Rana Pishva MSc.
Doctoral Candidate in Clinical Psychology

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Appendix C

Demographic Questionnaire and Initial Interview Guide

Demographic Questionnaire

Family ID

Date of Interview

You are being asked to take part in this interview because in the past 24 months you took part in the cognitive behavioural therapy group for parents of anxious youth at Hotel Dieu Hospital. The group took part on Thursdays and was facilitated by Dr. Julie Blais and Ms Danielle Procunier.

The goal of this interview is explore your perceptions and experiences in the group. You will be asked about the content and format of the group, specific exercises, and your perceived outcome. This interview consists of approximately 10 -15 questions and will take approximately 45 minutes to complete. Remember that there are no right or wrong answers.

First I would like some basic information about your family

Your full name

Your (anxious) child's name

Your relationship to the child

Child's gender

Your child's date of birth

When did you take part in the group?

Age of your child at the time of the group

Child's main anxiety

Was your child on medication?

Other siblings in the home?

Other caregivers in the home?

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Interview Template

Opening questions

Question	Knowledge/information being sought
1. Tell me about how you came to take part in the CBT group for parents of anxious youth at HDH.	<i>Understand what leads parents to get involved in their anxious child's treatment.</i>
2. Tell me your views on parents' role in the treatment of their child's anxiety? - Was your view different before taking part in the group	<i>Understand if parents view themselves as agents of therapeutic change.</i>
3. When, if at all, did you first notice a change in your role in regards to [anxious child name]?	<i>Identify the starting point of change during the transition from caregiver to at-home therapist</i>

Intermediate questions

Question	Knowledge/information being sought
4. You were required to practice CBT skills in the home with [anxious child name]. As you look back on doing homework with [anxious child name] during the group, what stands out the most?	<i>Generate information regarding parents' understanding of at-home practice.</i>
5. How did doing homework during the group influence (if at all) your current use of CBT skills at home?	<i>Explore the potential relationship between homework and long term implementation of CBT techniques in the home.</i>
6. Tell me how you go about practicing CBT at home with [anxious child name]? What do you do? - What is a typical practice like for you and [anxious child name]?	<i>Draw a picture of what being an at-home therapist is like for the parent, in terms of actions.</i>
7. What is it like for you to practice therapy skills with [anxious child name]?	<i>Draw a picture of what being an at-home therapist is like for the parent, in terms of internal experiences.</i>
8. What changes, if any, do you notice in your role as a parent when practicing CBT at home?	<i>Explore the transition in the parent's role.</i>
9. How does the home environment (e.g., other children, spouse, and work) influence the implementation of CBT in the home during and after the parenting group?	<i>Identify conditions under which the change took place, and the impact of those conditions.</i>
10. What aspect of CBT implementation has been most challenging for you? - How did you handle that? - What was a successful response? - What was not a successful response?	<i>Identify challenges and parents' responses to those difficulties.</i>

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11. What aspect of CBT implementation has been the easiest for you? Why do you think that was easiest?	<i>Identify positive factors in the process, and their impact.</i>
--	--

12. What role, if any, did the therapist play in this process?	<i>Identify the nature of the relationship between parent and therapist in the transfer of control model.</i>
--	---

Closing questions

Question	Knowledge/information being sought
13. What was the overall impact, if any, of CBT implementation on you, [<i>anxious child name</i>], and your home? - What has contributed to that impact?	<i>Explore the impact of being an at-home-therapist on various aspects of the parent's life. Explore the contributors of the change.</i>
14. How did your parenting style change (if at all) after taking part in the group?	<i>Identify changes specific to the parent (if not generated by Q13).</i>
15. What do you think is the most important way parents can successfully implement CBT at home with their anxious child? - How has your experience shaped this opinion?	<i>Explore that is important to the parent in the process and what factors shape this opinion.</i>
16. Is there a significant aspect of the process of transitioning from caregiver to at-home-therapist that we did not talk about?	<i>Generate information that is unknown to the researcher, or that might have been missed. Allow the participant to generate knowledge from their experience.</i>

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Appendix D

Iterations of the Interview Guide

Interview Template 2 (March 24th 2014)

Opening question

1. Tell me how you go about practicing CBT at home with [*anxious child name*]? What do you do?
 - What is a typical practice like for you and [*anxious child name*]?
-

Intermediate questions

1. How is your role as a parent different while you implement CBT at home with your child?
 - How is being a parent different from being an at-home therapist?
 - What influences this change?
 - What is the impact of this change?
 2. How does the home environment (e.g., other children, spouse, and work) influence the implementation of CBT in the home during and after the parenting group?
 5. What aspect of CBT implementation has been most challenging for you?
 - How did you handle that?
 - What was a successful response?
 - What was not a successful response?
 6. What aspect of CBT implementation has been the easiest for you? Why do you think that was easiest?
 7. What role, if any, did structured homework play in this process?
-

Closing questions

1. How would you describe the overall impact, if any, of CBT implementation on you, [*anxious child name*], and your home? (What has contributed to that impact?)
 2. Is there a significant aspect of the process of transitioning from caregiver to at-home-therapist that we did not talk about?
-

This is the end of the interview. Thank you for your time.

Interview Template 3 (May 14th 2014)

Opening question

1. Tell me how you go about practicing CBT at home with [*anxious child name*]? What do you do?
 - What is a typical practice like for you and [*anxious child name*]?
-

Parent's role

- How is your role as a parent different while you implement CBT at home with your child?
- How is being a parent different from being an at-home therapist?
 - What influences this change?
 - What is the impact of this change?
-

- What aspect of CBT implementation has been most challenging for you?
- How did you handle that?
 - What was a successful response?
 - What was not a successful response?
-

What aspect of CBT implementation has been the easiest for you? Why do you think that was easiest?

How did your parenting style change (if at all) after taking part in the group?

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Emotional experience

- Describe “scary”, what is that feeling for you?

Conditions/Environment

How does the home environment (e.g., other children, spouse, and work) influence the implementation of CBT?

How do you address these issues in the environment?

Perceptions

Tell me how your perception of your child has changed, if at all, since the implementation of CBT in the home?

Tell me how your perception of yourself as a parent has changed, if at all, since the implementation of CBT in the home?

Specific CBT methods/practice

“Putting self in his/her shoes”

- Can you describe the experience of “trying to put yourself in his shoes”?
- What is the meaning of it for you?
- How does it feel - asking these questions in this way?
- How does it feel to you as a mother?
- How do you do “put yourself in his shoes”- what is the process?

Success

- How do you feel in situations when it works?

Failure

- How do you feel in situations when it doesn’t work?

How do you deal with novel, possibly anxiety provoking event with your child?

- “to prepare or not to prepare”

Closing questions

1. How would you describe the overall impact, if any, of CBT implementation on you, [*anxious child name*], and your home? (What has contributed to that impact?)

2. Is there a significant aspect of the process of transitioning from caregiver to at-home-therapist that we did not talk about?

This is the end of the interview. Thank you for your time.

Interview Template version 4 (July 17th 2014)

Opening question

Tell me how you go about practicing CBT at home with [*anxious child name*]? What do you do?

- What is a typical practice like for you and [*anxious child name*]?
- Describe the interaction...

How do you proceed, Once you’ve identified that your child is anxious and understood the source of your child’s anxiety?

- Methods used, how the choice is made and why

Parental process

How is your role as a parent different while you implement CBT at home with your child?

- How is being a parent different from being an at-home therapist?

How did your parenting style change (if at all) after taking part in the group?

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What aspect of CBT implementation has been most challenging for you?

- How did you handle that?
- How successful was this?

What aspect of CBT implementation has been the easiest for you?

- How so? Why do you think that is?

What were some of the surprises that you encountered while practicing CBT with your child?

What do you think were the “important moments”?

How do you deal with novel, possibly anxiety provoking event with your child?

- “to prepare or not to prepare”
- Did you procrastinate?
- What influenced your decision making?

Tell me how your perception of yourself as a parent has changed, if at all, since the implementation of CBT in the home

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Child's symptoms and mental health

Before, during, or after the group, did you child every express having any suicidal ideations, or did she/he engage in any self-harm behaviours?

- Tell about what this was like as a parent
- How did you cope with this?
- How did it influence the implantation of CBT?

Tell me how your perception of your child has changed, if at all, since the implementation of CBT in the home?

Conditions/Environment

How does the home environment (e.g., other children, spouse, and work) influence the implementation of CBT?

- How do you address these issues in the environment?
- What is that like for your?

Closing questions

1. How would you describe the overall impact, if any, of CBT implementation on you, [*anxious child name*], and your home? What has contributed to that impact?

2. Is there a significant aspect of the process of transitioning from caregiver to at-home-therapist that we did not talk about?

This is the end of the interview. Thank you for your time.

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Appendix E Significant Analyses and Iterations of the Theory

Table 3

Frequency of Occurrence of Each Tentative Focused Codes over 10

Interviews

Tentative Focused Code	Source total
(1) Parent worries/concerns	8
(2) Parent seeks to know and understand the child	8
(3) Internal to the parent	3
(4) External to the parent	10
(5) Dilemmas for the parent	6
(6) Context/conditions	8
(7) Parenting Strategies	10
(8) Things that change: a) child; b) parent; c) home	9
(9) Implementation Process	9
(10) Control	7
(11) Parent emotional experience	8
(12) Dealing with new (potential) trigger	6
(13) Parent goes against instincts (unnatural)	5
(14) Child with suicidality and/or self-harm	4

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Table 4

Five Process Phases Based on Ten Interviews

<u>Procedural Phase</u>	<u>Description and codes</u>	<u>Corresponding codes for children with other mental health diagnosis</u>
I Crisis state and Awareness of the problem	Chaos Helplessness, confusion Parent worries	Worry for the child's safety.
II Buy-in and Mechanistic implementation of CBT	Parent strategies (planning). Mechanistic implementation of CBT methods.	Need to trust the mental health professionals. Putting safely mechanisms in place.
III Setbacks and Challenges	Spouse (relationship, parenting approaches) Other children in the home Consistency Dilemmas for parent "Unnatural", going against parental instincts	The stakes are very high, more anxiety for the parent.
IV New discoveries	Changes in the child, parent, home, and relationships Tailoring the approach and picking your battles. Understanding that being practical does not mean you can't be empathetic. Finding balance.	Child may have been "crying for help" and did not have the words to express himself. Risk of suicide and function of self-harm behaviours are re-evaluated and better understood.

V Coping effectively and planning for the future	Termination anxiety Predictability and structure in the home, typically with the use of rewards. Awareness of room for improvement New trigger situations Relapse, being on alert Natural CBT implementation Acknowledge fluctuating nature of anxiety.
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Theory Iteration A

The data suggests that the process of implementing CBT at home with an anxious child is comprised of five procedural phases, which is described in *Table 1*. The focused codes were first re-organized into these five procedural phases: 1) crisis and readiness of change; 2) buy-in and mechanistic implementation of CBT; 3) setbacks and challenges; 4) new discoveries; and 5) successful implementation and planning for the future, were further described and associated with corresponding quotes and codes. At this stage, the theory did not include the analysis of parents of anxious youth who also present with suicidal ideation and/or self-harm behaviours.

Table 5

Five procedural phases of CBT implementation in the home by mothers of anxious youth.

Sub-phase	Descriptor
Phase I Crisis and Readiness for Change	
1.1 State of crisis and chaos	Parent emotional experience Description of child’s behaviour Impact on the home environment and family dynamics
1.2 Mother unknowingly enables anxiety	Emotionally Behaviourally
1.3 Mother doesn’t know what to do “floating”	Negative parental experience Mother’s own mental health

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	Hopelessness
	Not knowing what to do
Phase II Buy-in and Mechanistic implementation of CBT	
2.1 Mother as the main implementer “her duty”	Parent (mother) expresses that she is the only person who is willing and/or able to help the child. or because of the circumstance, the mother is the main person doing the CBT
2.2 Initiation of practice: Awareness, understanding, and engagement	Getting the child onboard Understanding and awareness initiates action Parent makes links
2.3 Mechanistic CBT implementation	Explicit implementation Process and components: Noticing anxiety, Learning by doing, Detachment, Disengagement, Making steps explicit, Parents’ personal experience has facilitated the implementation, Practice and consistency
Phase III Setbacks and Challenges	
3.1 Other children	Increases complexity Anxious child is treated differently
3.2 Spouse	Unsupportive (Discrepancy in parenting styles) Not present (must re-teach) Supportive (tag teaming)
3.3 Finding balance	How much to push? Balancing for control Balancing challenges
3.4 CBT as unnatural	Detachment feels unnatural “against instincts” “withholding from the child”
3.5 Parent’s emotional response	Upset Feeling “mean”, “like I’m the bad parent ”
Phase IV New Discoveries	

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4.1	Natural CBT implementation	Describing the new approach to parenting Figuring out what works for the child Knowing the child and understanding the child New understanding of child's behaviour and its function Contributors to successful CBT implementation
4.2	Practical approach vs. emotional approach	Taking a practical approach that is separate from emotionality Picking your battles The shift to "natural" is associated with confidence
<hr/> Phase V Coping Effectively and Planning for the Future <hr/>		
5.1	New approach and attitude	Consistency and firmness Detachment Confidence and no guilt
5.2	Impact on the home	Generalize knowledge to other kids Calm Change in relationships (positive) Changes in child
5.3	Fear of termination and relapse	Worries about termination Doubt ability
5.4	Acknowledging ongoing needs of the child	Acceptance Advocacy The "slip"
5.5	Being aware/alert for the future	Be aware for changes Planning ahead Preparing for changes and novel situation/triggers

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Theory Iteration B

Through discussion and re-examination of data, phase 3 “Setback and Challenges” emerged as a set of determining factors that continuously influence and interact within each phase of CBT implementation. That is, the determining factors do not constitute an independent category, instead, different determining factors influence each phase of CBT implementation. Hence, the determining factors run parallel to and are intertwined with Phase 1 (crisis), Phase 2 (mechanistic implementation), Phase 4 (Natural), and Phase 5 (Future). *Figure 3* illustrates the second iteration of the procedural phases. Furthermore, the terminology was reviewed to better represent the content of each phase. *Figure 3* shows the evolution of the *Internalization* and *Sustaining Gains* phases.

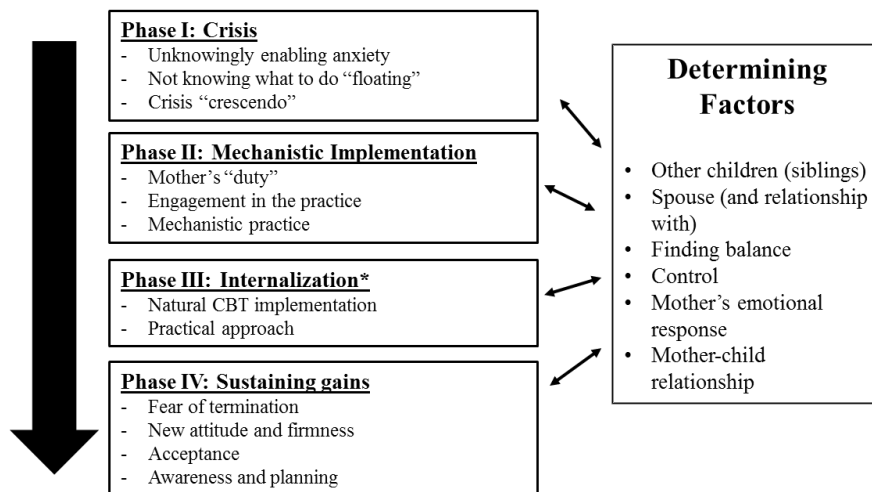


Figure 4. Iteration B of procedural phases.

The determining factors influence and interact with each phase.

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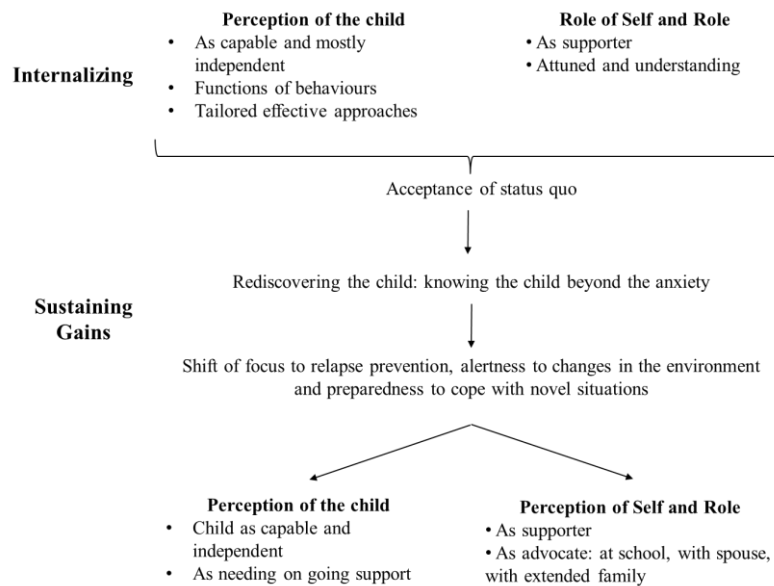


Figure 5. Detailed depiction of Internalization and Sustaining Gains.

Theory Iteration C

The next phase of data analysis (depicted in Figure 5) took the interactive approach into consideration to explicate the dynamic nature of the process of implementing CBT in the home. It also focused on the identification of the core categories and central phenomenon of the theory. This theory proposed that the phases of CBT implementation evolved based on two core categories: Mother's perception of the child and Mother's perception of the self. However the core categories were yet to be specifically defined and related to the existing literature.

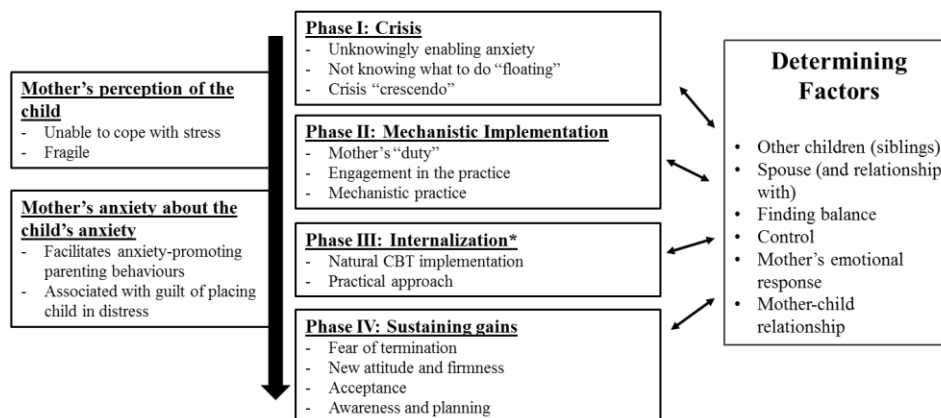


Figure 6. Iteration C of procedural phases.

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The determining factors influence and interact with each phase.

Theory Iteration D

In this phase of analysis, the focus was on drawing links between experiences and events and to clarify each category and subcategory. As depicted in *Figure 6*, the emotional experiences and behaviours associated with each core category are identified and the development of these categories, experiences, and meanings in each procedural phase is explicated. At this iteration, the first phase “Incremental Crisis” was referred to as a static transitional stage that precedes CBT implementation.

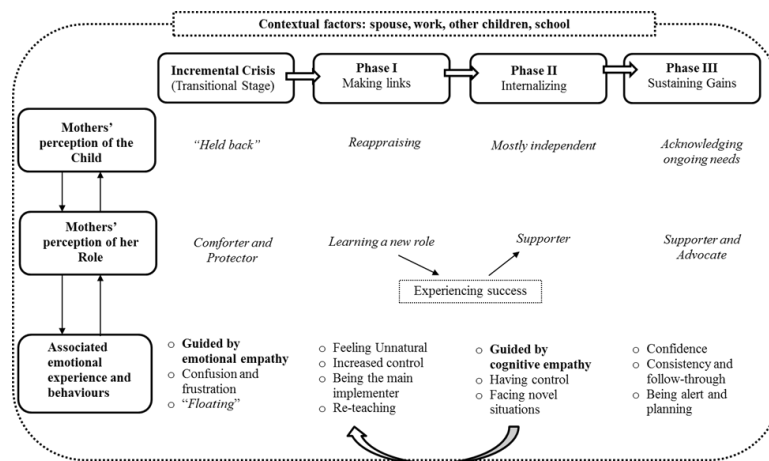


Figure 7. Iteration D of the grounded theory.

Emotional experiences and core categories are explicated across the procedural phases.

Theory Iteration E

With further analysis, it became apparent that “Incremental Crisis” is in fact a dynamic stage that should be included as procedural phase. Iteration E and the final theory refer to this stage as *Recognizing Crisis*. The goal at this stage was to streamline categories to insure clarity and simplicity of categories, subcategories, and the relationships among them. The visual representation (*Figure 7*) also aimed to incorporate the mothers’ emotional experiences and within each core categories as opposed to completely separately. Iteration E of the theory underwent a number of slight modifications for clarity, before the final theory was formulated. Finally, for the subsequent (and final) iteration of the theory, the phase

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Internalizing was modified to *Integrating* as it better represents the process of weaving new knowledge into an existing system, which is reflective of mothers' process.

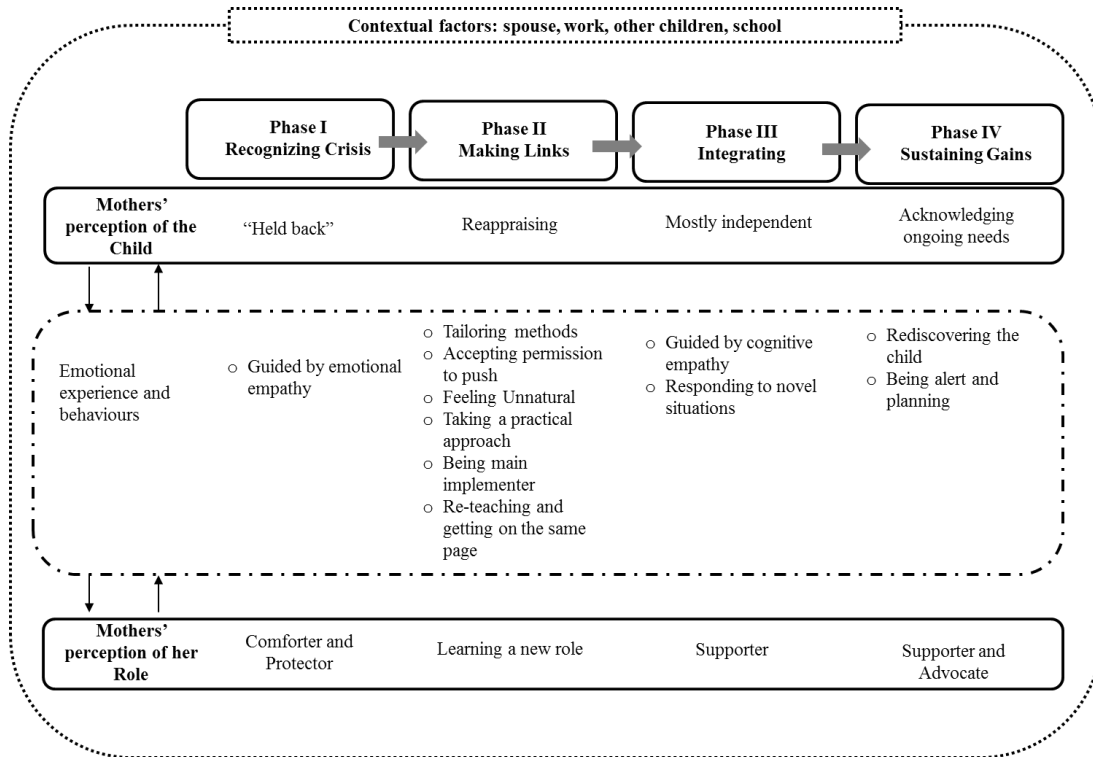


Figure 8. Iteration E of the theory

Ensuring clarity and simplicity of categories and relationships.