University of Southampton

Faculty of Environmental and Life Sciences

School of Psychology

The use of non-violent resistance interventions for challenging behaviours exhibited by young people

by

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Thesis for the degree of Doctor of Clinical Psychology

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<u>Abstract</u>

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This thesis examines the use of non-violent resistance (NVR) as a parenting model for parents and carers with children who exhibit antisocial behaviours. Chapter 1 is a systematic review of quantitative literature exploring the use of the NVR parenting model and its impact. A narrative synthesis of 12 papers revealed that the intervention has been delivered in a group and 1:1 setting, with target groups including parents, foster carers, and residential workers. Studies have reported positive results for both parents and carers (e.g., increased parental self-efficacy and reduced helplessness) and the young people (e.g., reduction in challenging behaviours). However, no positive change was found for parental stress and there was a limited positive impact on the work climate of residential workers. The approach has also been adapted to meet the needs of specific diagnoses, including Type 1 diabetes and attention deficit hyperactivity disorder. Existing literature limitations are explored, future research suggestions are discussed, and clinical implications are detailed.

The second chapter presents an empirical paper exploring quantitative data collected from participants who attended a 10-week face-to-face NVR parenting group facilitated by parent practitioners with lived experiences. Outcome measures of 40 parents and carers were examined using a multilevel model

analysis. The data collected at three time points (session one, five and ten) suggested that an NVR parent group significantly improved parental stress, self-efficacy, and parenting style. Positive results were also found when exploring the overall emotional and behaviour wellbeing of the children, as reported by parents/carers. The overall findings of the analysis suggest that an NVR parent group run by parent practitioners is an effective intervention for families with children who exhibit challenging behaviours, and the clinical implications are explored. Study limitations are discussed and suggestions for future research are also highlighted.

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Research Thesis: Declaration of Authorship

Print name: Raminta Petrauskaite

Title of thesis: The use of non-violent resistance interventions for challenging behaviours exhibited by young people.

I declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
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Acknowledgements

Chapter 1   The use and impact of non-violent resistance parenting interventions: a systematic review

This paper has been prepared in the format required by the Child and Adolescent Mental Health journal. See Appendix A for author guidelines.

1.1   Abstract

Background: Non-violent resistance (NVR) is a parenting intervention for families with children who exhibit internalising and externalising challenging behaviours. It aims to upskill parents with knowledge and confidence to parent children using an authoritative parenting style. **Method:** This systematic review explored the current evidence available for NVR as a parenting approach, with a focus on how it is used (e.g., mode of delivery) and what is its impact on outcomes for parents and carers and the young people. **Results:** The search strategy identified 505 articles, of which 12 studies met the inclusion criteria. A narrative synthesis of the quantitative findings revealed that overall, NVR interventions produced positive results for caregivers (e.g., increased parental self-efficacy and decreased helplessness) whilst being delivered both in a group and in a 1:1 setting. The review also found that there was a decrease in the number of challenging behaviours exhibited by the young people, revealing positive child outcomes. Desirable results were also achieved when working with specific diagnosis, such as Type 1 diabetes and substance misuse. Caution must be taken when interpreting results due to bias in the selection of reported results, for instance. There is also no statistical support for the results of the review. **Conclusions:** Despite the limitations, the current review suggests that an NVR parent intervention is a transferable model which can meet the diverse needs of families and services. Future research should continue to evaluate the intervention to further support the limited results available to date.

1.2   Key practitioner messages

- Young people's behavioural problems and disturbances account for a high volume of referrals to child health services. High demands are also placed on the education system as well as the criminal justice system.
- To date, no systematic review has explored the literature on the use and impact of NVR as a parenting approach.
- The evidence so far is promising, with positive outcomes for both the caregivers and the young people.

- The available literature has design limitations, as well as gaps which are yet to be addressed. Future research should aim to build on the current evidence, with a focus on randomised control trials and long-term follow-up periods.

1.3   Keywords

NVR; parenting; child; caregivers; adolescent

1.4   Introduction

Young people's behaviour that violates age-appropriate expectations (also referred to as challenging or antisocial behaviour) has been found to have a direct negative impact on the young person's life and their caregivers (Wehmeier et al., 2010; The National Institute for Health and Care Excellence, 2017; NICE). For example, reports have shown that both young people who exhibit challenging behaviour and their caregivers experience lower quality of life (Szentiványi & Balázs, 2018). More specifically, young people are less likely to perform well at school and more likely to experience social isolation (NICE, 2017). As adolescents, individuals are more likely to misuse substances and be involved with the criminal justice system (NICE, 2017). Furthermore, those who exhibit antisocial behaviour at a young age are significantly more likely to experience mental health difficulties in adult life (e.g., antisocial personality disorder; King, 1997; NICE, 2017). The caregivers of children who exhibit antisocial behaviour have been found to be at an increased risk of feelings of helplessness (Weinblatt & Omer, 2008), and isolation due to feelings of shame (Jackson, 2003).

Furthermore, young people's challenging behaviour has been found to have an impact on the wider society due to multiple agency involvement resulting in a significant workload for the health and social care systems. In the United Kingdom, aggressive, defiant, and antisocial behaviour is the most common reason for referrals to child and adolescent mental health services (CAMHS; NICE, 2017). Reports have shown that behavioural problems and disturbances account for 30% of consultations with general practitioners, 45% of community child health referrals and 28% of paediatric outpatient referrals (NICE, 2017). Further demands are placed on the education system (e.g., provisions for special-needs education), and the criminal justice system. The workload experienced by multiple systems adds up to a substantial economic cost (Romeo et al., 2006), highlighting the need for support to be made available to families.

A variety of parenting interventions have been developed with the aim to provide parents and caregivers with the skills and knowledge to improve their parenting practices. Researchers have argued that parenting interventions provide positive outcomes for both children and parents (e.g., enhanced psychological well-being for parents and children; Prinz et al., 2007; Barlow & Coren, 2018). Non-violent resistance (NVR), also referred to as New Authority is one type of parenting programme that

was developed based on coercion theory (Patterson, 2016). It suggests that negative reinforcement of a child's behaviour occurs when unsuccessful attempts to control a young person are abandoned. This type of harsh and inconsistent parenting has been linked to the onset of challenging behaviours in children (Loeber & Dishion, 1983; Patterson et al., 1993). The NVR approach coaches and encourages parents to learn and adopt new parenting skills, which enables them to approach situations in a non-aggressive and non-coercive manner. Group and/or 1:1 interventions are used to upskill caregivers on how to de-escalate situations using increased parental presence (e.g., involvement with the school) and delayed responses (e.g., 'strike when the iron is cold'), for example. Parents are also taught to repair relationships with their children using reconciliation gestures (Omer, 2004). One of the primary ways that NVR differs from other parenting programmes, is that the NVR model encourages parents to reach out to their wider community, where they invite support from others (e.g., extended family members, family doctor) for practical and emotional assistance (Omer, 2004).

Studies have shown NVR to be effective when working with foster carers (Van Holen et al., 2018) and in residential care settings (van Gink et al., 2018). Positive results such as reduced hopelessness and escalation behaviours and increased perceived social support have also been found when the approach has been taught to parents with children with acute behavioural problems and parents of adult entitled dependence (Weinblatt & Omer, 2008; Lebowitz et al., 2012). Others have found the approach to have a direct positive impact on attention deficit hyperactivity disorder symptoms (ADHD; Schorr-Sapir et al., 2022). Studies have also suggested when NVR is used with individuals with mild intellectual disability, aggressive incidents reduce (Visser et al., 2022).

To date, no systematic review has explored the use and impact of NVR interventions on young people and caregiver outcomes. A review of the current literature available can be used to guide future services and practices that provide support to families. Thus, the purpose of this paper is to summarise the evidence that is currently available, with the aim to answer two primary questions: how is NVR used as an intervention for challenging behaviour exhibited by young people and what is its impact? The current review also aims to direct future research in NVR by providing information on how NVR interventions have been adapted so far and identifying limitations of the available evidence.

1.5   Method

Prior to the commencement of the systematic review, a protocol was developed and registered on PROSPERO (registration number: CRD42022377821). The review process was conducted using the Preferred Reporting Items for Systematic Review and Meta-Analyses (PRISMA; Moher et al., 2009) guidelines.

1.5.1   Search strategy

The systematic search was conducted in November 2022, using five electronic databases for articles published in the English language: PsychINFO, MEDLINE, EMBASE, Web of Science, and Scopus. Electronic theses and dissertations were searched using ProQuest and Ethos. No date restrictions were imposed. Specific requirements of each database were adapted whilst using search terms to identify studies (see Table 1.1).

Table 1.1   Search strategy

[1]	"nonviolent resistance" OR "non violent resistance" OR "non-violent resistance" OR "new authority" OR NVR AND
[2]	Child* OR adolescen* OR teen* OR "young people" OR "young person" OR juven* OR youth OR
[3]	parent* OR carer* OR "care giver" OR caregiver OR famil* OR guardian OR mother* OR father* OR foster OR "children's home" OR "foster care*"

1.5.2   Eligibility criteria

All studies were independently screened using titles and abstracts by the lead author and a voluntary research assistant. Any discrepancies were resolved by discussion. For articles to be included in the analysis, the following criteria had to be met:

- *Type of studies.* Studies, including single case studies, had to include pre- and post-intervention quantitative data. If a study included a mixed design, only the quantitative data was included as part of the analysis. Both randomised and non-randomised studies were eligible.
- *Types of participants.* No limitations were placed on the types of caregivers (e.g., biological family, extended family, foster families, care staff) or the setting (e.g., family home, children's home, and other institutes). The age of the young people had to fall under 18 years old. If the young person's participant group included a wide age range (e.g., under and over 18 years of age), the mean age had to be below 18 years old. There were no limitations on what challenging behaviour was targeted.

- *Type of intervention.* For a study to be included, NVR had to be the primary intervention. Participants who were also medicated for their challenging behaviour, were not excluded. No limitations were placed on the delivery of the NVR intervention (e.g., group, 1:1). No limitations on the length of the intervention. There were also no limitations on the content that was covered during the intervention.

- *Type of outcome measures.* No limitations were placed on the type of outcomes used. Studies did not have to include both caregiver and young people outcomes.

1.5.3   Study selection

Rayyan was used to manage search results (https://www.rayyan.ai). Rayyan is an online resource for organising and screening literature for the purpose of a systematic review. All papers were screened by the main author and the research assistant. All disagreements were resolved through discussion.

1.5.4   Data extraction

Prior to the literature search, a coding document was developed by the lead author. The document contained headings for publication information (e.g., title, author, year), research design (e.g., the type of design implemented), sample characteristics for caregivers (e.g., demographic information), demographic information young people (e.g., age), intervention characteristics (e.g., length of intervention, mode of delivery), and results (e.g., pre- and post-intervention, follow-up). The data was extracted by the lead author. To ensure inter-rater reliability, data from 10% (three articles) of the papers was also extracted by a voluntary research assistant. There was a 100% agreement between the author and the voluntary research assistant.

1.5.5   Quality appraisal and risk of bias

The PRISMA statement recommends that researchers include information on the steps undertaken to reduce the risk of bias (Moher et al., 2009). To achieve this, an inclusion-based approach was adopted throughout the review. This involved not excluding studies based on methodology (Kraemer et al., 1998). Steps were also taken to identify studies that were both published and unpublished. This was completed whilst being mindful of publication and selective reporting biases (Liberati et al., 2009). Secondly, each study was assessed using risk-bias-tools. To date, no single tool has been developed for the assessment of risk of bias for both randomised and non-randomised trials. As a result, two separate tools were used for the assessment of risk of bias in studies of randomised and non-randomised trials: the Revised Cochrane risk-of-bias tool (RoB 2; Sterne et al., 2019) was used for randomised trials (see Table 1.2) and the Risk of Bias in Non-Randomised Studies – of Interventions (ROBINS-I; Sterne et al., 2016) was used to assess bias in non-randomised trial studies (see Table 1.3). The lead author

independently completed the assessment of risk of bias of all 12 studies. To ensure accuracy and consistency, 10% (three articles) of the papers were also assessed for risk of bias by a voluntary research assistant. There was a 100% agreement between the lead author and the research assistant

Table 1.2   Revised Cochrane risk-of-bias tool for randomised trials

Study	Randomization process	Deviations from intended interventions	Missing outcome data	Measurement of the outcome	Selection of the reported results	Overall bias
Lavi-Levavi et al. (2013)	Low	Some concern	Low	Low	Some concern	Some concern
Schorr-Sapir et al. (2022)	Low	Low	Low	Low	Some concern	Some concern
Van Holen et al. (2018)	Low	Low	Low	Low	Some concerns	Some concerns
Weinblatt & Omer (2008)	Low	Low	Low	Low	Low	Low

Table 1.3   Risk of bias in non-randomised studies of interventions for non-randomised trial studies

Study	Bias due to confounding	Bias in selection of participants into the study	Bias in classification of interventions	Bias due to deviations from intended interventions	Bias due to missing data	Bias in measurement of outcomes	Bias in selection of the reporter results	Overall bias
Attwood et al. (2020)	Low	Low	Low	Low	Moderate	Moderate	Low	Moderate
Newman et al. (2014)	Low	Low	Low	Low	Moderate	Moderate	Low	Moderate
Rothman et al. (2014)	Low	Low	Low	Low	No information	Moderate	Low	Moderate
Van Gink et al. (2018)	Low	Moderate	Low	Low	Moderate	Moderate	Low	Moderate
Van Holen et al. (2016)	Low	Low	Low	Low	Moderate	Moderate	Low	Moderate
Visser et al. (2021a)	Low	Low	Low	Low	Moderate	Moderate	Moderate	Moderate
Visser et al. (2021b)	Low	Low	Low	Low	Moderate	Moderate	Moderate	Moderate
Visser et al. (2022)	Low	Low	Low	Low	Moderate	Moderate	Low	Moderate

1.5.6   Synthesis

A meta-analysis could not be conducted due to the small number of studies meeting the inclusion criteria and heterogeneity of study outcome variables. As a result, a narrative synthesis of the findings was completed. This involved collating study findings and presenting a summary of the results in written and organised format, which enabled the author to answer the systematic review questions. A narrative synthesis of the findings from the included studies is detailed in this review below.

1.6   Results

1.6.1   Included studies

The search strategy identified a total of 546 articles, including duplicates. Following the screening process, 12 were included in the systematic review (see Figure 1.1 for PRISMA flow diagram). From the 12 included studies, four were randomised trials and eight were non-randomised trial studies.

Figure 1.1   PRISMA flow diagram
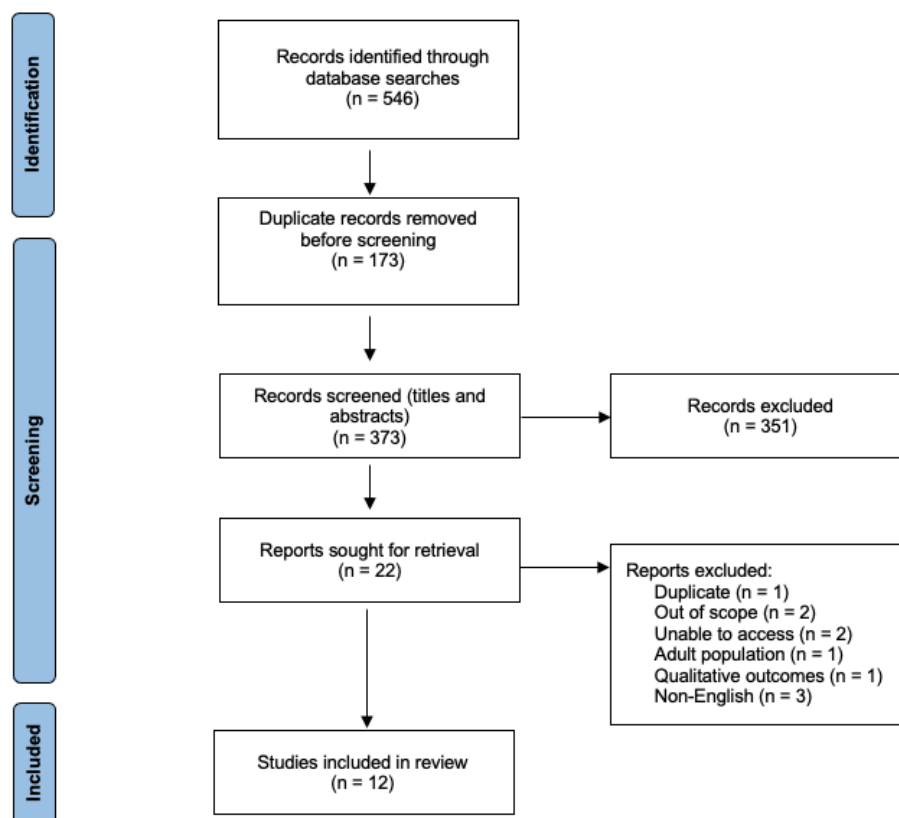
1.6.2 Participants and study characteristics

A total of 309 parents (mothers and fathers; n= 6 studies; Attwood et al., 2020; Newman et al., 2014; Rothman-Kabir et al., 2022; Lavi-Levavi et al., 2013; Schorr-Sapir et al., 2022; Weinblatt & Omer, 2008), 87 foster carers (n = 2 studies; Van Holen et al., 2016; Van Holen et al., 2018) and 450 care staff (n = 4 studies; Van Gink et al., 2018; Visser et al., 2021a; Visser et al., 2021b; Visser et al., 2022) participated across the 12 studies. A total of three published papers collected data from the same pool of participants (Visser et al., 2021a; Visser et al., 2021b; Visser et al., 2022). The age of those being looked after by caregivers ranged between four and 50 years of age. The mean age for all studies was below 18 years of age. Studies were conducted in four different countries (United Kingdom, Israel, Netherlands, and Belgium) and out of the 12 studies, only two reported the ethnicity of the participants (Attwood et al., 2020; Van Holen et al., 2016). The complete summary of participant and study characteristics is detailed in Table 1.4.

Table 1.4   Participant and intervention characteristics

Authors	Country	Study type	Mode of delivery	Number of sessions	Target behaviour	Target group	Number of participants (female)	Ethnicity
Attwood et al. (2020)	United Kingdom	Non-RCT	Group	10	Substance misuse	Parents	18 (13)	White
Newman et al. (2014)	United Kingdom	Non-RCT	Group	12	Behavioural difficulties	Parents	29 (22)	Not reported
Rothman-Kabir et al. (2022)	Israel	Non-RCT	1:1	10	Diabetes Type 1 management	Parents	67 (36)	Not reported
Van Gink et al. (2018)	Netherlands	Non-RCT	Group	3	Behavioural difficulties.; staff work climate	Care staff	186	Not reported
Van Holen et al. (2016)	Belgium	Non-RCT	Group and 1:1	13	Behavioural difficulties	Foster carers	25 (20)	White

Visser et al. (2021a)	Netherlands	Non-RCT	Group	3	Behavioural difficulties	Care staff	264 (200)*	Not reported
Visser et al. (2021b)	Netherlands	Non-RCT	Group	3	Behavioural difficulties	Care staff	264 (200)*	Not reported
Visser et al. (2022)	Netherlands	Non-RCT	Group	3	Work climate	Care staff	264 (200)*	Not reported
Lavi-Levavi et al. (2013)	Israel	RCT	1:1	4-10	Behavioural difficulties	Parents	46	Not reported
Schorr-Sapir et al. (2022)	Israel	RCT	1:1	12	ADHD	Parents	76	Not reported
Van Holen et al. (2018)	Belgium	RCT	1:1	10	Behavioural difficulties	Foster mothers	62 (62)	Not reported
Weinblatt & Omer (2008)	Israel	RCT	1:1	6	Behavioural difficulties	Parents	73 (41)	Not reported

Note. * = the same pool of participants; RCT = randomised control trial; non-RCT = non-randomised control trial

1.6.3   *Study quality*

The quality of the 12 included studies was varied. Out of the four randomised trials reviewed, only one study scored *low* (suggesting low chance of the presence of risk of bias) when the overall bias was taken into account (Weinblatt & Omer, 2008). The remaining three randomised trials overall bias score indicated that there are some concerns (Lavi-Levavi et al., 2013; Schorr-Sapir et al., 2022; Van Holen et al., 2018). The primary concerns identified were related to the selection of the reported results. All the included non-randomised trials were rated to have moderate concerns (n = 8; Attwood et al., 2020; Newman et al., 2014; Rothman et al., 2014; Van Gink et al., 2018, Van Holen et al., 2016; Visser et al., 2021a; Visser et al., 2021b; Visser et al., 2022). The main reasons for concern included bias due to missing data and bias in measurement of outcomes.

1.6.4   *Intervention characteristics*

NVR approach was the primary intervention in all studies, although the length, mode of delivery and targeted behaviour varied (see Table 2.4). The number of sessions offered ranged between three and 15 sessions. Six studies evaluated the use of the approach in a group setting (n = 6; Attwood et al., 2020; Newman et al., 2014; Van Gink et al., 2018; Visser et al., 2021a; Visser et al., 2021b; Visser et al., 2022). The approach was also delivered and evaluated in a 1:1 setting (n = 5; Rothman-Kabir et al., 2022; Lavi-Levavi et al., 2013; Schorr-Sapir et al., 2022; Van Holen et al., 2018; Weinblatt & Omer, 2008). One study explored the use of NVR in both a group and 1:1 setting (Van Holen et al., 2016). The primary cause for parents to seek support was due to their children's externalising behavioural difficulties (e.g., verbal and physical aggression, vandalism, theft, and truancy; n = 7; Newman et al.,2014; Van Holen et al., 2016; Visser et al.,2021a; Visser et al., 2021b; Lavi-Levavi et al., 2013; Van Holen et al., 2018; Weinblatt & Omer, 2008). One study focused on substance misuse (Attwood et al., 2020) and one study looked at Diabetes Type 1 management (Rothman-Kabir et al., 2022). Perceived work climate was also research by Van Gink et al. (2018) who collected data on both behavioural difficulties and the experiences of staff and Visser et al. (2022) explored the change in the work environment only. Out of the 12 studies, four were randomised trials (Lavi-Levavi et al., 2013; Schorr-Sapir et al., 2022; Van Holen et al., 2018; Weinblatt & Omer, 2008) and eight were non-randomised trials (Attwood et al., 2020; Newman et al., 2014; Rothman-Kabir et al., 2022; Van Gink et al., 2018; Van Holen et al., 2016; Visser et al., 2021a; Visser et al., 2021b; Visser et al., 2022).

1.6.5   *Intervention outcomes*

All included studies used outcome measures for the assessment of interventions and data collection was carried out a minimum of two times (i.e., pre-intervention measures and post-intervention measures).

A total of six studies collected follow-up data and the follow-up period varied between four to 12 weeks (Attwood et al., 2020; Rothman-Kabir et al., 2022; Lavi-Levavi et al., 2013; Schorr-Sapir et al., 2022; Van Holen et al., 2018; Weinblatt & Omer, 2008). For full details see Table 1.5.

Table 1.5   Intervention outcomes

Author	Outcomes assessed	Measures used (*completed by*)	Results	Follow-up period results
Attwood et al. (2020)	1) Parental self-efficacy 2) Family functioning 3) Goal based outcomes	(a) The Brief Parental Self-Efficacy Scale (*parents*) (b) The Score-15 (*parents*) (c) Goal Based Outcomes (*parents*)	• Increased parental self-efficacy • Improved goal attainment • No change to family patterns of interactions	6-8 weeks • Increased parental self-efficacy was maintained • Goal attainments maintained • No change to family parents of interactions
Newman et al. (2014)	1) Young persons behavioural, social and emotional strengths and difficulties	(a) Parental Strengths and Difficulties Questionnaire (*parents*)	• Improvement with young peoples emotional difficulties and their psychological and social functioning • Improved goal attainment	No follow-up data collected

	2) Young personas functioning	(b) Children's Global Assessment Scale (professionals)		
	3) Goal based outcomes	(c) Goal Based Outcomes (*parents*)		
Rothman-Kabir et al. (2022)	1) Diabetes family conflict	(a) Diabetes Family Conflict Scale (*parents and children*)	• Decreased diabetes related conflict	10 weeks
	2) Parental monitoring of diabetes care	(b) Parental Monitoring of Diabetes Care Questionnaire (*parents*)	• Decreased parental monitoring of diabetes care	• Improvements in young peoples self-care maintained
	3) Parental helplessness		• Improved parental helplessness	• Decreased diabetes related conflict maintained
	4) Self-care	(c) Parental Helplessness Questionnaire (*parents*)	• Improved young peoples self-care	

		(d) Self-Care Inventory (*parents and children*)		
Van Gink et al. (2018)	1) Work climate	(a) Living Group Work Climate Inventory (*care staff*) (b) Prison Group Climate Inventory (*care staff*) (c) GCIC-8-15 (*care staff*) (d) Brief Problems Monitor (*care staff*)	• No significant improvement of work climate	No follow-up data collected
Van Holen et al. (2016)	1) Young peoples behavioural difficulties 2) Carer stress	(a) CBCL/6–18 (*foster carers*) (b) Nijmegen Questionnaire for	• Decreased externalising and internalising problem behaviours • No improvement in carer stress	No follow-up data collected

		the Parenting Situation (*foster carers*)		
Visser et al. (2021a)	1) Work climate	(a) Group Climate Instrument for Children (*care staff*) (b) Group Climate Instrument Revisited (*care staff*)	• Improved open group climate • No effect on closed group climate	No follow-up data collected
Visser et al. (2021b)	1) Young peoples challenging behaviour	(a) Melding Incident Client (*care staff*) (b) Reaction to Unacceptable Behaviour (*care staff*)	• Decrease in aggressive incidents	No follow-up data collected

		(c) Brief Problem Monitor (*care staff*)		
		(d) Child Behaviour Checklist (*care staff*)		
Visser et al. (2022)	1) Work climate	(a) Living Group Working Climate Inventory (*care staff*)	• No significant improvement of work climate	No follow-up data collected
		(b) PANTRIX (care staff)		
		(c) The List of Task Perception and Organizational Climate (*care staff*)		

		(d) Perceived Workload (*care staff*)		
		(e) Shared Vision and Commitment (*care staff*)		
Lavi-Levavi et al. (2013)	1) Parental helplessness 2) Behaviour escalation	i. Parental Helplessness Questionnaire (*parents*) ii. Escalation Questionnaire (*parents*)	• Decease in parental helplessness for both mothers and fathers • Decrease in behavioural escalation for fathers, but not mothers	6 weeks • No significant difference between end of treatment and follow-up
Schorr-Sapir et al. (2022)	1) Young persons behavioural and emotional difficulties 2) ADHD symptoms	(a) Child Behaviour Checklist (*parents*) (b) Conners' Rating Scale for Parents (*parents*)	• Decrease in internalising and externalising behaviour in young people • Decrease in ADHD symptoms • Decrease in parental helplessness • Improvement in parental anchoring	12 weeks • Decrease in internalising and externalising behaviour maintained

3) Emotional regulation	(c) The Difficulty in Emotion Regulation Scale (*parents*)	• Improvements with parental helplessness maintained
4) Parental helplessness	(d) Parental Helplessness Questionnaire (*parents*)	• Improvements with parental anchoring maintained
5) Parental anchoring	(e) Parental Anchoring Questionnaire (*parents*)	
6) Home environment	(f) The Chaos Questionnaire (*parents*)	
	(g) Fidelity checklist (*professionals*)	

Van Holen et al. (2018)	1) Young persons behavioural difficulties 2) Parental stress 3) Parental practices	(a) CBCL/6-18 (*foster carers*) (b) Nijmegen Parenting Situation Scale (*foster carers*) (c) Ghent Parental Behaviour Scale (*foster carers*)	• No significant changes were found	12 weeks • No significant changes were found
Weinblatt & Omer (2008)	1) Parental helplessness 2) Young persons behavioural difficulties 3) Social support	(a) Parental Helplessness Questionnaire (*parents*) (b) Child Behavioural Checklist (*parents*)	• Decrease in parental helplessness • Decrease in escalatory behaviours • Increase in perceived social support • Decrease in young peoples behavioural difficulties	4 weeks • Decrease in parental helplessness maintained • Decrease in young peoples challenging behaviour maintained

4) Parental authority

5) Parental distress

6) Parental self-efficacy

7) Behaviour escalation

(c) Perceived Social Support Questionnaire (*parents*)

(d) Parental Authority Questionnaire (*parents*)

(e) Mental Health Inventory (*parents*)

(f) Parental Self-Efficacy Questionnaire (*parents*)

(g) Parent Behaviour Telephone Checklist (*parents*)

- Perceived levels of support returned to baseline

When exploring parent outcomes, Attwood et al. (2020) reported improvement in parental self-efficacy and the results were maintained at six-to-eight-week follow-up. However, no significant results in parental self-efficacy were reported by Weinblatt & Omer (2008). Parental helplessness was examined, and positive outcomes were reported by all authors (n = 4; Rothman-Kabir et al., 2022; Lavi-Levavi et al., 2013; Schorr-Sapir et al., 2022; Weinblatt & Omer, 2008), with some reporting further improvements at follow-up (Shorr-Sapir et al., 2022; Weinblatt & Omer, 2008). When measuring stress, no positive results were found across all studies included in this review (n = 3; Van Holen et al., 2016; Van Holen et al., 2018; Weinblatt & Omer, 2008).

Goal based outcomes were reported in two studies, where the attainment of goals set at the start of intervention were measured once the intervention was completed (Attwood et al., 2020; Newman et al., 2014). Both authors reported improvements in goal attainment, and the results were maintained at six-to-eight-week follow-up (Attwood et al., 2020). Behavioural escalation was also assessed, specifically looking at the way parents and carers responded to their child's challenging behaviour. Weinblatt and Omer (2008) reported a decrease in escalatory behaviours, whilst Levi-Levavi et al. (2013) detailed that there was a decrease in behavioural escalation for fathers, but not for mothers.

Parental anchoring refers to the ability for a child to be emotionally regulated as a result of their parents' responses. This was explored by Shorr-Sapir et al. (2022), and their results suggest that an NVR intervention improves parental anchoring, and these results were maintained at 12-week follow-up. Perceptions of social support were examined by Weinblatt and Omer (2008) who found that following a 1:1 NVR intervention, there was an increase in perceived social support. At four-week follow-up these results returned to baseline, suggesting that this was not maintained in the short follow-up period.

Work climate refers to a number of factors including supervision, and education, for instance, which influence staff functioning and wellbeing whilst at work, (Van Gink et al., 2018). This was explored by three studies in residential settings (Van Gink et al., 2018; Visser et al., 2021; Visser et al., 2022), with reports of varying results. No significant improvements of work climate were published by Van Gink et al. (2018) and Visser et al. (2022). However, Visser et al. (2021a) detailed that improvements were found in open group climate (a work environment consisting of mutual respect, autonomy, and responsibility, for example), but no effect was discovered on closed group climate (referring to staff who are labelled as too repressive or too flexible, for instance).

Different measures were also used to explore the outcomes experienced by the young people of the parents and carers who received an NVR intervention. The overall emotional and behavioural wellbeing was assessed by Newman et al. (2014) who found that following the NVR intervention, there was an improvement in young people's emotional, psychological, and social functioning. Behavioural difficulties were also explored (n = 4; Van Holen et al., 2016; Visser et al., 2021b; Van Holen et al.,

2018; Weinblatt & Omer, 2008), with results suggesting that following an NVR intervention, there was a decrease in the number of externalising and internalising challenging behaviours exhibited by the young people (Van Holen et al., 2016; Schorr-Sapir et al., 2022; Weinblatt & Omer, 2008; Visser et al., 2021b) and these results were maintained at follow-up. However, no significant changes were found by Van Holen et al. (2018). NVR interventions were also delivered to specific target groups. When used for Diabetes Type 1 management, it was reported that there was a decrease in diabetes related conflict between parents and young people. There was also a decrease in the overall parental monitoring of diabetes care (Rothman-Kabir et al., 2022). Schorr-Sapir et al. (2002), reported a reduction of ADHD symptoms in young people post-intervention.

1.7   Discussion

To date, no systematic review has explored the use of NVR as a parenting intervention. The primary aims of the current review were to summarise the available literature in order to answer how the NVR parenting model has been used to date and what is its impact on the outcomes of caregivers and their children. In the review, a total of 12 studies evaluating NVR as a parenting intervention were included from four different countries (United Kingdom, Israel, Netherlands and Belgium). An inclusion-based approach was adopted throughout the process, resulting in four randomised trials and eight non-randomised trials being reviewed.

When exploring the ways in which the model was used, the review revealed that the intervention has been adapted to meet the needs of parents (mothers and fathers), foster carers and residential workers. The length of interventions has varied between three to 15 weeks and the majority of interventions have been delivered in a group setting. The model has also been delivered as a 1:1 approach, and one study explored a mixed model of delivery where caregivers attended group sessions and received 1:1 support (Van Holen et al., 2016).

Evidence from the available studies suggests that NVR had a beneficial impact on the outcomes of parents and carers. Following the completion of the interventions, parents and carers reported improvements in parental self-efficacy and parental helplessness, although these results were not consistent across all studies (Lavi-Levavi et al., 2013). Differences between mothers and fathers were discovered when assessing the ways in which parents respond to challenging behaviour. Levi-Levavi et al. (2013), detailed that following an NVR intervention, fathers reported a decrease in behavioural escalation, whilst mothers did not. This may be due to the different ways mothers and father parent. For instance, a systematic review of differences between mothers and fathers in parenting styles and approaches reported that mothers are more likely to be behaviourally demanding and controlling (Yaffe, 2020). Differences in parenting between mothers and fathers should be taken into consideration by clinicians considering developing an NVR parenting intervention. For the assessment of parent and

carer outcomes, stress was also explored, and no positive improvements were found across the three studies. This suggests that levels of stress did not improve as a result of the parent intervention. With this in mind, when developing parenting interventions with the aim to reduce parental stress, NVR may not be an appropriate model to apply.

Attwood et al. (2020) and Newman et al. (2014) reported the goals set at the start of the intervention were being attained following the completing of the NVR parenting programme, suggesting that the NVR intervention provided the support and guidance desired by those attending. Positive results immediately after the end of the intervention were also detailed in relation to perceived social support (Weinblatt & Omer, 2008). This is a key factor in the NVR parenting model, which encourages parents and carers to reach out to friends and family, for instance, for social support during the challenging times (Omer, 2004). However, the perceived social support scores were not maintained and returned to baseline at four-week follow-up. From this it can be argued that not only were the increased levels of perceived social support not maintained, but that they appear to return to baseline in a short space of time (within four weeks). This raises questions regarding the long-term benefits of NVR interventions which required further investigation in future research.

Work climate and the experiences of staff have been documented and the majority of studies have found no significant changes to the work environment post NVR intervention. However, one study did find that some improvements were experienced in regard to the open group climate (Visser et al., 2021a). These results suggest that when applying the NVR model, desirable results are more difficult to obtain. Future research should focus on barriers experienced in a work environment and the potential influence this has on residential workers.

In regard to the young people's outcomes, the evidence suggesting that NVR parenting interventions improve children's overall emotional, psychological and social functioning and reduces externalising and internalising challenging behaviours. Studies with follow-up data also indicated that the positive results are maintained (Schorr-Sapir et al., 2022). Young people's behavioural difficulties were the primary target behaviour, which was unsurprising when taking into the account the high volume of referrals to services for antisocial behaviour (NICE, 2017). The minority of studies explored the specific needs of families with children with substance misuse, Type 1 Diabetes and ADHD diagnoses: nonetheless they all detailed positive outcomes. This highlights the transferability of the model to diverse target behaviours.

The majority of studies included self-reported caregiver outcomes, and those that reported children outcomes relied on measures that were completed by adults. This is unsurprising when the approach aims to directly upskill the caregivers, with the view that this will have an impact on the young people's behaviour, once the NVR model is applied (Omer, 2004). However, there are several disadvantages when using adult reported measures when assessing young people outcomes. For instance, parents and

carers may present with social desirability bias (e.g., care givers may be more likely to report positive results, due to fears of being judged as failing). In addition, parent-reported measures are unlikely to provide a complete representation of the young people's experience. Nonetheless, not working with young people directly can be seen as an advantage for cases where non-attendance or engagement refusal occurs (Gulliver et al., 2010), resulting in service and economic benefits.

The NVR approach for parenting is relatively new, first being applied in Israel in 2004 (Omer, 2004), which may partially explain why there were only 12 papers that were identified for this review. The inclusion criteria is also likely to have influenced this. For instance, case studies were excluded from the systematic review, and only papers written in the English language were included. When evaluating the NVR parenting approach and making comparisons, it is important to note that not one protocol is used universally. Instead, individual protocols are developed and adapted to meet the needs of diverse target groups (e.g., parents, foster carers, care staff) and target behaviours (e.g., substance misuse, physical health management). With this in mind, it can be argued that the NVR parenting approach is at the early stages, thus making it challenging to draw final conclusions. Further investigation into which factors of the NVR model are associated with the positive outcomes for caregivers and children is required.

Conclusions regarding the maintenance of the positive results are difficult to state, due to the limited number of studies which collected follow-up data (n = 6). It can also be argued that the follow-up time periods used are relatively short, with some studies reporting data only four weeks post-intervention. Nonetheless, the follow-up data showed promising results, with some studies reporting maintenance of positive outcomes (Rothman-Kabir et al., 2022), whilst others report a continuous improvement at follow-up (Schorr-Sapir et al., 2022). However, this is not consistent across all studies (e.g., Weinblatt & Omer, 2008), highlighting the need for further research, with short-to-long term follow-up data. More specifically, future research should aim to identify the barriers to the maintenance of desirable results.

Out of the 12 studies, only two reported the ethnicity of the participants (Attwood et al., 2020; Van Holen et al., 2016). Future research should expand demographic information to include the ethnicity of their samples. This would enable further conclusions to be drawn and questions answered such as is the NVR parent approach generalisable to different ethnicity groups? It should be noted, the lack of diverse population representation may be the result of the inclusion criteria. This is because only papers written in the English language were included. In order to expand the demographic information, future research should be conducted in different countries, revealing answers for questions such as: what is the impact of an NVR parenting intervention on different populations and cultures? This is because parenting styles and approaches vary across different cultures (Smetana, 2017) and may have an influence on the impact of the NVR parenting model. This also has clinical implications; clinicians should be mindful when

delivering services with parents from diverse ethnic and cultural backgrounds, to ensure that all needs are met.

The current systematic review consists of a number of limitations. Firstly, there is no statistical support for the results of this review, due to the small number of studies meeting the inclusion criteria and the heterogeneity of study outcome variables. Future research should aim to address this. However, despite this, useful information can be drawn from the reported findings when referring to the target groups and outcomes that have thus far reported desirable results. Secondly, the minority of the studies included in the review used randomised trials study design. This limits the final conclusions that can be made regarding the parenting approach and its efficacy, due to the presence of possible bias in the non-randomised trials (e.g., selection bias). In addition, the studies included in the review raise some concerns which should be addressed in future research (e.g., bias selection of the reported results). Finally, the current review excluded qualitative studies, preventing a more detailed and in-depth understanding of the experiences and outcomes of parents and carers and their young people (Cleland, 2016).

In regard to further clinical implications, based on the current review, it can be argued that the NVR model can be considered as an effective option for supporting parents and carers with children who exhibit challenging behaviours. The review demonstrates the variety of ways in which the intervention can be delivered (e.g., group, 1:1), over different time frames (e.g., three to 15 weeks), targeting a range of behaviours (e.g., externalising, and internalising behaviours, health management). As a result, this model could meet the unique and varying service needs and can be adapted based on the resources that are available at the time. Due to the small number of studies available, conclusions cannot be made regarding, for example, whether more positive results are produced in a group setting, versus 1:1 NVR parenting interventions. This information may be paramount when setting up new services, thus future research should aim to examine this. In addition, families seeking parenting support often experience multiple stressors, which may require individualised adaptations (Jakob, 2016). The current literature included in this review has primarily focused on challenging behaviour exhibited by the young people, and further research is needed to examine if the NVR parenting model can meet the needs of different family factors (e.g., families of low socio-economic status).

1.8   Conclusions

To date, limited research has been conducted looking at the use and impact of the NVR model when applied to parenting practices. Nonetheless, the current review has found that the model has been used and adapted to different target groups (e.g., challenging behaviour, diabetes management) and delivered in both group and 1:1 setting, demonstrating the flexibility and transferability of the model. The available evidence suggests that an NVR intervention has a positive impact on caregiver (e.g., improved

self-esteem and reduced hopelessness) and child outcomes (e.g., decrease in challenging behaviours, reduction in ADHD symptoms). However, caution must be taken when drawing final conclusions due to a number of limitations that are present. For instance, following the assessment of risk of bias, concerns were raised regarding the selection of the reported results and bias in measurement of outcomes. There is also a lack of representation of diverse ethnic and cultural backgrounds, limiting the generalisability of the results. Further research is also required for the assessment of the long-term benefits and maintenance of the results. Nonetheless, the NVR parenting model can be considered as an option for services aiming to provide support for families with children who exhibit challenging behaviours.

1.9   Acknowledgments

1.10   References

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Chapter 2   The effectiveness of a non-violent resistance parent group intervention run by parent practitioners

This paper has been prepared in the format required by the Child and Adolescent Mental Health journal. See Appendix A for author guidelines.

2.1   Abstract

Background: Young people's antisocial behaviour places high demands on the healthcare, criminal and education systems. Non-violent resistance (NVR) has been developed as an intervention for parents and carers of children who exhibit antisocial behaviours. Based on coercion theory, this systematic approach is made up authoritative parenting skills such as parental presence and de-escalation and promotes connections with the wider social system for support. **Methods:** Outcome measures of 40 participants who attended a 10-week face-to-face NVR parenting group led by NVR parent practitioners were analysed. Parental/carer (self-efficacy, stress, and parenting styles) and child (parent/carer reported overall emotional and behavioural wellbeing) outcomes were measured at three time points (sessions one, five and ten). Processes of change (self-efficacy, parenting style) and their association with target outcomes (parent/carer reported overall emotional and behavioural wellbeing, parental stress) over time were also examined. **Results:** A multilevel model analysis revealed a significant improvement in all measures over time. No association was found between processes of change and target outcomes. **Conclusions**: NVR parent group, run by parent practitioners, is an effective intervention for families with children who exhibit challenging behaviour. The development and delivery of NVR groups can be used to address the need for additional support to be made available to families. Future research should address study limitations by adopting a randomised trial design and including a sample representative of fathers and diverse ethnic and cultural backgrounds.

2.2   Key practitioner messages

- Young people's antisocial behaviour has a negative impact on child and parent/carer outcomes.
- Research into NVR suggests it may be a useful parenting intervention, but evidence is limited.
- The current study demonstrates the effectiveness of an NVR parent group run by NVR parent practitioners, with lived experiences.

- The results suggest an NVR parenting group increases parental self-efficacy, reduces stress, promotes an authoritative parenting style, and improves the overall emotional and behavioural wellbeing of the young people.
- Future research should adopt a randomised control trial design and address generalisability limitations.

2.3   Keywords

NVR; parenting; adolescent; child; caregivers

2.4   Introduction

Young people's antisocial behaviour (also referred to as challenging behaviours) can be seen as a systemic challenge faced by families and professionals. Families with children who exhibit challenging behaviours report lower quality of life and are at higher risk of mental health difficulties (Szentiványi & Balázs, 2018; King, 1997; the National Institute for Health and Care Excellence, 2017; NICE). Reports show antisocial behaviours account for the majority of referrals to children's mental health services, whilst also placing high demands on paediatric services, the criminal justice and education systems (NICE, 2017). Despite its prevalence, it is argued there are insufficient resources and support available (Condry & Miles, 2012).

Studies have reported a relationship between parenting styles and the onset of antisocial behaviour in young people. Parenting factors such as harsh and inconsistent discipline, lack of positive parent and child interactions, and poor supervision have been found to be significant predictors of challenging behaviour in childhood (Loeber & Dishion, 1983; Patterson et al., 1993). More recent studies indicate positive outcomes for young people are more likely to occur when children are parented with positive practices and parenting styles. For example, research suggests children who are parented in an authoritative style (i.e., focus on positive relationships and setting appropriate boundaries), instead of authoritarian (i.e., focus on punishment over discipline) or permissive (i.e., no focus on appropriate boundaries), are more likely to develop high self-esteem (DeHart et al, 2006), and skills for emotional and behavioural adjustments (Scott et al., 2010). Park and Walton-Moss (2012) suggested authoritarian parenting style is associated with higher levels of parental stress. Further links have been found between high parental self-esteem and parent-child interactions; parents who report high self-esteem are more likely to set appropriate boundaries and have good communication skills (Small, 1988), and children with parents with low self-esteem are more likely to engage in challenging behaviours (Albanese et al., 2019).

Parents/carers often face situations in which they are required to respond and react to acutely challenging behaviours exhibited by their children. The non-violent resistance (NVR) model was first applied in the socio-political field, where groups of people and leaders used non-violent actions to fight their cause (Sharp, 2005). The model has since been adapted as a parenting intervention, which aims to upskill parents to be able to respond to challenging behaviour in a non-coercive manner (Omer, 2004). The NVR approach to parenting is based on coercion theory (Patterson, 2016). When applying this model to parenting, it suggests parental coercion (i.e., parents/carers making attempts to control their children), which is experienced by the child as aversive and manipulative, leads to oppositional behaviour from the young person. This type of interaction often results in parents/carers abandoning their attempts to control, thus resulting in a negative reinforcement of the child's misbehaviour. This theory is supported by empirical evidence, which suggests harsh parenting practices are predictors of behavioural difficulties (Rowe et al., 2015). Coercion theory describes an inconsistent parenting style, and this can be linked to attachment theory (Bowlby, 2008). Extensive research has found that attachment styles (i.e., the type of bond the care giver has with the child) is linked to behavioural difficulties in young people. For instance, a meta-analysis concluded that those with an insecure and disorganised attachment style (characterised by inconsistent behaviours which make the young person feel both at threat and safe at different times) are most likely present in families with children who exhibit challenging behaviours (Theule et al., 2016). Despite the link between attachment and coercion theory, attachments styles have not yet been considered part of the NVR model.

The NVR parenting approach is made up of several therapeutic factors. The model encourages parental presence, as opposed to parental avoidance or withdrawal, which often occurs due to conflict that is experienced in the parent-child relationship when the young person exhibits antisocial behaviour (Omer, 2004). Parents/carers are taught de-escalation techniques, which also involves the identification of the parent/carer response patterns to their child's behaviour. The approach coaches' parents to act in a non-escalating manner, with the message that unlike young people's behaviour, they can control their own responses. This in turn reduces conflict and promotes positive family functioning. The importance of reconciliatory interactions is also emphasised. Parents/carers are encouraged to repair relationships through small gestures (Omer, 2004). The NVR model differs from other parenting programmes, in that it places high importance on connecting with the wider family and community (e.g., family friends and family doctor), making this a systemic intervention (Omer, 2004; Jakob, 2016). The inclusion of extended family members and other professionals involved in the young person's life, has been shown to have a positive effect on behavioural difficulties (Carr, 2009). Unlike other parenting programmes, NVR also emphasises the importance of father engagement (Omer, 2004).

There is growing evidence illustrating the effectiveness of the NVR model. Studies have found the approach improves young people's emotional and behavioural difficulties as well as psychological and social functioning (Newman et al., 2014). An NVR intervention has also produced positive results when working with substance misuse (Attwood et al., 2020) and Type 1 diabetes management (Rothman-Kabir et al., 2022), highlighting the transferability of the model. The NVR approach has been successfully adapted to different settings including foster placements (e.g., Van Holen et al., 2016) and residential settings (e.g., Visser et al., 2021). However, the emerging literature is often reporting outcomes from small groups of participants and there is evidence of reporting bias, where only complete sets of data are included in the analyses. Additionally, to date, no studies have explored the effectiveness of an NVR parent group run by parent practitioners, with lived experiences. Finally, key processes that are targeted by NVR, such as change in parenting style, is yet to be explored, which could provide insight into who may be more likely to benefit from the group.

The current study had two aims. Firstly, the study aimed to examine change on parent/carer (parental self-efficacy, parental stress, and parenting style) and child outcome (parent/carer reported overall emotional and behavioural wellbeing). It was hypothesised following the completion of the group parental self-efficacy will increase, parental stress will decrease, and the style of parenting will become less dysfunctional. The NVR model does not directly target young people's behaviour, and instead upskills parents/carers with the aim for the change in parenting to have a positive influence on the child's behaviour. With this in mind, the current study aimed to investigate child outcomes as reported by parents/carers. It was predicted following the completion of the group, parents/carers will report an improvement in the overall emotional and behavioural wellbeing of their children. To date research has not explored the potential processes of change in NVR and how they are related to key outcomes (e.g., parenting stress and child wellbeing). Thus, the second aim for the study was to examine processes of change and their association with target outcomes over time. It was predicted over the 10-week period there will be an association between parenting style and parental stress and the parent/carer reported overall child emotional and behavioural wellbeing. It was also hypothesised parental self-efficacy will be associated with the outcomes of parental stress and the parent/carer reported overall child emotional and behavioural wellbeing.

2.5 Methods

2.5.1 Ethics

Ethical approval for this study was obtained from the Faculty Ethics Committee at University of Southampton (ERGO: 77381.A1).

2.5.2   *Participants*

Participants were parents/carers of young people who exhibit challenging and defiant behaviour that was difficult to manage. Access to the group was obtained through self-referral and links with the local authorities and schools. This means that parents/carers were able to contact the group facilitators via email to express an interest in attending the group. In addition, local authorities such as social care and schools signposted parents/carers through advertisement of the group. Parents/carers were not required to explain reasons for attending (i.e., what the challenging behaviours were), thus no threshold was placed on group entry.

2.5.3   *Intervention*

The NVR parent groups were run by an independent NVR organisation in the United Kingdom. The groups ran over 10 sessions lasting three hours each, covering different skills and interventions proposed by the NVR model. The content of the group was developed with reference to Omer's (2004) book and Day and Heismann (2010) NVR handbook. The content of the 10-week group covered ten primary NVR topics and skills (raising parental presence, de-escalation, relational gestures, the 'three baskets' exercise, supporters, announcements, vigilant care, the traffic light system, message campaign, and the sit in technique). Each group had between 10-15 participants and the sessions were facilitated face-to-face by NVR parent practitioners. NVR parent practitioners were group facilitators who all had lived experience of caring for children with challenging behaviours. All the NVR parent practitioners had previously attended an NVR parent group, and later trained in NVR and became NVR practitioners.

2.5.4   *Outcome measures*

As part of routine procedures, all group attendees completed a set of questionnaires. Measures were completed at four time points (session one, five, ten and, 8-10 week follow-up).

The Brief Parental Self-efficacy scale (BPSES; Woolgar, 2013) is a five-item self-report, assessing parental self-efficacy. Participants respond to each statement on a five-point Likert scale, with higher scores indicating higher levels of parental self-efficacy. No psychometric data is currently available; however, the measure has been used in previous research looking at NVR parenting group interventions (e.g., Attwood et al., 2020). Additionally, the current sample was found to have adequate reliability (session one $\alpha = .68$, session 5 $\alpha = .61$, session 10 $\alpha = .84$).

The Parental Stress Scale (PSS; Berry & Jones, 1995) is a self-report measure of parental stress. Parents rate 18 statements using a five-point Likert-scale, where lower scores indicate lower levels of stress. The scale has been found to have adequate reliability ($\alpha = .83$; Berry & Jones, 1995). The current sample was found to have good reliability: session one $\alpha = .78$, session five $\alpha = .86$, session ten $\alpha = .90$.

The Parental Strengths and Difficulties Questionnaires (pSDQ; Goodman, 1997) is a parent-reported measure of child emotional and behavioural wellbeing. It can be interpreted using the total score, with higher scores indicative of high levels of emotional and behavioural difficulties. A score of 0-13 is indicative of *close to average* amount of emotional and behavioural difficulties, 14-16 suggests *slightly raised* difficulties, 17-19 indicates a *high* level of difficulties, and 20-40 suggests a *very high* level of emotional and behavioural difficulties. Yao et al. (2009) found evidence of internal consistency (α = .81). There is also evidence of good concurrent and discriminant validity (Muris et al., 2003; Lundh et al., 2008). The current sample's reliability was adequate (session one α = .66, session five α = .63, session ten α = .70).

The Parenting Scale (PS; Arnold et al., 1993) is a 30-item self-report measure of dysfunctional parenting styles, focusing on discipline across three factors (laxness/permissive discipline, over-reactivity/authoritarian discipline, and verbosity/prolonged reprimands). Low scores indicate good parenting (i.e., authoritative parenting) and higher scores suggest dysfunctional parenting (i.e., authoritarian and/or permissive parenting). It has adequate internal consistency and good test-retest reliability (α = .84; Arnold et al., 1993). There was good reliability in the current sample (session one α = .78, session five α = .86, session ten α = .89).

2.5.5   *Study procedure*

The outcome measures were routinely collected during the NVR group at three time points (at the start of session one, five, and ten). As part of this process, participants were asked whether they consent to the data being shared with outside organisations for research purposes. Those who did not consent for their data to be shared, were able to complete the measures for personal use only. The measures were completed on paper. Following ethics approval, the anonymised outcome measures data was shared with the author. The data was received in paper form, and was later transferred onto an electronic document, which was stored securely, and only the author had access. The original documents were returned to the NVR practitioners.

2.5.6   *Data analysis*

The decision to exclude follow-up data was made due to the small number of responses (n = 14; 35% of the overall sample). There was also a large variability in the timing of the data collection at follow-up ranging from 17 to 53 weeks post-intervention, making it difficult to interpret meaningful change over follow-up period. No other exclusions of data were carried out. Data was analysed in SPSS for Mac version 29.0.0 (IBM Corp., 2022). Multilevel modelling was used to measure the effect the attendance to an NVR parent group had on the parent/carer and child outcomes. To explore change over time, time was set as the independent variable. Separate analyses were run for all parent/carer outcomes

(parental self-efficacy, parental stress, parenting style), and parent/carer reported child outcome (overall child emotional and behavioural difficulties). To explore how variables were associated over time, parenting style was set as the independent variable and individual analyses were run to explore the impact on parenting stress and parent/carer reported overall child emotional and behavioural challenges. This was also done with parental self-efficacy. For each analysis, participant level and time were set as random effects. Estimation method was set to restricted maximum likelihood. Assumptions of normality were not met ($p > .05$) and outliers were present. As a result, percentile bootstrap function was used (number of replications set to 1000; 95% confidence interval). Linear trends over time (i.e., steady change time point by time point) and quadratic trends over time (i.e., non-linear trends over time) were examined for all outcomes.

2.6 Results

2.6.1 Sample characteristics

Data was collected from four separate groups and a total of 40 participants completed the outcome measures; 35 (87.5%) were female and five (12.5%) were male. From group one, there were nine (22%) participants, group two had 15 (37.5%) participants, group three had nine (22%) participants and group four had seven (17.5%) participants. Children of the participants were aged between 3-16 years ($M =$ 9.26, $SD = 3.64$; did not disclose = 6). A total of 15 of the children were male (35.71%), 22 were female (52.38%) and three did not disclose the gender of their child (7.14%). Out of the 40 parents/carers, 35 (87.5%) identified as either English, Welsh, Scottish, Northern Irish, or British, whilst five (12.5%) indicated their ethnicity was any other white background.

2.6.2 Change over time

Descriptive data is reported in Table 2.1 and the complete results from the multilevel analyses can be found in Table 2.2. When exploring change over time, results suggested the attendance to the NVR group significantly increased the scores on the BPSES measure. This suggests parental self-efficacy improved over the 10-week period. There was a significant main effect of the factor time on parenting style, suggesting that over the 10-week period parenting styles became less authoritarian. There was also a significant reduction in the scores reported on the PSS measure, indicating that parental stress reduced over time. Finally, there was a significant main effect of the factor time on the overall young people's emotional and behavioural wellbeing, as reported by the parents/carers. The results suggested parent-reported child emotional and behavioural challenges initially and temporarily increased during the first few weeks of treatment and decreased by the end of the intervention (see Figure 2.1). These results suggest the NVR group did not have an immediate positive impact on the outcomes of the

children, and instead, the children's overall wellbeing worsened in the first five weeks and improved in the last five weeks of the group.

Table 2.1   Descriptive statistics for outcome measures at baseline, mid-intervention, and end of intervention

	Baseline (Session 1)			Mid-intervention (Session 5)			End of intervention (Session 10)		
	n	*M*	*SD*	n	*M*	*SD*	n	*M*	*SD*
BPSES	39	16.33	3.37	39	19.13	2.39	29	20.9	2.99
PS	40	103.9	30.46	39	92.33	2.39	29	81.45	13.47
PSS	38	50.37	8.69	38	46.68	8.94	30	39.3	9.72
pSDQ	39	24.79	5.63	38	23.24	5.6	29	10.03	3.27

Note. BPSES = the Brief Parental Self-efficacy scale; PS = the Parenting Scale; PSS = the Parenting Stress Scale; pSDQ = the Parental Strengths and Difficulties Questionnaires

Table 2.2 Change over time in parental stress, parent-reported child behavioural challenges, parental self-efficacy, and parenting style

Outcome	Predictors of outcome during intervention	B	Boot. SE	Bootstrapped 95% Confidence Intervals		p
				Lower	**Upper**	
Parent/carer-reported child behavioural challenges (pSDQ)	Time (linear trend)	4.38	2.59	.21	8.3	.014
	Time (quadratic trend)	-5.87	1.3	-7.7	-3.81	.001
Parenting stress (PSS)	Time (linear trend)[+]	-5.07	.79	-6.44	-3.34	<.001
Parental self-efficacy (BPSES)	Time (linear trend)[+]	2.29	.32	1.59	2.9	<.001
Parenting style (PS)	Time (linear trend)[+]	-12.62	2.31	-16.97	-7.99	<.001

Note. [+] Quadratic trend was tested, but not statistically significant; BPSES = the Brief Parental Self-efficacy scale; PS = the Parenting Scale; PSS = the Parenting; Stress Scale; pSDQ = the Parental Strengths and Difficulties Questionnaires

Figure 2.1   Parent/carer reported young people overall emotional and behavioural difficulties; quadratic trend
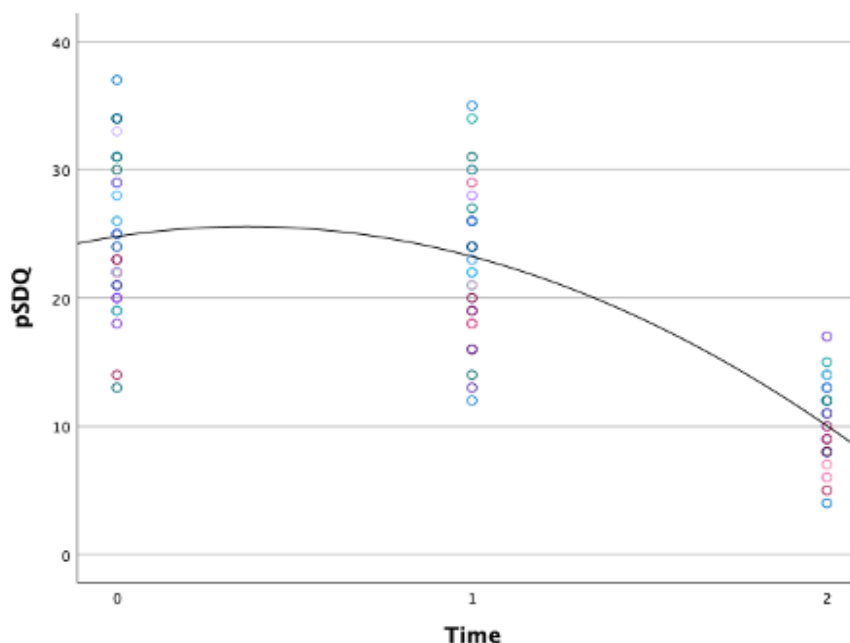
Note. 0 = baseline; 1 = mid-intervention; 2 = end of intervention; pSDQ = the Parental Strengths and Difficulties Questionnaires

2.6.3   Processes of change

Relationships between variables over time were also examined. The multilevel model analyses indicate the hypothesised mediators parenting style and parental self-efficacy, were not associated with the outcomes over time ($p > .05$; see Table 2.3). This suggests parenting style and self-efficacy did not influence parental stress and children's overall wellbeing, as reported by parents/carers.

Table 2.3   Processes of change in parental self-efficacy and parenting style

Predictors of outcome during treatment	Outcome	B	Boot. SE	Bootstrapped 95% Confidence Intervals		*p*
				Lower	**Upper**	
Parental self-efficacy (BPSES)	Parent/carer reported child behavioural challenges (pSDQ)	-.17	.33	-.67	.64	.477
	Parental stress (PSS)	-.44	39.8	-1.19	.83	.217
Parenting style (PS)	Parent/carer reported child behavioural challenges (pSDQ)	.07	.59	-.72	1.92	.933
	Parental stress (PSS)	.39	.45	-.54	1.37	.392

Note. BPSES = the Brief Parental Self-efficacy scale; PS = the Parenting Scale; PSS = the Parenting; Stress Scale; pSDQ = the Parental Strengths and Difficulties Questionnaires

2.7   Discussion

The current project set out to explore the effectiveness of an NVR parent group intervention attended by caregivers seeking support when parenting young people who exhibit challenging behaviours. The study had two aims. Firstly, the project aimed to investigate parent/carer (parental self-efficacy, parental stress, and parenting style) and child outcomes (parent/carer reported overall emotional and behavioural wellbeing) following the completion of a 10-week NVR intervention. Secondly, the research aimed to examine the processes of change and their associations with target outcomes over time. The results revealed that there was a significant improvement in all measures over time. However, no association was found between processes of change and target outcomes. The investigation of the outcomes of the NVR intervention was deemed important due to the negative impact antisocial behaviour has on both the parents/carers and their children, and the health and social systems (Szentiványi & Balázs, 2018; NICE, 2017). It has also been argued there are insufficient resources currently available to support families (Condry & Miles, 2012), highlighting the need for further interventions to be made available. To date, no literature has explored the effectiveness of NVR groups led by parent practitioners or the process of change that is hoped to take place in relation to the parent/carer and child outcomes.

Change over time on parent/carer and child outcomes was investigated. The analysis revealed parental self-efficacy and stress improved significantly following the completion of the 10-week group. Improvements in parental self-efficacy have also been found in previous studies exploring the effectiveness of NVR parent groups (Newman et al., 2014; Attwood et al., 2020). However, the current results of reduced parental stress are contradictory to previous research, that found NVR parent groups to have no significant impact on levels of stress (Van Holen et al., 2018; Van Holen et al., 2016). One possible reason may be due to different outcome measures being used. Change in parenting style was also examined. The results revealed the parenting style scores significantly reduced over time, indicating parents/carers were less likely to apply authoritarian parenting styles. Using these results, it can be argued the attendance to an NVR parent group has a positive influence on the way in which caregivers' parent their children. To the best of our knowledge changes in parenting styles has not been explored in previous NVR parent group research. However, the measure (PS) has been used in the evaluation of other parenting groups, which have concluded parenting interventions have a positive impact on parenting styles (Fujiwara et al., 2011). Risk of demand characteristics may be present when measuring parenting style. This is because participants are informed NVR parent groups aim to upskill caregivers with different parenting tools and they are encouraged to practice and apply these at home. When exploring changes in parenting style, future researchers should consider collecting outcome data both from parent/carer self-reports and from professional observations.

Parent/carer-reported young people's outcomes were also explored. The NVR group does not specifically target the child's behaviour, and instead aims to upskill the caregivers. Nonetheless, it was deemed important to explore the impact the caregiver's attendance to the group had on the young people, particularly because the young people's challenging behaviour was the motivator for the initial referral. The analysis suggests the group had a positive impact on the young people's overall emotional and behavioural wellbeing as reported by the caregivers. This is in line with previous research (Newman et al, 2014). When exploring this further, the authors found the parent/carer-reported children overall emotional and behavioural wellbeing the scores moderately increased between session one and five, suggesting a decrease in the overall emotional and behaviour wellbeing of the children. However, the scores rapidly decreased between week five and 10, indicating the overall emotional and behavioural wellbeing of the children significantly improved. It can be hypothesised this may have been due to different family dynamics present in the house, as a result of parents/carers applying new ways of parenting, thus causing some levels of distress to the children. This is in line with literature which suggests that routine within the family household plays a significant role in children's overall wellbeing (Spagnola et al., 2007). Further research is required to explore this in more detail. In addition, future research should consider incorporating child-reported measures for representation of the lived experience of the young people.

The second aim of the study was to examine processes of change. It was predicted there will be an association between parenting style and parental stress and the parent/carer reported overall child emotional and behavioural wellbeing. It was also hypothesised parental self-efficacy will be associated with the outcomes of parental stress and the parent/carer reported overall child emotional and behavioural wellbeing. However, no associations were found. This raises questions regarding what factors improve parenting stress and the overall emotional and behavioural wellbeing of children. These findings are unlike previously reported results which show links between low parental self-esteem and challenging behaviours in children (Albanese et al., 2019), as well as links between parenting style and levels of stress (Park & Walton-Moss, 2012). Thus, further research is required to explore what factors of the NVR model influence outcomes.

The current results highlight the positive impact an NVR parent group can have on both the parents/carers and their children and that these results can be achieved in groups being delivered by NVR parent practitioners. Previous research has found peer-to-peer interventions reduce barriers to accessing services and provide positive working relationships (as a result of shared experiences, for example), which may be more difficult to achieve between service users and professionals (Dennis, 2003; Thomson et al., 2014). Future development of groups should consider employing parent practitioners to increase accessibility to the intervention. Peer-to-peer intervention may also provide economic benefits when taking into account the cost of training professionals, versus the training of parent practitioners.

Having an intervention available that does not require the direct participation of the young person can be seen especially desirable by families with children who present with oppositional behaviours. Researchers have also reported a high percentage in dropout rates in young people's outpatient mental health services (De Haan et al., 2013), thus highlighting the importance of family interventions that do not require direct child engagement.

The attendance to the group was not restricted by the severity of the difficulties experienced, or the types of challenging behaviours exhibited by the children. This highlights the transferability of the NVR parenting model, which can meet the needs of a variety of needs. Furthermore, the groups were accessed through self-referrals. A self-referral route has been found to open access to services and be appealing to individuals who may be resistant to seek support from professionals such as their family GP (Brown et al., 2010). This may also have positive clinical implications, due to the reduced reliance on services to assess and re-refer families.

The group size varied between 10-15 participants. Thus, it can be argued that there was a good response rate from each group and risk of non-response bias is low. Nonetheless, there are limitations to the generalisability of the results. All participants were from a white ethnic background. When considering diverse ethnic backgrounds and associated parenting styles, coercive parenting does not always have a negative impact on children, as some have suggested (e.g., Rowe et al., 2015). For instance, in Chinese culture, this type of parenting style is common and has been shown to have a positive effect on children's academic achievements (Chao, 2001). This can be seen as a limitation of the model as it may not be able to meet culturally diverse needs. Further research is required to explore this and how it relates to a broader spectrum of cultures. Furthermore, despite the approach emphasising the importance of father engagement (Omer, 2004; Gershy & Omer, 2017), only five males participated in the groups explored in this study. Previous research has suggested father engagement has a positive impact on child functioning (Dubowitz et al. 2001), emphasising the importance of father engagement in parenting programmes.

The current study does not provide insight into the maintenance of the results achieved during the 10-week parent group. Longitudinal research is required with short-to-long term follow-up data collection, to explore whether positive significant results gained are maintained post-intervention. This study aimed to achieve this, however, due to the small response rate, follow-up data was not included in the final analysis. Furthermore, the current study used a non-randomised design with no comparison groups. As a result, the presence of selection bias is increased, for instance. Future research should adopt a randomised controlled trial design, to minimise bias and control for confounding variables.

2.8   Conclusions

The current study supports the use of NVR as a parenting intervention. The results of the study suggest the NVR model is an effective approach for the improvement of parental self-efficacy and stress, as well as having a positive influence on parenting styles. There is also evidence that desirable outcomes are experienced by the children, with parent/carer reports suggesting there is an improvement in the overall child emotional and behavioural wellbeing.

The current study only used self-reports of parents/carers and no follow-up data was included. There are also study design limitations, including the use of non-randomised design and sample of non-representative participants. Future research should aim to address these limitations. With the above in mind, it can be suggested NVR is an effective intervention for supporting parents/carers with children who exhibit antisocial behaviours in the short-term. In practice, the use of parent practitioners, as well as the self-referral route can be seen as an advantage, which can address the need for additional support to be made available to families in a cost-effective way.

2.9   Acknowledgements

2.10   References

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Appendix A   Author guidelines

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1. Contributions from any discipline that further clinical knowledge of the mental life and behaviour of children are welcomed. Papers need to clearly draw out the clinical implications for mental health practitioners. Papers are published in English. As an international journal, submissions are welcomed from any country. Contributions should be of a standard that merits presentation before an international readership. Papers may assume any of the following forms: Original Articles; Review Articles; Innovations in Practice; Narrative Matters; Debate Articles.

CAMH considers the fact that services are looking at treating young adults up until the age of 25, with the evidence that brains continue to develop until the age of 25, as well as the fact that a lot of issues that affect young adults and students are also relevant and topical to older adolescents. CAMH offers a discretionary approach and will take into consideration papers that extend into young adulthood, if they are pertinent developmentally to the younger population and contribute further to a developmental perspective across adolescence and early adult years.

Authors are asked to remember that CAMH is an international journal and therefore clarification should be provided for any references that are made in submitted papers to the practice within the authors' own country. This is to ensure that the meaning is clearly understandable for our diverse readership. Authors should make their papers as broadly applicable as possible for a global audience.

Original Articles: Original Articles make an original contribution to empirical knowledge, to the theoretical understanding of the subject, or to the development of clinical research and practice.

Review Articles: These papers offer a critical perspective on a key body of current research relevant to child and adolescent mental health. The journal requires the pre-registration of review protocols on any publicly accessible platform (e.g. The International Prospective Register of Systematic Reviews, or PROSPERO).

Short Research Articles: Short Research Articles should consist of original research of any design that presents succinct findings with topical, clinical or policy relevance. For example, preliminary novel findings from pilot studies, important extensions of a previous study, and topical surveys.

Letters to the Editor: These are short articles that offer readers the opportunity to respond to articles published in CAMH. Letters must only discuss issues directly relevant to the content of the original article such as to add context, correction, offer a different interpretation, or extend the findings.

Innovations in Practice: These papers report on any new and innovative development that could have a major impact on evidence-based practice, intervention and service models.

Narrative Matters: These papers describe important topics and issues relevant to those working in child and adolescent mental health but considered from within the context and framework of the Humanities and Social Sciences.

Debate Articles: These papers express opposing points of view or opinions, highlighting current evidence-based issues, or discuss differences in clinical practice.

Technology Matters: These papers provide updates on emerging mental health technologies and how they are being used with and by children and young people.

2. Submission of a paper to *Child and Adolescent Mental Health* will be held to imply that it represents an original submission, not previously published; that it is not being considered for publication elsewhere; and that if accepted for publication it will not be published elsewhere without the consent of the Editors.

3. Manuscripts should be submitted online. For detailed instructions please go to: **http://mc.manuscriptcentral.com/camh_journal** and c*heck for existing account* if you have submitted to or reviewed for the journal before, or have forgotten your details. If you are new to the journal c*reate a new account.* Help with submitting online can be obtained from the Editorial Office at ACAMH (email: **publications@acamh.org**)

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Disclosure of interest form
All authors will be asked to download and sign a full Disclosure of Interests form and acknowledge this and sources of funding in the manuscript.

Ethics
Authors are reminded that the *Journal* adheres to the ethics of scientific publication as detailed in the ***Ethical principles of psychologists and code of conduct*** (American Psychological Association, 2010). These principles also imply that the piecemeal, or fragmented publication of small amounts of data from the same study is not acceptable. The Journal also generally conforms to the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors (**ICJME**) and is also a member and subscribes to the principles of the Committee on Publication Ethics (**COPE**).

Informed consent and ethics approval

Authors must ensure that all research meets these ethical guidelines and affirm that the research has received permission from a stated Research Ethics Committee (REC) or Institutional Review Board (IRB), including adherence to the legal requirements of the study county. Within the Methods section, authors should indicate that 'informed consent' has been appropriately obtained and state the name of the REC, IRB or other body that provided ethical approval. When submitting a manuscript, the manuscript page number where these statements appear should be given.

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The Journal requires authors to conform to CONSORT 2010 (see **CONSORT Statement**) in relation to the reporting of randomised controlled clinical trials; also recommended is the **Extensions of the CONSORT Statement** with regard to cluster randomised controlled trials). In particular, authors must include in their paper a flow chart illustrating the progress of subjects through the trial (CONSORT diagram) and the CONSORT checklist. The flow diagram should appear in the main paper, the checklist in the online Appendix. Trial registry name, registration identification number, and the URL for the registry should also be included at the end of the methods section of the Abstract and again in the Methods section of the main text, and in the online manuscript submission. Trials must be registered in one of the ICJME-recognised trial registries:

Australian New Zealand Clinical Trials Registry
Clinical Trials
Netherlands Trial Register
ISRCTN Registry
UMIN Clinical Trials Registry

Manuscripts reporting systematic reviews or meta-analyses will only be considered if they conform to the **PRISMA Statement**. We ask authors to include within their review article a flow diagram that illustrates the selection and elimination process for the articles included in their review or meta-analysis, as well as a completed PRISMA Checklist. The journal requires the pre-registration of review protocols on

any publicly accessible platform (e.g. The International Prospective Register of Systematic Reviews, or PROSPERO).

The **Equator Network** is recommended as a resource on the above and other reporting guidelines for which the editors will expect studies of all methodologies to follow. Of particular note are the guidelines on qualitative work **http://www.equator-network.org/reporting-guidelines/evolving-guidelines-for-publication-of-qualitative-research-studies-in-psychology-and-related-fields** and on quasi-experimental **http://www.equator-network.org/reporting-guidelines/the-quality-of-mixed-methods-studies-in-health-services-research** and mixed method designs **http://www.equator-network-or/reporting-guidelines/guidelines-for-conducting-and-reporting-mixed-research-in-the-field-of-counseling-and-beyond**

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5. Manuscripts should be double spaced and conform to the house style of *CAMH*. The title page of the manuscript should include the title, name(s) and address(es) of author(s), an abbreviated title (running head) of up to 80 characters, a correspondence address for the paper, and any ethical information relevant to the study (name of the authority, data and reference number for approval) or a statement explaining why their study did not require ethical approval.

Summary: Authors should include a structured Abstract not exceeding 250 words under the sub-headings: Background; Method; Results; Conclusions.

Key Practitioner Message: Below the Abstract, please provide 1-2 bullet points answering each of the following questions:

- **What is known?** - What is the relevant background knowledge base to your study? This may also include areas of uncertainty or ignorance.
- **What is new?** - What does your study tell us that we didn't already know or is novel regarding its design?
- **What is significant for clinical practice?** - Based on your findings, what should practitioners do differently or, if your study is of a preliminary nature, why should more research be devoted to this particular study?

Keywords: Please provide 4-6 keywords use **MeSH Browser** for suggestions

6. Papers submitted should be concise and written in English in a readily understandable style, avoiding sexist and racist language. Articles should adhere to journal guidelines and include a word count of their paper; occasionally, longer article may be accepted after negotiation with the Editors.

7. Authors who do not have English as a first language may choose to have their manuscript professionally edited prior to submission; a list of independent suppliers of editing services can be found at **http://authorservices.wiley.com/bauthor/english_language.asp**. All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

8. Headings: Original articles should be set out in the conventional format: Methods, Results, Discussion and Conclusion. Descriptions of techniques and methods should only be given in detail when they are unfamiliar. There should be no more than three (clearly marked) levels of subheadings used in the text.

9. All manuscripts should have an Acknowledgement section at the end of the main text, before the References. This should include statements on the following:

Study funding: Please provide information on any external or grant funding of the work (or for any of the authors); where there is no external funding, please state this explicitly.

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References to journal articles should include the authors' surnames and initials, the year of publication, the full title of the paper, the full name of the journal, the volume number, and inclusive page numbers. Titles of journals must not be abbreviated. References to chapters in books should include authors' surnames and initials, year of publication, full chapter title, editors' initials and surnames, full book title, page numbers, place of publication and publisher.

11. Tables: These should be kept to a minimum and not duplicate what is in the text; they should be clearly set out and numbered and should appear at the end of the main text, with their intended position clearly indicated in the manuscript.

12. Figures: Any figures, charts or diagrams should be originated in a drawing package and saved within the Word file or as an EPS or TIFF file.
See **http://authorservices.wiley.com/bauthor/illustration.asp** for further guidelines on preparing and submitting artwork. Titles or captions should be clear and easy to read. These should appear at the end of the main text.

13. Footnotes should be avoided, but end notes may be used on a limited basis.

Data Sharing and Supporting Information

CAMH encourages authors to share the data and other artefacts supporting the results in the paper by archiving them by uploading it upon submission or in an appropriate public repository. Examples of possible supporting material include intervention manuals, statistical analysis syntax, and experimental materials and qualitative transcripts.

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Original Articles

Original Articles make an original contribution to empirical knowledge, to the theoretical understanding of the subject, or to the development of clinical research and practice. Adult data is not usually accepted for publication unless it bears directly on developmental issues in childhood and adolescence.

Your Original Article should be no more than 5,500 words including tables, figures and references.

Review Articles

Research Articles offer our readers a critical perspective on a key body of current research relevant to child and adolescent mental health and maintain high standards of scientific practice by conforming to systematic guidelines as set out in the **PRISMA statement**. These articles should aim to inform readers of any important or controversial issues/findings, as well as the relevant conceptual and theoretical models, and provide them with sufficient information to evaluate the principal arguments involved. All review articles should also make clear the relevancy of the research covered, and any findings, for clinical practice.

Your Review Article should be no more than 8,000 words excluding tables, figures and references and no more than 10,000 including tables, figures and references.

Short Research Articles

Short Research Articles should consist of original research of any design that presents succinct findings with topical, clinical or policy relevance. For example, preliminary novel findings from pilot studies, important extensions of a previous study, and topical surveys. Short Research Articles will be peer

reviewed and authors might be asked to revise and edit their article to acceptable standards for publication. Short Research Articles should follow standard guidelines, such as STROBE for observational studies, CONSORT extension for pilot trials etc.

Your Short Research Article should be 1500 words, excluding references, tables and graphs/figures. Your article should be structured, including the subheadings Introduction/Methods/Results/Discussion. There is a maximum of 1 table and 1 graph/figure. Please do not include more than 12 references.

Narrative Matters: The Medical Humanities in CAMH

These articles are both submissions and directly commissioned papers. They will be peer-reviewed. The articles should be on a humanities topic relevant to those working in child and adolescent mental health. The topics can include but are not restricted to: aspects of child mental health service history; representations of abnormal mental states or mental illness in children and teenagers in film, literature or drama; depictions of child mental health clinicians within popular culture; ethical dilemmas in the speciality. Interest and originality are valued. If in doubt, please contact the section editor: **Gordonbates@virginmedia.com**

The essays should be between 1500 and 2000 words and written for an audience of child mental health professionals. For publishing reasons, there is an upper limit of 8 references for the article. Additional references may be given in the text if necessary.

Letters to the Editor

Letters to the Editor are short articles that offer readers the opportunity to respond to articles published in CAMH. Letters must only discuss issues directly relevant to the content of the original article such as to add context, correction, offer a different interpretation, or extend the findings. Letters will be evaluated for relevance to the index paper, scientific merit, and importance.

Letters should be submitted not later than 2 weeks after publication of the print issue of the Journal containing the paper of interest. Please note - all papers are published on Early View as soon as they are accepted. The letters should avoid personal attacks and unscholarly communication.

Letters will not be peer reviewed. However, the section Editor will review the letters and might consult another Editor before acceptance or rejection.

Due to the short length of this article type, your Letter should be between 500 and 700 words with a maximum of one figure or table. If in doubt, please contact the section editor **c.ani@imperial.ac.uk**

Innovations in Practice

Innovations in Practice promote knowledge of new and interesting developments that have an impact on evidence-based practice, intervention and service models. These might have arisen through the application of careful, systematic planning, a response to a particular need, through the continuing evolution of an existing practice or service, or because of changes in circumstances and/or technologies. Submissions should set out the aims and details of the innovation including any relevant mental health, service, social and cultural contextual factors, and give a close, critical analysis of the innovation and its potential significance for the practice of child and adolescent mental health.

Due to the short length of this article type, your Innovations in Practice article should be no more than 2,200 words including tables, figures and references and contain no more than 8 references.

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Our debate articles express opposing points of view or opinions, highlighting current evidence-based issues, or discuss differences in clinical practice. Although discussion of evidence is welcome, these articles generally do not include primary data. The evidence on which your arguments are based and how that was sourced should be explicit and referenced, and the quality of your evidence made clear.

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Technology Matters

Technology Matters provides updates on emerging mental health technologies and how they are being used with and by children and young people. We aim to cover established technologies such as computer-assisted psychological interventions as well as more novel technologies (e.g. mobile apps, therapeutic games, virtual reality). We will present the evidence base for their use, showcase how they can complement other interventions and are being used in practice and address wider cross-cutting issues (such as technology accreditation, regulation, cost etc.) relevant to practitioners and service funders.

Your paper should be between 1000 and 1500 words. Please do not include more than 7 references. If in doubt, please contact the section editors **Kapil.Sayal@nottingham.ac.uk** or **Jennifer.Martin@nottingham.ac.uk**.

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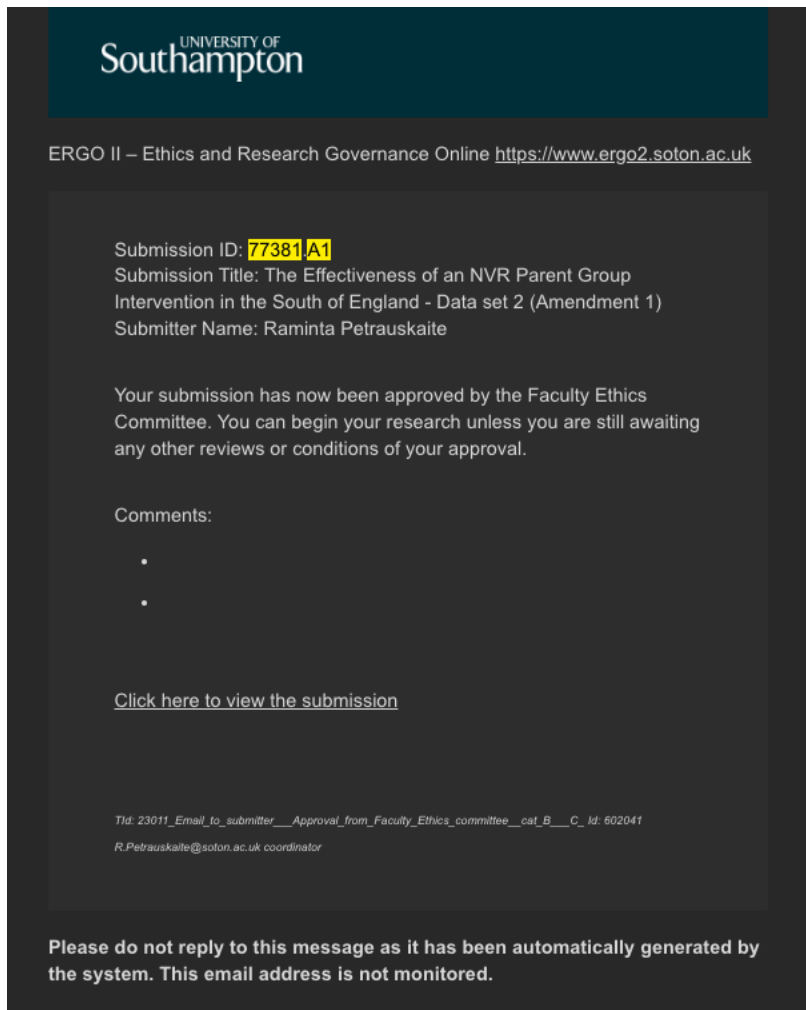
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Appendix B   Confirmation of ERGO ethics approval

Appendix C   Brief parental self-efficacy scale

The following are a number of statements about you and your child.

Please say **how much you agree or disagree** with each one.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. Even though I may not always manage it, I know what I need to do with my child.					
2. I am able to do the things that will improve my child's behaviour.					
3. I can make an important difference to my child.					
4. In most situations I know what I should do to ensure my child behaves.					
5. The things I do make a difference to my child's behaviour.					

Appendix D   The parental strengths and difficulties questionnaire

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviour over the last six months.

Name ....

Date..

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other children (treats, toys, pencils etc.)	☐	☐	☐
Often has temper tantrums or hot tempers	☐	☐	☐
Rather solitary, tends to play alone	☐	☐	☐
Generally obedient, usually does what adults request	☐	☐	☐
Many worries, often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other children or bullies them	☐	☐	☐
Often unhappy, down-hearted or tearful	☐	☐	☐
Generally liked by other children	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous or clingy in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
Picked on or bullied by other children	☐	☐	☐
Often volunteers to help others (parents, teachers, other children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets on better with adults than with other children	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Sees tasks through to the end, good attention span	☐	☐	☐

Do you have any other comments or concerns?

Appendix E   Parental stress scale

The following statements describe feelings and perceptions about the experience of being a parent. Think of each of the items in terms of how your relationship with your child or children typically is. Please indicate the degree to which you agree or disagree with the following items by placing the appropriate number in the space provided.

1 = Strongly disagree 2 = Disagree 3 = Undecided 4 = Agree 5 = Strongly agree

1	I am happy in my role as a parent	
2	There is little or nothing I wouldn't do for my child(ren) if it was necessary.	
3	Caring for my child(ren) sometimes takes more time and energy than I have to give.	
4	I sometimes worry whether I am doing enough for my child(ren).	
5	I feel close to my child(ren).	
6	I enjoy spending time with my child(ren).	
7	My child(ren) is an important source of affection for me.	
8	Having child(ren) gives me a more certain and optimistic view for the future.	
9	The major source of stress in my life is my child(ren).	
10	Having child(ren) leaves little time and flexibility in my life.	
11	Having child(ren) has been a financial burden.	
12	It is difficult to balance different responsibilities because of my child(ren).	
13	The behaviour of my child(ren) is often embarrassing or stressful to me.	
14	If I had it to do over again, I might decide not to have child(ren).	
15	I feel overwhelmed by the responsibility of being a parent.	
16	Having child(ren) has meant having too few choices and too little control over my life.	
17	I am satisfied as a parent	
18	I find my child(ren) enjoyable	

Appendix F   Parenting scale

At one time or another, all children misbehave or do things that could be harmful, are "wrong," or that parents don't like. Examples include: hitting someone, forgetting homework, having a tantrum, whining, throwing food, lying, arguing back, not picking up things, refusing to go to bed, coming home late. Parents have many different ways or styles of dealing with these types of problems. Below are items that describe some styles of parenting.

For each item, fill in the bubble that best describes your style of parenting during the **PAST TWO MONTHS**.

At meal time... I let my child decide how I decide how much to eat	○ ○ ● ○ ○ ○ ○	I decide how much my child eats

IN THE PAST TWO MONTHS

1. When my child misbehaves... *I do something right away*	○ ○ ○ ○ ○ ○ ○	*I do something later*
2. Before I do something about a problem... *I give my child several reminders and warnings*	○ ○ ○ ○ ○ ○ ○	*I use only one reminder or warning*
3. When I'm upset or under stress... *I am picky and on my child's back*	○ ○ ○ ○ ○ ○ ○	*I am not more picky than usual*
4. When I tell my child NOT to do something... *I say very little*	○ ○ ○ ○ ○ ○ ○	*I say a lot*
5. When my child pesters me... *I can ignore the pestering*	○ ○ ○ ○ ○ ○ ○	*I can't ignore the pestering*
6. When my child misbehaves... *I usually get into a long argument with my child*	○ ○ ○ ○ ○ ○ ○	*I don't get into an argument*
7. I threaten to do things that... *I'm sure I can carry out*	○ ○ ○ ○ ○ ○ ○	*I know I won't actually do*
8. I am the kind of parent that... *Sets limits on what my child is allowed to do*	○ ○ ○ ○ ○ ○ ○	*Lets my child do whatever he/ she wants*
9. When my child misbehaves... *I give my child a long lecture*	○ ○ ○ ○ ○ ○ ○	*I keep my talks short and to the point*
10. When my child misbehaves... *I raise my voice or yell*	○ ○ ○ ○ ○ ○ ○	*I speak to my child calmly*
11. If saying no doesn't work right away... *I take some other kind of action*	○ ○ ○ ○ ○ ○ ○	*I keep talking and try to get through to my child*
12. When I want my child to stop doing something... *I firmly tell my child to stop*	○ ○ ○ ○ ○ ○ ○	*I coax or beg my child to stop*
13. When my child is out of sight... *I often don't know what my child is doing*	○ ○ ○ ○ ○ ○ ○	*I always have a good idea of what my child is doing*

Acknowledgements

14. After there's been a problem with my child... *I often hold a grudge*	O	O	O	O	O	O	O	*Things get back to normal quickly*
15. When we're not at home... *I handle my child the way I do at home*	O	O	O	O	O	O	O	*I let my child get away with a lot more*
16. When my child does something I don't like... *I do something about it every time it happens*	O	O	O	O	O	O	O	*I often let it go*
17. When there is a problem with my child... *Things build up and I do things I don't mean to do*	O	O	O	O	O	O	O	*Things don't get out of hand*
18. When my child misbehaves I spank, slap, grab, or hit my child... *Never or rarely*	O	O	O	O	O	O	O	*Most of the time*
19. When my child doesn't do what I ask... *I often let it go or end up doing it myself*	O	O	O	O	O	O	O	*I take some other action*
20. When I give a fair threat or warning... *I often don't carry it out*	O	O	O	O	O	O	O	*I always do what I said*
21. If saying "no" doesn't work... *I take some other kind of action*	O	O	O	O	O	O	O	*I offer my child something nice so he/she will behave*
22. When my child misbehaves... *I handle it without getting upset*	O	O	O	O	O	O	O	*I get so frustrated or angry that my child can see I'm upset*
23. When my child misbehaves... *I make my child tell me why he/she did it*	O	O	O	O	O	O	O	*I say "no" or take some other action*
24. If my child misbehaves and then acts sorry... *I handle the problem like I usually would*	O	O	O	O	O	O	O	*I let it go that time*
25. When my child misbehaves... *I rarely use bad language or curse*	O	O	O	O	O	O	O	*I almost always use bad language*
26. When I say my child can't do something... *I let my child do it anyway*	O	O	O	O	O	O	O	*I stick to what I said*
27. When I have to handle a problem... *I tell my child I'm sorry about it*	O	O	O	O	O	O	O	*I don't say I'm sorry*
28. When my child does something I don't like, I insult my child, say mean things, or call my child names *Never or rarely*	O	O	O	O	O	O	O	*Most of the time*
29. If my child talks back or complains when I handle a problem... *I ignore the complaining and stick to what I said*	O	O	O	O	O	O	O	*I give my child a talk about not complaining*
30. If my child gets upset when I say "no"... *I back down and give in to my child*	O	O	O	O	O	O	O	*I stick to what I said*

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