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Highlights

- Parental anxiety is a risk factor for child mental ill-health and effective prevention efforts targeting this pathway are possible and should be prioritised
- Although evidence on promoting child mental health is available, anxious parents often struggle to access or engage with it; information must be delivered in ways that enable parents to use it effectively to promote their preschool children's mental health
- Anxious parents often lack awareness of early signs in their children, the potential impact of their own anxiety, and how to seek help; they also fear being judged as inadequate parents if they ask for help
- This study offers insights into the characteristics of an acceptable and accessible service aimed at promoting the mental health of children with anxious parents. This knowledge can be relevant beyond the context of parental anxiety and could inform the development and implementation of preventive services across multiple clinical domains

Promoting the Mental Health of Children with Anxious Parents: A Qualitative Investigation of Parents' Views and Needs

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SHORT TITLE: Anxious parents promoting their pre-schoolers' mental health

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Ethical Consideration

Informed consent has been appropriately obtained. The study received ethical approval from the NHS Research Ethics Committee (IRAS ID: 331503) and the University of Southampton’s Psychology Research Ethics Committee (ERGO ID: 84929).

Data Availability

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

Abstract

Objective: Parental anxiety is highly prevalent and is a known risk factor for mental health difficulties in children. Providing targeted support to anxious parents can represent an effective way to reduce the intergenerational transmission of mental ill-health. This study aimed to qualitatively explore what parents who have accessed an NHS talking therapy service for anxiety need from a service aimed at supporting them in minimising the potential negative impacts of parental anxiety on their preschool-aged children.

Methods: Semi-structured interviews were conducted with 16 UK-based parents and data were analysed using reflexive thematic analysis.

Results: Four themes were generated to summarise participants' views: "*There's just not enough support*" highlighted the current lack, in England, of a service that supports anxious parents in preventing their children's mental ill-health; "*It's not easy to find your way to help*" explored existing and potential barriers to service access; "*It's a balance*" collected the characteristics of an accessible and usable service to support parents in supporting their children; and "*Advertise it well*" focused on strategies to facilitate promotion and access to the service. The overarching theme, "*We just need more support for parents. Full stop.*", captured the urgent need for more support for anxious parents and for action to prevent child mental ill-health.

Conclusions: Findings provide insights on characteristics of an adequate prevention service to promote the mental health of children with anxious parents, and can help direct future research, clinical, and policy efforts towards the development of accessible and acceptable prevention programmes.

Keywords: anxiety, child development, intergenerational transmission, mental health, parents, PPI, prevention.

1. Introduction

Mental ill-health is recognised as the primary threat to the health, wellbeing and productivity of young people (McGorry et al., 2024); it affects 10%-20% of children and young people (CYP) worldwide, with a steady increase in prevalence and impact registered over the past two decades and a major surge driven by the COVID-19 pandemic and its aftermath (McGorry et al., 2024). The latest follow-up report to the United Kingdom Mental Health of Children and Young People survey indicates that 1 in 6 (16.7%) children aged 7 to 16 years and 1 in 4 (25.7%) children aged 17 to 19 years have a probable mental disorder (Newlove-Delgado et al., 2022). Meta-analytic evidence shows that mental disorders are already established by age 14 in 35% of individuals, and by age 25 in 63% of individuals (Solmi et al., 2022), and are associated with long-term negative impacts in multiple life domains, including educational attainment, social relationships, mental and physical health, and overall quality of life (Mojtabai et al., 2015; Weitkamp et al., 2013). Currently, mental ill-health accounts for at least 45% of the overall burden of disease in those aged 10 to 24 years (Patton et al., 2016), and is a leading cause of disability in this age group globally (Castelpietra et al., 2022). However, only 2% of global health budgets are allocated to addressing it (McGorry et al., 2024). Further, only a small minority of CYP in need currently accesses adequate care (Gandhi et al., 2022; McGorry et al., 2024), and a recent analysis of more than 71,000 children's health records in England showed that vulnerable children (e.g., from deprived areas, with social services involvement for current concerns) are systematically more likely to be refused access to National Health Service (NHS) Child and Adolescent Mental Health Services compared to their more advantaged peers (Mannes et al., August 2024).

Effective prevention of mental ill-health in youth could help minimise these negative impacts and limit the burden that mental disorders pose over the life course on individuals, societies, and health-care systems, making it one of the best investments in health and social policy reform (McGorry et al., 2024).

The identification of modifiable risk factors is crucial to implement effective prevention strategies (Lawrence et al., 2020). Although genetics play an important role in the development of mental disorders, environmental factors, including parental mental health, parenting practices, and the support available to families, are critical (Ahmadzadeh et al., 2019; Reupert et al., 2022).

Parental psychopathology is one of the most robust modifiable risk factors for the development of mental health difficulties in CYP. Anxiety disorders are the most prevalent psychiatric condition in adults worldwide, with an estimated prevalence of 4.4% in 2021 (IHME, 2024), and higher rates among new parents (Dennis et al., 2017; Leiferman et al., 2021). Moreover, the scientific literature consistently shows that parental anxiety is associated with the development of emotional and behavioural problems in their children (e.g., Lawrence et al., 2019; Trepiak et al., 2022; Zecchinato et al., 2025). With regards to the mechanisms involved in the transmission of risk, theoretical frameworks propose that anxious parents may environmentally transmit vulnerability to mental health difficulties to their children via a social learning pathway (Bandura & Walters, 1977; Grusec, 1994), specifically by the modelling of anxious behaviours or practices, or by the verbal communication of threat-relevant information, in social situations (Askew & Field, 2008; Fisak & Grills-Taquechel, 2007; Murray et al., 2009), as supported by longitudinal observational studies of clinically anxious parents and experimental studies with non-clinical populations (Aktar et al., 2013; de Rosnay et al., 2006; Gerull & Rapee, 2002; Murray et al., 2008; Nimphy et al., 2024; Thirlwall & Creswell, 2010). Importantly, child-to-parent influences are also likely to be at play (Hudson et al., 2009; Lebowitz et al., 2016; Villarreal & Nelson, 2018). Specifically, having a child with emotional and/or behavioural difficulties, including anxiety, can significantly shape parenting behaviours and place significant strain on a parent's mental health, intensifying parental worry and distress and potentially increasing their vulnerability to developing or maintaining mental health conditions (Hudson et al., 2009; Meltzer et al., 2011; Villarreal & Nelson, 2018). This dynamic may contribute to a feedback loop that perpetuates mental health difficulties within the family system (Campbell et al., 2021; Gross et al., 2008; Meltzer et al., 2011). Indeed, rates of anxiety disorders are significantly higher among parents of clinically anxious children compared to parents of non-clinical children (Cooper et al., 2006).

The first years of life are a particularly sensitive period for the exposure to environmental adversity (Cowan et al., 2016), making preschool-age children of anxious parents a high-risk population. Prevention efforts should target these parents to improve their mental health and promote healthier developmental outcomes in their children.

However, the prevention of mental ill-health among children of anxious parents has received limited research attention and, in England, there are currently no clinical NHS services aimed at preventing the negative impacts that parental anxiety can have on their children (Reardon et al., 2018). Therefore, there is an urgent need to understand how to best support parents with lived experience of anxiety in the promotion of their children's mental health.

Elucidating anxious parents' needs and providing them with adequate support in the promotion of their children's positive mental health is crucial. Qualitative approaches allow for in-depth investigation of phenomena directly from individuals with lived experience (Braun & Clarke, 2013) and have been recognised as important to understand barriers and facilitators to access by the UK Medical Research Council (Craig et al., 2008). Prior qualitative studies have focused on perceived barriers and facilitators to access *treatment* for common mental health problems (Radez et al., 2021), including child anxiety difficulties (Reardon et al., 2018), to access targeted anxiety *prevention* programmes (Lawrence et al., 2020), and to participate in preventive research (Festen et al., 2014), from the perspective of both parents and adolescents who had themselves experienced mental ill-health. These studies have identified the following key factors affecting service access: limited mental health knowledge and negative perceptions of help-seeking, lack of awareness of needing professional help and of the support available, perceived or feared social stigma and embarrassment, as well as structural barriers associated with services (e.g., lack of adequate services, high demand of existing services; Festen et al., 2014; Lawrence et al., 2020; Radez et al., 2021; Reardon et al., 2018). The needs of parents who have lived experience of anxiety disorders *and* preschool children have not been rigorously examined with respect to supporting their young children's mental health.

In light of this evidence, the current study aimed to qualitatively explore what parents who have completed an NHS talking therapy for anxiety and have at least one preschool-age child would want and need from a service designed to help prevent the potential negative impacts of parental anxiety on their young children. Specifically, we sought to understand the types of support parents need, the desired characteristics of such a service, and the potential and existing facilitators and barriers to access. By doing this, we hoped to 1) provide useful insights on what a prevention service to promote the mental health of children with anxious parents could look like, and 2) help direct future research, clinical and policy efforts towards the development of prevention programmes that are accessible and acceptable. Importantly, this study focuses on the voices of adults with lived experience of clinical anxiety and NHS mental health service use, who are also parents, rather than on parents who have not accessed such services. These individuals offer unique perspectives on the challenges of parenting with anxiety, including navigating stigma, accessing help, and managing fears of transmitting anxiety to their children. Their familiarity with NHS mental health services may also make them more receptive to prevention efforts and more motivated to engage with initiatives that promote their children's mental health. Rather than examining parenting support more broadly, this study aimed to explore how these parents make sense of, and respond to, prevention-focused initiatives designed to reduce the intergenerational transmission of mental illness.

2. Methods

2.1 Participants

Parents were eligible to participate if they were 18 years old or above, had at least one preschool-age child (between 18 months old and 5 years old, who had not yet started primary school), had lived experience of an anxiety disorder or impairment caused by anxiety, self-identified that they had recovered from the impact of anxiety or felt that anxiety no longer had a significant impact on their life, had completed an NHS psychological therapy for anxiety, were resident in the UK, and were able to have an online interview (e.g., had a device with internet access). We expected that participants would be able to communicate in English. However, because we aimed to recruit a diverse participant group, we recognized potential barriers to participation such as being a native speaker of a language other than English. Therefore, if non-English speaking individuals expressed interest in participating, we planned to use independent interpreters and informed potential participants of this option in the participant information sheet.

We anticipated that we would need to recruit 10-15 parents, based on sample sizes from previous qualitative studies with comparable research aims (e.g., Lawrence et al., 2020; Reardon et al., 2018). Nevertheless, recruitment was governed by the concept of information power (Malterud et al., 2016) and ended once the research team determined that enough data of sufficient quality and depth had been collected to answer the research questions.

2.2 Procedure and Materials

The study received ethical approval from the NHS Research Ethics Committee (IRAS ID: XXXX) and the University of XXXX Psychology Research Ethics Committee (ERGO ID: XXXX). See Supplement S1 for details on the procedure and material used. A patient and public involvement (PPI) advisory group provided consultation from study design through to dissemination and details of their involvement are reported in Table 1, following the short form of the Guidance for Reporting Involvement of Patients and the Public Checklist 2 (Staniszewska et al., 2017).

2.3 Data Analysis

Qualitative data were analysed using reflexive thematic analysis (RTA; Braun & Clarke, 2006, 2022), an approach that involves the systematic identification and organisation of patterns of meaning across a dataset. RTA was chosen as it fits with the purpose of addressing a research question related to people's experiences and views, acknowledges the active role of the researcher in interpreting the experiences of participants as they make sense of them, and has established parameters to facilitate high-quality, robust analyses (Braun & Clarke, 2022). We took an inductive approach to data analysis, meaning that the analysis was data-driven and closely linked to participants' accounts. We followed the Reflexive Thematic Analysis Reporting Guidelines (RTARG; Braun & Clarke, 2024) to ensure a comprehensive, rigorous, conceptually and methodologically coherent report of our qualitative study.

RTA is theoretically flexible; it has no specific epistemological or ontological framework (Braun & Clarke, 2022). Given our aim to understand parents' views and needs to prevent their preschooler's mental ill-health, we adopted an experiential qualitative orientation. Experiential qualitative approaches are focused on meaning and experience, on how people make sense of their realities, their worldviews, and frames of reference (Braun & Clarke, 2022). We adopted a critical realist ontological perspective, which recognises the concept of truth and reality (realism) and that the world is knowable, whilst acknowledging that there is no one objective reality, because human practices always shape how we experience and know it (relativism) (Braun & Clarke, 2013, 2022). Our epistemic approach was phenomenological, which is centred on the study of first-person lived experience and treats subjective experiences as a valid and meaningful focus of inquiry (Braun & Clarke, 2022).

The authors actively reflected on how their own experiences, values, knowledge, and identities shaped the study. This was achieved through group supervisory meetings and PPI meetings for the duration of the project, as well as reflexive diaries (see Supplement S2 for reflexivity statement).

Qualitative data analysis was flexibly guided by the six-phase process by Braun and Clarke (2022; see Supplement S3). To promote trustworthiness, we addressed the four criteria outlined by Lincoln and Guba (1988), namely credibility (i.e., we followed Braun and Clarke's 6-phase process), dependability (via the specification of our theoretical assumptions and orientations, and adherence to the RTARG), confirmability (i.e., we used reflexivity and involved our PPI advisory group throughout the study process), and transferability (via reflexivity and purposive sampling).

3. Results

3.1 Participant Characteristics

Twenty-six parents completed the online demographic questionnaire and consent form on Qualtrics. Of these, *n* = 1 was deemed ineligible as they had not completed an NHS talking therapy for anxiety difficulties, and *n* = 3 did not respond to the researcher to arrange the online interview. A further *n* = 6 were eligible in principle, but were not interviewed as the research team, guided by the concept of information power, determined that sufficient high-quality data had been collected and that these additional participants would not enhance the demographic diversity of the sample. This resulted in a final dataset of *N* = 16 participants (11 mothers and 5 fathers). Thirteen parents were recruited through social media, nurseries, schools and parent groups, and three were recruited through NHS trusts. Participants were 24-42 years old (*M* = 33.69, *SD* = 4.40) and the majority (62.50%)

were White British (see Table 2 for participant characteristics. As a note, the names reported in Table 2 are pseudonyms).

3.2 Themes

A thematic map of the results is shown in Figure 1. The views and needs of our participants regarding the prevention of mental ill-health in their children are explored through four themes ("There's just not enough support": Absence of a service; “It’s not easy to find your way to help”: Barriers to prevention; “It’s a balance”: What parents need from a service; and “Advertise it well”: Strategies to facilitate access) and one overarching theme ("We just need more support for parents. Full stop.”). The overarching theme is presented first and is seen as infiltrating the other themes and subthemes, that are presented in the order in which parents may experience them.

3.2.1 Overarching Theme. "We Just Need More Support for Parents. Full Stop.”

Overall, parents repeatedly stressed the need of more support for parents who have (had) anxiety difficulties and the crucial importance of acting to prevent child mental ill-health (*“it's so important to be able to prevent it [child anxiety and poor mental health]”*, Grace). With the term *support*, participants referred to informational (e.g., psychoeducation about the impact of parental anxiety), emotional (e.g., feeling understood and not judged), and practical (e.g., accessible services, flexible formats) assistance that helps parents manage their own mental health while promoting their children’s mental health and development.

Participants highlighted that being a parent is hard and comes with difficulties and concerns that need to be recognised and adequately addressed. Specifically, parents struggling with their mental health face unique challenges and *“deserve a huge amount of priority”* (Nadia), and that is where it is worth investing resources and support:

> *“If you want to invest in children, you need to invest in mothers, parents.”*(Nadia)

As recognised by our participants, this is key considering that parents experiencing mental ill-health can have their caring abilities negatively affected (*“Anxiety affected every single part of my parenting up until I was on the correct medication and having therapy"*, Grace), thus potentially impacting children’s development, and that this represents a main concern for parents.

> *“And sometimes you go, ‘oh, my word, like, what's wrong with my child? Like, have I done this? Is it my fault?’."*(Alice)
>
> *"It's not great to be responsible for small children and to be struggling emotionally precisely because the parenting relationship in it is all about emotions [...] and so it's difficult to see that [children] wouldn't be affected by a parent who's like anxious or depressed or whatever."*(Nadia)

3.2.2 Theme 1: "There's Just Not Enough Support": Absence of a Service

This theme focuses on parents’ experiences with the existing mental health services in England, ultimately highlighting that currently there is not an NHS service that adequately supports anxious parents in the promotion of their children’s mental health, and that these parents’ needs and concerns about their young children remain unaddressed or unmet.

> *"There's just not enough support... like health visitors and people like that, no one promotes [young children’s mental health] enough."*(Grace)

In this regard, participants emphasised that the mental health of parents, of their children, and their potential associations, are not systematically discussed in perinatal parenting classes, and that new parents are not provided with the knowledge and tools that would be useful after the child is born, to face potential emotional or behavioural difficulties manifesting in their children. It was stressed that particular attention regarding the discussion of mental health, and the impact of parental mental health on child development, should be given to those parents who have struggled with their mental health in the past (*"if there's somebody like me who has a history of it, the conversation could be a bit different."*, Laura).

3.2.3 Theme 2: "It's Not Easy to Find Your Way to Help": Barriers to Prevention

Central to parents' reporting was the identification of existing or potential barriers to accessing help and preventive services. These are explored through three subthemes.

3.2.3.1 Lack of Awareness. Participants highlighted lack of awareness of at least three relevant issues as a key barrier to access prevention. These included: (a) awareness of having an impact on their child's mental health (*"Some parents might not be aware of what impact it [parental clinical anxiety] can have on the child"*, Fiona); (b) awareness of needing help to support their child *("If people don't realise that they need the help, they might not actually actively go and seek it."*, Emma); and (c) awareness of the help and resources available to support parents promote their children's mental health, and of the ways to reach out for help (*"My fear is that a lot of people would be left out because they don't have the capacity to reach out for help. It's quite difficult to reach out for help."*, Ivy).

3.2.3.2 Fear of Judgement. Participants reported that key obstacles to accessing preventive services for parents include the *"element of shame [related to] admitting that you need help as a parent"* (Alice), the guilt that may be triggered by the realisation of having negatively impacted your child, and the fear of being labelled as a *"bad parent"* (Grace) (*"You don't want to think that if you sign up to something, you get flagged on a* *system as 'I'm anxious therefore I could be a risk to my child'*.", Laura). A particularly recurring concern among parents was their fear that reaching out for help or accessing a mental health service would raise concerns among social services, with the risk of *"having the child taken away"* (Alice, Grace). Participants also reported that group settings themselves could become *"toxic"* (Nadia), adding pressure and worries to parents, together with the concern of being judged or *"ridiculed"* (Owen) by other parents.

3.2.3.3 Impacted Accessibility.

> *"You can't sign somebody off from their parenting duties, right?*
> *Can you really take a break from that?"*(Nadia)

Our participants highlighted that having caring responsibilities makes it difficult to engage with programmes, impacting the time available to attend services as well as the ability to implement mental health advice. Participants identified that experiencing financial difficulties and lack of childcare may be particularly relevant barriers to accessing preventive services.

3.2.4 Theme 3: "It's a Balance": What Parents Need from a Service

This theme focuses on what parents who have (had) anxiety difficulties would need from a service aimed at supporting them to promote their children's mental health. These needs are explored through four subthemes, linked by a common thread related to the importance of finding a *"balance"*(Laura).

3.2.4.1 Informing Without Alarming. Core to our participants' reports was the importance for the service to share evidence-based information that is relevant for parents, educating parents on the impact that their mental health might have on their children's development (*"Making people aware that your mental health could have an impact on your children's mental health"*, Laura) and on the mechanisms of risk transmission, informing on the reality of having a baby and on *"signs to look out for"* (David), addressing parents' concerns and unrealistic expectations, and teaching coping strategies and tools that can ultimately help parents help their children.

> *"I think it'd be really helpful to know how to tackle things in advance [before the development or manifestation of a mental health problem]. [...] if I was pre-armed with that sort of thing, that would be helpful."*(Laura)

This knowledge should be promoted without alarming parents, but rather normalising and validating their experiences (*"I suppose just making it very normal [...] You don't want to make the people feel that they're abnormal"*, Jessica).

3.2.4.2 Sharing Without Fear of Repercussions. Parents emphasised the need of creating a *"safe environment"* (Alice) where discussions around mental health and parenting struggles are encouraged and where parents feel comfortable disclosing, without feeling judged and without fearing negative repercussions for them or their children.

> *" I think it's very important [for health professionals] to send a reassuring message around those things, because - and I'm very mental health positive - but I still kind of felt a bit... 'Should I tell them this [mental health difficulties] or should I keep it to myself? Because I don't know what they're gonna do with this information'? Like, what's gonna happen? Will they have someone check on me because they're like, 'oh, this person might do whatever', you know."*(Ivy)

Some participants suggested that this supportive and safe space could be achieved if the service consisted of rather informal (to avoid an over-medicalisation of the process and the fear of having a track record of having been referred to a service) and *“regular check-ins”* (Laura), which would help build relationships and create a *“sense of belonging”* (Benjamin) to a supportive *“community”*(Holly).

3.2.4.3 Having Options. When considering the format of the service, parents expressed the importance of flexibility and having a range of options available, including the possibility of bringing or involving their children and accommodating individuals’ circumstances and need.

Generally, participants recognised that an online service would be particularly convenient for parents, but at the same time an in-person service could be beneficial to create a supportive network and reduce the feelings of isolation.

> *"In person is always better, just because that helps build relationships between people. But online is a really useful tool as well. And you wouldn't want people to miss out just because they couldn't come in person for whatever reason. So maybe having different sessions, because I think it wouldn't work as well if it was like mixed."*(Holly)

3.2.4.4 There is No Perfect Time. Participants expressed different opinions regarding when a preventive service would be most helpful, ranging from prenatally (*“the earlier the better”*, Fiona; *“not everyone has to, but it's having the option to access it before you've had your child"*, Martha) to the preschool years. It was also flagged that pregnant mothers are already *“bombarded”* (Nadia) with information, so for some parents it might be overwhelming to receive additional, potentially worrying, information at that stage.

> *"You don't want to increase people's anxiety or depression by emphasising the fact that, you know, on top of everything else,*

> *they're falling short as a parent. But at the same time, you do want to give them help when they themselves worry about those things. I think that's a really tricky balance."*(Nadia)

Overall, most participants indicated that help should be readily available when parents are concerned and *"feel the need"* (Philip), or when a professional identifies the need for additional support.

3.2.5 Theme 4: "Advertise it Well": Strategies to Facilitate Access

This theme focuses on potential strategies that participants identified to facilitate access to preventive services and relates to the way services should be advertised.

3.2.5.1 Reaching Parents Where They Are. Efforts should be made to *"find people at the places where they are"* (Laura), carefully considering that often *"people who need it the most might not access [help]"*(Holly).

Parents and experts by experience indicated ways in which the service could be effectively promoted, including sharing leaflets via social media, workplaces, nurseries, libraries, churches, community leaders. GPs, health visitors, midwives and mental health professionals were also suggested to be in a good place to signpost such services, particularly considering the trusting relationship that has been likely already established with the parent.

3.2.5.2 No Triggers for Parents. Attention should be paid to the words used to promote the service (*"The way the information is relayed to people [is key]."* Ivy), clearly communicating that the aim is to help parents and their children thrive ("*you're joining something to be proactive about your children's mental health, [...] we're prioritising children's mental health"*, Laura), and that *"there's nothing wrong with you for accessing the service. If anything, it's good."*(Martha).

> *"Maybe not having it as a 'stopping your poor mental health affecting children' but presenting it in a way that was about creating positive and really good well-being for yourself so that you can create good well-being for your children. And you know, because we can pass on positive things as well. We can pass on positive coping strategies. And I think that's really the key to overcome these barriers."*(Holly)

4. Discussion

In this study, we sought to understand how to best support anxious parents to promote good mental health in their young children. Considering the high prevalence of anxiety disorders among parents (Dennis et al., 2017; Leiferman et al., 2021), and the risk for subsequent mental ill-health posed to their children (Lawrence et al., 2019; Zecchinato et al., 2025), this represents an area of key research and clinical relevance that has not been explored in previous studies. We examined the views, experiences, and needs of parents who have completed an NHS talking therapy for anxiety-related difficulties and have at least one preschool-age child. Using semi-structured qualitative interviews, we explored parents' accounts and organised them into four key themes, covering the available services in England, barriers to accessing prevention programmes, the needs of anxious parents, and facilitators of access. One overarching theme, the need of more support, resonated through all four themes.

Overall, this study clearly illustrates the need to take action to provide better and more accessible and acceptable support to parents who have experienced mental health disorders, and anxiety specifically, recognising the crucial role that parents play in their children's developmental outcomes (overarching theme). The term *support*, in the context of this study, refers broadly to informational, emotional, and practical assistance provided to parents to help them understand, navigate, and mitigate the potential impact of their anxiety on their children's mental health and development. This imperative resonates with the call to action advocated by the Lancet Psychiatry Commission on youth mental health (McGorry et al., 2024), where, in order to tackle the youth mental health crisis, it is recommended to invest in prevention and early intervention programmes that target modifiable risk factors, including parental mental illness.

When discussing their needs to promote their young children's mental health, parents highlighted that, currently, there is an absence of such services, and that anxious parents' concerns remain unaddressed or unmet (Theme 1). Based on theory and research, we would expect that a programme targeting parental modelling of anxiety and controlling behaviours may be effective (e.g., Ginsburg et al., 2015; Thirlwall & Creswell, 2010), although more studies investigating the causal mechanisms of risk transmission specifically from fathers to preschool-age children are needed. Parents identified several existing or potential barriers to accessing prevention programmes, that should be considered when planning initiatives to support parents in supporting their children (Theme 2). These include: parents' lack of awareness of i) the risk posed by their anxiety to their child's mental health, ii) needing help to support their child, and iii) the help available; fear of being judged as inadequate parents and facing negative consequences because of their anxiety, including raising concerns among social services; and impacted accessibility due to caring responsibilities. The barriers identified in our study are consistent with the findings of previous studies (Festen et al., 2014; Lawrence et al., 2020; Radez et al., 2021), and highlight the importance of educating parents who experience mental health difficulties regarding early signs of poor mental health among children and the sensitive issue of intergenerational risk transmission. Indeed, similar to previous research (Festen et al., 2014), although most parents reported concerns about their children's mental health, they often did not perceive a direct link between their own anxiety symptoms and their children's development. Key for parents was also the fear of being labelled as unfit parents and the stigma associated with needing mental health support for themselves or their children. Indeed, despite the extensive efforts to raise mental health awareness and destigmatise mental illness in the last two decades, stigma around mental illness remains a widespread problem (Foulkes & Andrews, 2023) and currently represents a major obstacle to prevention and early intervention (McGorry et al., 2024).

As outlined in Theme 3, our findings indicate that parents desire multi-faceted support that balances different needs, including: i) access to evidence-based information about the intergenerational transmission of mental health risk and child development; ii) practical tools and coping strategies to address emerging emotional or behavioural challenges in children; iii) safe, non-judgmental spaces for disclosure and peer connection; and iv) flexible, non-stigmatising modes of service delivery, such as informal check-ins rather than formal referrals. These findings align with a growing body of research and service evaluations that emphasise the importance of normalising parenting struggles and addressing fears of judgement and guilt in parent-focused mental health interventions (Aguirre Velasco et al., 2020; Campbell & Poon, 2020; Festen et al., 2014; Reardon et al., 2018; Serchuk et al., 2021; Wilson & Crowe, 2009), while also highlighting the value of empowering parents through knowledge, community connection, and a sense of belonging (Darzi, 2024; Darzi et al., 2018; Grafft et al., 2024; Sanders, 2003; Sanders et al., 2020). Although there was no consensus around an optimal time to receive support to promote children's mental health, parents highlighted the importance of easy and prompt access, consistent with previous research in which other potential service users identified systemic-structural aspects of services as relevant for accessing mental health support (Geist, 2004; Reardon et al., 2017).

To facilitate access (Theme 4), parents recommended to promote services widely, e.g., via social media, to reach as many parents as possible, as well as involving community leaders, midwives, and (mental) health professionals. Parents also discussed the importance of carefully considering the language used to advertise the service. Considering the sensitive focus of the service, which could potentially worry parents with lived experience of anxiety, the advertisement should emphasise the goal of promoting children's mental health and equipping parents with knowledge and strategies to help their children thrive, rather than preventing problems.

4.1 Strengths, Limitations and Clinical Implications

This study has several strengths. We ensured methodological quality following Braun and Clarke's 6-step process for data analysis (Braun & Clarke, 2022) and reporting our research in accordance with the Reflexive Thematic Analysis Reporting Guidelines (RTARG; Braun & Clarke, 2024), and promoted trustworthiness by adhering to the four criteria outlined by Lincoln and Guba (1988). A PPI advisory group of experts by experience provided substantial consultation throughout the research process, adding value and relevance to the research question for anxious parents, clinicians and the wider public; enhancing the ethical robustness of our qualitative study; improving the experience of participation in research; and strengthening the interpretative depth of our analysis. Our dataset comprises both mothers and fathers, which is important considering that fathers are often under-represented in research concerning the intergenerational transmission of psychopathology (Zecchinato et al., 2025). Our sample reflects some diversity in terms of ethnicity and socioeconomic status.

There are also important limitations to consider. First, despite our efforts to recruit a diverse sample, the views expressed by our participants may not be representative of all anxious parents. We specifically focused on the voices of individuals who had completed NHS psychological therapy and who were motivated and willing to participate in a qualitative interview. As such, there is a potential self-selection bias toward parents who are more engaged with services and with the promotion of their children's mental health, more help-seeking, and potentially more receptive to prevention-focused approaches. However, we do not assume that our findings will generalise to the wider population of anxious parents and view this focus as a strength of the study: these participants were uniquely positioned to reflect on parenting with anxiety from a standpoint of lived experience with both clinical anxiety and mental health service use, offering valuable insight into what they would find acceptable and accessible in a preventive intervention. Future research should investigate the specific experiences of other ethnic and socioeconomic groups, who may have different needs and experience additional barriers to access mental health services (Mian et al., 2015). Second, while we included only participants who self-identified as having recovered from the impact of anxiety or who felt it no longer significantly affected their lives, this definition remains subjective. We did not apply a formal or standardised clinical measure of recovery, and interpretations of recovery likely varied among participants. Finally, we did not confirm with participants our final themes; however, seeking participant confirmation of the results is seen as a realist practice and is not advised in RTA approaches (Braun & Clarke, 2022); moreover, experts by experience were involved in data analysis and interpretation.

Our findings highlight an important opportunity for adult mental health services to more explicitly recognise and support the parenting role of service users. Parents with lived experience of anxiety described a desire to protect their children from similar struggles but often felt unsure where to turn for guidance. While these parents may be well positioned to engage with prevention efforts, they also expressed fears of being judged or misunderstood when raising parenting concerns in adult-focused services. This suggests a need for adult services to more proactively acknowledge the dual identity of service users as both individuals with mental health difficulties and as parents. Doing so could help foster a more integrated and supportive context for discussing intergenerational mental (ill-)health and facilitate earlier, family-centered approaches to prevention and treatment, also extending beyond the mother-child dyad (Peris et al., 2021; Strawn & Peris, 2024). Importantly, these efforts should be grounded in principles of accessibility, normalisation, and non-judgment: values that participants repeatedly identified as critical to feeling safe and supported. Embedding psychoeducation about intergenerational risk into routine care, providing staff with training on how to sensitively explore mothers' and fathers' concerns, and creating pathways for referrals to family-focused or preventive services could all be potential steps forward.

5. Conclusions

This qualitative study explored the needs of mothers and fathers who have (had) an anxiety disorder with regard to the promotion of their preschool-age children's mental health. Overall, parents consistently emphasised the need for more support, pointing the absence of an adequate NHS service in England; identified existing and potential barriers and facilitators to accessing preventive programmes; and shared their perspectives on what an accessible and acceptable service to help parents support their children should entail.

The findings of this study have important theoretical and clinical implications. Theoretically, they contribute to the literature promoting the importance of targeted prevention programmes, informing what would facilitate their accessibility and acceptability to anxious parents, thus helping direct future research and policy efforts. Clinically, the findings emphasise the need to promote awareness among anxious parents regarding the promotion of mental health in their children, providing useful insights on prevention strategies that could be extended to other clinical domains. Importantly, the study also underscores the potential for existing adult mental health services to play a greater role in preventing child mental ill-health by recognising and addressing the needs and concerns of parents with lived experience of anxiety, or other mental illness, as part of routine care.

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Table 1 Guidance for Reporting Involvement of Patients and the Public Checklist 2 - Short Form (GRIPP2-SF)

Section and Topic	Item	Explanation
1: Aim	Report the aim of PPI in the study	To ensure that the research focused on priorities relevant for people who may benefit from it; to ensure that the study material was appropriate and sensitive to the intended audience; to ensure that the results and discussion were understandable by, and relevant for, the intended audience.
2: Methods	Provide a clear description of the methods used for PPI in the study	Two parents with lived experience of anxiety and an NHS clinical service lead were recruited to the research team to assist at all stages of the study. They were involved in refining the focus of the research questions, in refining the study material (advertisements, participant information sheet, consent form, indicative topic guide used during the interviews), in analysing the data (refining the themes and naming

Section and Topic	Item	Explanation
		them), and in discussing the findings. The PPI advisory group members contributed to edits of the paper and are coauthors.
3: Study results	Outcomes - Report the results of PPI in the study, including both positive and negative outcomes	PPI contributed to the study in several ways, including: • Considering their experience as parents with lived experience of anxiety or as clinicians, the PPI group members reflected and shared their opinions regarding the value of the study and important aspects to consider (e.g., language used), as well as potential implications (e.g., relevance for prevention and intervention programmes, not only in the context of anxiety) and limitations of the study (e.g., need to collect the needs of underrepresented groups); • Shaping the study material to ensure that it was acceptable and understandable for the targeted audience, and not alarming or triggering; • Helping develop the indicative topic guide, suggesting areas to investigate and providing feedback to ensure that the questions and language used were adequate and sensitive
4: Discussion and conclusions	Outcomes - Comment on the extent to which PPI influenced the study overall. Describe positive and negative effects	PPI in this study was effective and influenced important aspects of the study, improving the acceptability of the study for the participants and the relevance and overall quality of the research conducted. However, there were limitations. The broad research question was already decided; hence, this limited the possibility for the PPI members to shape the aim of the study. One PPI member only took part in the initial stages (first meeting aimed at refining the research questions and initial feedback on the study material), while another member only took part in the final stages (theme refinement, discussion and final edits). At each stage, time for feedback was quite limited, due to the timeframe in which the study needed to be completed, and it was not always possible for all the researchers and PPI members to meet at the same time. In future studies, scheduling these meetings in advance or allowing more time for the research to be completed might overcome this limitation.
5: Reflections/critical perspective	Comment critically on the study, reflecting on the things that went well and those that did not, so others can learn from this experience	PPI was embedded into all the stages of the research process for this study. The PPI members provided valuable inputs for the study and felt that the experience of being part of this project was overall positive and rewarding. Allowing more time for each stage of the study, including initial training on conducting mental health research, could help PPI members better familiarise with the study aims, material, results and discussion, allowing an even more in-depth and meaningful involvement. PPI consultations prior to establishing the research questions for the study would also be key to ensure that the research focus is relevant for and important to the intended audience.

Note. PPI = patient and public involvement.

The table is an adapted version of the GRIPP2-SF (Staniszewska et al., 2017), with an explanation of how each item was addressed in the study in the last column, rather than the page number of where the item is reported in the manuscript. The table provides evidence of how PPI was embedded in the present study.

Table 2 Participant Demographics

Participant's pseudonym	Parent	Parent's age (years)	Parent's ethnicity	Parent's highest education level [a]	Parent's current employment status [b]	Household income [c]	Number of children	Age of children	Household type	Marital status	Recruitment source	NHS access	Type of NHS service
Alice	Mother	32	White British	5	6	3	1	2Y	Two-parent household	married	Social media	Before and after child was born	CBT; EMDR; compassion-based therapy
Benjamin	Father	35	Black British	4	4	3	2	5y; 2y	Two-parent household	married	Social media	Before and after children were born	CBT in person
Chloe	Mother	36	White British	5	3	7	2	2y; 4y	Two-parent household	married	Social media	Before and after children were born	steps2well-being; silver cloud (online)
David	Father	31	Mixed White and African	4	3	3	2	7y; 3y	Two-parent household	married	Social media	Before children were born	One-to-one sessions in person

Participant's pseudonym	Parent	Parent's age (years)	Parent's ethnicity	Parent's highest education level [a]	Parent's current employment status [b]	Household income [c]	Number of children	Age of children	Household type	Marital status	Recruitment source	NHS access	Type of NHS service
Emma	Mother	39	White British	4	2 and 3	4	1	3Y	Two-parent household	married	Social media	Before child was born	step2 well-being counselling for anxiety and hair pulling
Fiona	Mother	26	White British	5	4	2	1	1,5y	Two-parent household	married	Social media	After child was born	counselling
Grace	Mother	29	White British	4	5	1	3	10y; 8y; 1,5y	Two-parent household	domestic partner-ship	Parent group	After children were born	one-to-one and group therapy
Holly	Mother	24	White British	5	3	3	1	1,5y	Two-parent household	married	Social media	Before child was born (while pregnant)	talking therapy
Ivy	Mother	31	White other	5	1	4	1	2y and 3months	Two-parent household	married	University of Southampton	Before child was born	CBT via steps2 well-bei

Participant's pseudonym	Parent	Parent's age (years)	Parent's ethnicity	Parent's highest education level [a]	Parent's current employment status [b]	Household income [c]	Number of children	Age of children	Household type	Marital status	Recruitment source	NHS access	Type of NHS service
													ng (an online course and a one-to-one therapy over the phone)
Jessica	Mother	32	White British	5	4	3	2	2y; 9months	Two-parent household	married	Social media	After children were born	CBT
Kevin	Father	42	White Irish	4	4	4	1	3y	Two-parent household	married	Nursery	Before child was born	CBT; in person group therapy
Laura	Mother	35	White British	4	4, but currently on maternity leave	4	2	3,5Y; 1Y	Two-parent household	married	Nursery	Before children were born	CBT; one-to-one counselling

Participant's pseudonym	Parent	Parent's age (years)	Parent's ethnicity	Parent's highest education level [a]	Parent's current employment status [b]	Household income [c]	Number of children	Age of children	Household type	Marital status	Recruitment source	NHS access	Type of NHS service
Martha	Mother	29	Black British	4	3	4	1	19months	Two-parent household	married	NHS trust	After child was born	CBT online and telephone call
Nadia	Mother	42	White other	5	4	6	4	12y; 10y; 7y; 4y	Two-parent household	domestic partner-ship	Nursery	After preschool child was born	CBT group therapy
Owen	Father	36	White British	3	4	3	2	2,5Y; 5Y	I live on my own and the children live with their mother	separated	NHS trust	After children were born	one-to-one sessions over the phone
Philip	Father	40	White British	3	2	3	1	3Y	Two-parent household	married	NHS trust	Before and after child was born	CBT and counselling, online and in person; iTalk

Note. CBT = Cognitive Behavioural Therapy; EMDR = Eye Movement Desensitisation and Reprocessing.

[a] 1 = Completed GCSE/CSE/O-levels or equivalent (at school till aged 16); 2 = Completed post-16 vocational course; 3 = A-levels or equivalent (at school till aged 18); 4 = Undergraduate degree or professional qualification; 5 = Postgraduate degree.

[b] 1 = Student; 2 = Self-employed; 3 = In part-time employment; 4 = In full-time employment; 5 = Unable due to disability.

[c] 1 = Less than £16,000 a year (£310 a week); 2 = £16,000-£29,999 a year (£310-£569 a week); 3 = £30,000-£59,999 a year (£569-£1149 a week); 4 = £60,000-£89,999 a year (£1500-£1729 a week); 5 = £90,000-£119,999 a year (£1730-£2299 a week); 6 = More than £120,000 a year (£2300 a week); 7 = Prefer not to say.

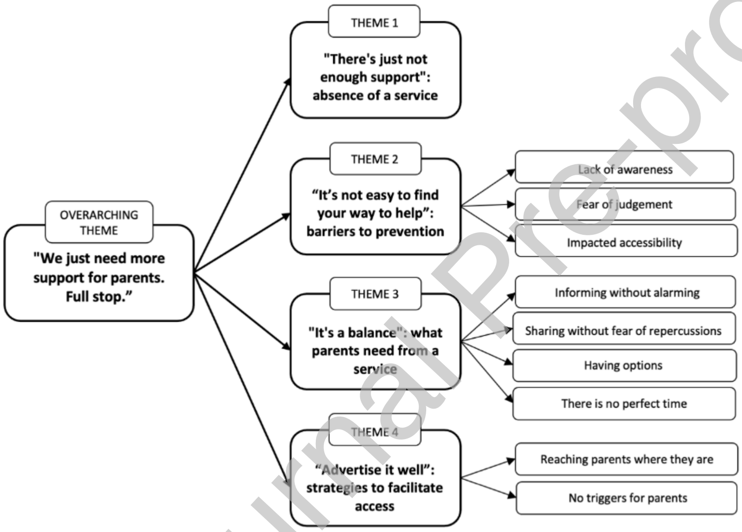

Figure 1 Thematic Map

Declaration of interests

The authors confirm that they have no competing interests to declare.