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**The development and feasibility evaluation of Being a Parent-Enjoying Family Life
A peer-led, group parenting intervention for parents with significant emotional and interpersonal difficulties**

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Awarding institution:
King's College London

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**The development and feasibility evaluation of Being a Parent-Enjoying Family
Life: A peer-led, group parenting intervention for parents with significant
emotional and interpersonal difficulties.**

PhD submitted to King's College London for the degree of Doctor of
Philosophy

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Abstract

Group-format parenting interventions are effective at reducing challenging child behaviour. However, there is significantly less evidence about the performance of these interventions for parents with significant emotional and interpersonal difficulties, including personality disorder diagnoses. Parent emotional and interpersonal difficulties are a substantial risk factor for inconsistent parenting practices and the development of emotional and behavioural difficulties during childhood. Therefore, developing evidence-based parenting interventions for parents with significant emotional and interpersonal difficulties is potentially important in improving and maintaining positive child developmental outcomes and reducing the intergenerational transmission of mental health difficulties. Following the MRC framework for complex intervention development, this PhD aimed to develop and evaluate a novel peer-led, group parenting intervention, Being a Parent-Enjoying Family Life, for parents with significant emotional and interpersonal difficulties and who have concerns about their child's (aged 2-11 years) behaviour.

First, a systematic review was conducted to examine the impact of parental personality disorders and symptoms on parenting of children aged 2-12 years. Second, systematic review findings, wider evidence synthesis and consultation with stakeholders were used to identify targets for intervention and develop the programme theory for a novel intervention (Being a Parent (BaP)-Enjoying Family Life) specifically designed for parents with significant emotional and interpersonal difficulties. The programme theory was used to adapt a well-established peer-led group intervention, the Empowering Parents Empowering Communities- Being A Parent intervention (BaP-Standard), for parents with significant emotional and interpersonal difficulties. Third, this PhD reports findings from a two-arm, parallel groups Feasibility Randomized

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Controlled Trial (RCT), comparing BaP-Enjoying Family life to an active control of BaP-Standard. Quantitative findings are evaluated using pre-specified feasibility criteria related to trial recruitment and retention, and intervention fidelity and acceptability. Initial indicators of intervention effect are presented based on descriptive analysis of questionnaire and observational clinical outcome data collected across three time points (baseline, post-intervention, and 6 months post intervention). Fourth, the results of a reflexive thematic analysis of participant experience of trial methods and intervention was conducted. Finally, a mixed-method integration of quantitative and qualitative findings was performed to address key uncertainties around the feasibility, acceptability, intervention implementation and impact. Further hypothesis for research and areas for intervention development are articulated.

The findings from this PhD indicate that parents with personality disorder diagnoses or characteristics may inconsistently use positive parenting strategies; demonstrate greater use of negative and hostile parenting responses and behaviours; and experience greater parenting stress and parent-child conflict. Interventions which target parent emotion regulation and reflective function, support consistent use of positive parenting strategies, and use a strengths-focused, experiential learning methods may significantly benefit parents and their children. Furthermore, peer-led, group delivery and community recruitment methods may increase access for parents who experience stigma and whose needs may not adequately be met by services.

The findings also demonstrate the feasibility and acceptability RCT trial methods for evaluating the effectiveness of two peer-led, low-intensity, group-based interventions, one specifically adapted for parents with significant emotional and interpersonal difficulties. The underpowered feasibility RCT indicated that both interventions show promise in improving parent and child outcomes for the target

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population and differences between interventions appear to be negligible. Qualitative findings indicate participant's experience of intervention and trial methods was informed by how relatable the intervention and trial aims were to the individual's & family contexts; the qualities of the relationships formed in the intervention and research; the information they received and their interaction with the intervention and trial methods. Based on integration of quantitative and qualitative findings, options for future evaluations and intervention refinement are outlined. Implications of this PhD include identifying intervention targets to improve parent and child outcomes in families with a high-risk of chronic mental health difficulties; investigating recruitment and engagement strategies for parents with significant emotional and interpersonal difficulties in clinical and research settings; and evaluating the use of peer-led support and multi-method research designs for this population.

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Statement of Contribution

The core research aims and basic methodology of the PhD (testing the feasibility of randomised control trial evaluating a peer-led parenting intervention for parents with personality difficulties) was initially conceptualized by Dr. Joshua Harwood and Prof. Crispin Day prior to the PhD project start. Dr. Harwood left King's College London in December 2020 and was unable to continue contributing to the project.

The PhD researcher further developed the specific research aims, questions and methodology, with the support of Dr. Day and Dr. Smith and stakeholder consultation. Stakeholders included Jo Nicoll and Dr. Joanna Gibbons, Clinical Leads of the Empowering Parents Empowering Communities (EPEC) team and Helping Families Team (HFT) respectively. Jo Nicoll and Dr. Gibbons supported and contributed their experience and expertise in peer-led group parenting support and parent mental health to the trial planning and manual development. Jo Nicoll and Dr. Gibbons also facilitated researcher recruitment of further stakeholders (Clinical consultants, PGLs, parents with relevant lived experience) and provided researcher training and access to supervision to develop an in depth understanding of the intervention and support the researcher with clinical concerns e.g., managing participant distress and participant safety and safeguarding. Finally, Jo Nicoll and Dr Gibbons coordinated the clinical teams (EPEC and HFT) to train, plan, deliver and supervise the peer-led parenting groups.

The PhD researcher completed all recruitment, data collection, analysis and write up of the studies in this thesis, supported by Prof. Day and Prof. Smith. Research activities were also supported by the CAMHs Research Unit at King's College London, with the researcher developing trial operating procedures and safety protocol based on the Research Unit's existing documents. Jordan Troup, research assistant, was a second rater for the systematic review. She also managed communication between research and clinical teams where there was a risk of unmasking, including randomisation allocation and collection of attendance, clinical contact and fidelity data. She also supported the

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PhD researcher develop the purposive sampling method for qualitative interviews. Nadine Kendall, research assistant, conducted one qualitative interview of an ineligible participant. Both Jordan and Nadine were safety contacts for PhD researcher when conducting home visits.

Conflict of interest: Prof Day is the lead developer of the Empowering Parents Empowering Communities parenting programmes. Under Prof. Day's supervision, the PhD candidate led the development the Being a Parent-Enjoying Family Life programme. Prof. Smith has no conflict of interest.

The development and feasibility evaluation of Being a Parent-Enjoying Family Life: A peer-led, group parenting intervention for parents with significant emotional and interpersonal difficulties.

Chapter 1 Introduction

1.1 Chapter Overview

This chapter identifies the rationale and purpose of the PhD, including the theoretical and empirical understanding of parenting, its determinants, and the impact of parenting on child behaviour and development. Then, the possible impact of significant emotional and interpersonal difficulties on parenting and child development is proposed. Third, the rationale for intervention development and the application of the MRC framework to guide intervention development and feasibility evaluation is outlined. Finally, the aims, chapter outline and specific objectives of this PhD are stated.

1.2 Background

Globally, the prevalence of mental health difficulties in children is between 11-16% (Polanczyk et al., 2015), with approximately one in six children aged 6-16 years in the UK currently experiencing a probable mental health difficulty (Lifestyles Team, NHS Digital, 2020). Behavioural difficulties are the most prevalent condition for children under 11 years, have a global prevalence of 5.7% [95% CI 4.0-8.1] and an early age of onset, with disruptive behaviour first observed during toddlerhood (Ford et al., 2003; Kessler et al., 2007a; Polanczyk et al., 2015; Sadler et al., 2018). Behavioural difficulties impact social and emotional development, educational outcomes and family functioning in the short term (McDaid et al., 2019; Sadler et al., 2018). These difficulties can persist, increasing risk for adult psychopathology and result in significant long-term costs in healthcare and productivity across the individual's life

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span (Bee et al., 2014; Bonin et al., 2011). Roughly half of all lifetime mental health disorders start by mid-adolescence, with 14.5 years as the peak age at onset for any mental health difficulty ([Kessler et al., 2007b](#); [Solmi et al., 2022](#)). The estimated annual costs of mental health conditions in the UK is £118 billion (5% of UK GDP), mostly due to lost productivity and provision of specialist mental health care (McDaid & Park, 2022). Developing preventative interventions which support positive child development and mental health is vital to prevent the entrenchment of chronic difficulties, reduce the risk of mental health difficulties over a lifespan, and decrease costs for the wider society in later lost productivity and mental health care.

Parenting interventions are the recommended treatment for behavioural difficulties in children under 11 (NICE, 2017) and have been highlighted as “good buys” for preventing mental health problems across the life course (McDaid et al., 2019; McDaid & Park, 2022). These interventions may be less effective for parents who experience mental health difficulties, such as personality disorders (Bee et al., 2014; Stepp et al., 2011). Significant emotional and interpersonal difficulties, including diagnoses of personality disorders, in parents are a substantial risk factor for emotional and behavioural difficulties such as disruptive behaviour in childhood (Petfield et al., 2015; Steele et al., 2020). Child emotional and behavioural difficulties in turn increase parenting stress, impact parent mental health and may reinforce negative parent-child interactions. Furthermore, childhood emotional and behavioural difficulties can potentially develop into adolescent and adult mental health disorders. The intergenerational transmission of mental health difficulties from parent-to-child is influenced by both genetic and environmental mechanisms (Condon et al., 2022; Eilertsen et al., 2022), with parenting an important mechanism for this transmission (Belsky, 1984a; Day et al., 2020; Rutherford et al., 2015; Taraban & Shaw, 2018).

Therefore, developing evidence-based parenting interventions for parents with significant emotional and interpersonal difficulties is important in improving and maintaining positive child developmental outcomes and reducing the intergenerational transmission of mental health difficulties.

Development of such parenting interventions is informed by theories of child development and parenting, which are critically reviewed in the following section to develop the theoretical foundation and rationale for this PhD and intervention development. Second, the limitations of current parenting interventions for parents with significant emotional and interpersonal difficulties are described. Finally, the framework for intervention development and evaluation is outlined.

1.3 Theories of child development and parenting

Human development takes place through progressively more complex, reciprocal and bi-directional interactions with persons, objects and symbols in the individual's external environment (Bronfenbrenner, 1977; Bronfenbrenner & Morris, 2007). These interactions must occur on a regular basis and become increasingly more complex to encourage developmental advance. For children, their parents or primary caregivers are the principal person with whom they interact and are most influential in shaping the environments around them (Bronfenbrenner, 1977; Belsky et al., 1984). Furthermore, the child's biological parents' genes contribute to child temperament and development both via genetic transmission and also often through influencing the parenting environment around the child (Day et al., 2020; Eilertsen et al., 2022). Therefore, parents are influential in both directly and indirectly shaping child development through genetic and environmental mechanisms. Interventions focused on parents as opposed to the child can directly change the day-to-day micro-environment around the child and encourage more regular positive interactions which influence child

development (Bronfenbrenner, 1977; Bronfenbrenner & Morris, 2007). Parenting interventions are therefore underpinned by the theoretical assumption that supporting parents to provide positive environments and interactions with their children will lead to positive child developmental outcomes.

To develop and evaluate support for parents which impacts child development, it is important to understand first, what parenting involves and second, what determines parenting. Furthermore, it is important to understand how parenting and its determinants influence child behaviour and development. The following sections define parenting and reviews evidence demonstrating a link between parenting and child outcomes. The determinants of parenting are then outlined using theory and recent findings in parenting research.

1.3.1 Conceptualising parenting

Parenting is a developmental and dynamic process that occurs in a dyadic or triadic relationship (alongside other caregivers) and is constantly changing as the child grows in order to meet the child's needs (Bronfenbrenner, 1977; Rutherford et al., 2015). Parenting can be done by biological and non-biological caregivers of any gender. Parent gender may explain differences in parenting styles within the same parenting constructs, for example fathers tend to use more rough-and-tumble play and encourage risk taking compared to mothers (Cabrera et al., 2014). However, parenting is not conceptually different based on gender, in that there are not elements of parenting which are only associated with fathers and mothers, and both mothers and fathers influence child development (Fagan et al., 2014). In addition, parenting roles are changing as working practices change, with fathers contributing more to childcare practices (Altintas & Sullivan, 2017; Cabrera et al., 2014). It is therefore important to offer parenting interventions for parents of any gender.

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There are a variety of models which define parenting constructs and styles (Baumrind, 1966, 1991; Maccoby & Martin, 1983; McCabe, 2014; Skinner et al., 2005). Broadly, the different parenting constructs fall under four domains: (i) affective, such as warmth, sensitivity, hostility, (ii) behavioural, such as control, positive and negative reinforcement, autonomy support, coercion, maltreatment (iii) cognitive, such as parenting knowledge, appraisals, self-efficacy, stress, and (iv) relational, such as conflict, role-reversal. The affective parenting domain captures the parent's emotional expressions in responding to their child and their responsiveness to their child's emotions & needs (Baumrind, 1966, 1991; Macfie et al., 2017; McCabe, 2014; Skinner et al., 2005). Evidence of impact of affective parenting constructs on child outcomes is most well-established, with meta-analyses demonstrating hostile or negative parenting responses are associated with greater child internalising and externalising problems (Pinquart, 2016, 2017a, 2017b, 2021). Whereas sensitive and warm caregiving are associated with better self-regulation and academic achievement and less internalising and externalising problems (Pinquart, 2017a, 2017a; Vasquez et al., 2016).

The behavioural parenting domain captures parent's behaviours towards the child, such as structuring play and routines, provision of stimulating materials, and their management of child's behaviour, such as through discipline (Baumrind, 1966, 1991; Skinner et al., 2005). The impact of behavioural parenting constructs on child behaviour is also well-established. Meta-analyses demonstrates that parenting which supports the child's autonomy (e.g. allowing choice, encouraging self-care) and lays out consistent expectations is related to greater academic achievement, self-esteem and child wellbeing (Vasquez et al., 2016). In contrast, negative parenting practices such as inconsistent or harsh discipline, laxness or lack of involvement are related to child

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hyperactivity, conduct and emotional problems and lower academic achievement (Pinquart, 2016, 2017a; Speyer et al., 2022).

The cognitive parenting domain reflects parent knowledge and evaluative beliefs about parenting, the child and the parent-child relationship (Bornstein et al., 2018; Nuttall et al., 2021; Vance & Brandon, 2017). The nature of the relationship between cognitive parenting constructs and child outcomes is less established, with theories currently in development suggesting parenting cognitions may generate, give meaning to and mediate parenting practices to shape child's development (Bornstein et al., 2018). Self-report evidence shows direct and indirect effects of parental self-efficacy on child outcomes, with Trecca et al., (2022) finding increased parenting self-efficacy was associated with more prosocial behaviour, less hyperactivity, conduct problems and emotional problems in children.

Finally, the relational parenting domain captures the communication, roles and expectations of parent and child in the dyadic relationship (Macfie et al., 2017; Macfie & Kurdziel, 2020). Considerable and varied quality evidence has demonstrated direct and indirect effects of different relational constructs such as parent-child attachment (Cooke et al., 2019; Koehn & Kerns, 2018) and role-reversal (Linde-Krieger & Yates, 2021; Nuttall et al., 2019, 2021) on child outcomes. For example, role reversal in early childhood (3-6 years) where there is a break-down in parent-child roles with the child adopting an adult-like role is associated with poorer child self-concept (Nuttall et al., 2019) and negative parent representations at age 8 and greater psychopathology aged 10 (Linde-Krieger & Yates, 2021).

Constructs within these four parenting domains interact, are interdependent, and can have a positive or negative impact on a child's development (Belsky, 1984; Skinner et al., 2005). For example, a parent may respond to challenging behaviour using warmth

and in an autonomy supportive way. Parenting research tends to focus on constructs from one or two domains to evaluate the impact on child development. As a result, affective, behavioural, cognitive and relational parenting domains have varying strengths of evidence which demonstrates their influence child behaviour and development. Theories of what determines parenting responses across these domains are critically evaluated in the following section, forming the theoretical foundation for this research.

1.3.2 Multiple Determinants of Parenting

Belsky's (1984) Multiple Determinants of Parenting (MDP) model captures both individual, transactional and contextual influences on parenting and child development (Cabrera et al., 2014; Taraban & Shaw, 2018). Belsky (1984) argued there are three key determinants of parenting and child development (i) the characteristics of the child, such as temperament, (ii) the personal and psychological resources ("personality") of the parent, including parent age and depression and (iii) the contextual sources of stress and support for the parent, including social support, marital relations and work. These components lie on a continuum from supportive to stress modes and interact to determine child developmental outcomes such as mental health. Belsky's (1984) model also highlights the role of the parent's own proximal and distal developmental histories in shaping the personal and psychological resources of the parent.

Belsky's (1984) model offers a dynamic conceptualization of parenting which is pragmatic, parsimonious and useful in both research and clinical practice. However, the model is also limited in how applicable it may be. First, the model is grounded within its historical context and is less applicable to families where parents may no longer be married or living together or may both be working. Secondly, decades of research has developed a clearer understanding and definition of each determinant (e.g. Taraban &

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Shaw, 2018). Furthermore, the model does not consider the role of biology, culture or wider environmental influences such as socioeconomic status (Day et al., 2020; Taraban & Shaw, 2018). Finally, the model does not define the concept of “personality” and the parent’s personal coping resources well.

Subsequent developments of the MDP (e.g., Cabrera et al., 2014; Taraban and Shaw, 2018; Day et al., 2020) have introduced additional components such as socioeconomic status (Cabrera et al., 2014; Taraban & Shaw, 2018) genetic contributions and the separate influence of psychopathology to the model (Day et al., 2020). In the most recent review of the MDP model, Taraban and Shaw (2018) found empirical literature continues to support the associations between the characteristics of the parent (including parent’s developmental history, personality and psychopathology), the characteristics of the social environment (including social support, marital quality) and characteristics of the child (focusing on negative emotionality) in predicting parenting behaviour. They also begin to highlight how these factors interact and moderate one another. However, Taraban and Shaw (2018) conducted an updated review of evidence for the components of Belsky’s (1984) original model and did not consider new and emerging areas of research. Indeed, Taraban and Shaw (2018) identified the effect sizes for the association between personality traits and parenting behaviour are small and argued that further model developments should consider what cognitive and affective processes alongside personality traits influence parenting.

This PhD integrated interdisciplinary and neurobiological research to the MDP model to expand and clarify characteristics of the parent which contribute to parenting and child development, including adjustment to parenting role (see Figure 1). As highlighted, the current PhD research concerns parenting interventions to improve child behavioural, emotional and development outcomes and disrupt the intergenerational

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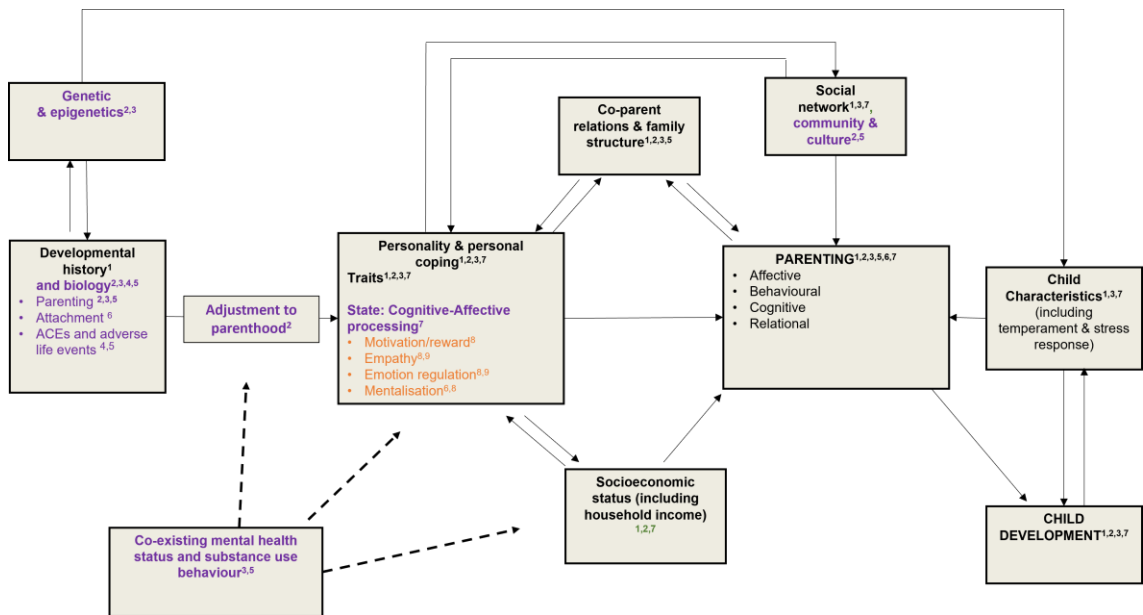


Figure 1. Updated Multiple Determinants of parenting model developed for this PhD.

1-Belsky et al., 1984; 2-Cabrera et al., 2014; 3- Day et al., 2020; 4-Lomanowska et al. 2019; 5- Condon et al., 2022; 6- Camoraino et al., 2017; 7- Taraban & Shaw, 2018; 8- Feldman et al., 2019; 9-Rutherford et al., 2015

Note. Black font indicates original components of Belsky’s (1984) model. Purple indicates additional components identified in subsequent models. Orange indicates components identified by this PhD.

transmission of mental health difficulties. A structured review and testing of the theoretical model was beyond the scope of the research. However this PhD identified and integrated findings from a number of reviews (Camoirano, 2017; Rutherford et al., 2015) supported by neuroscientific research (e.g. Abraham & Feldman, 2018; Feldman et al., 2019) to identify personality, cognitive and affective parenting constructs which may influence parenting and child development. Therefore, the following section seeks to expand and critically evaluate the characteristics of the parent which influence parenting and child development.

1.3.3 *Personality and personal coping of the parent:*

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Both trait-based and situational models of personality can help to explain underlying individual variance in parenting behaviour. Trait-based models describe categorical dimensions of individual difference in behaviour which are stable over time (McCabe et al., 2014). The most frequently used trait-based model of personality is the Five-factor model, which categorizes personality characteristics into 5 dimensions: Extraversion, Agreeableness, Conscientiousness, Neuroticism and Openness to experience (McCabe, 2014; McCrae & Costa, 2008; Prinzie et al., 2009). Meta-analyses show small associations between these personality traits and three components of parenting; maternal warmth, maternal behavioural control and autonomy support (e.g., Prinzie et al., 2009; McCabe et al., 2014). Compared to trait-based determinants of parenting behaviour, only a few studies have examined the relationship between parent personality traits and child outcomes, with one moderate quality cross-sectional quality study finding that parental agreeableness was an independent predictor of adolescent prosocial behaviour (Truhan et al., 2022). In another high quality cross-sectional study, maternal openness to experiences was indirectly associated with child socioemotional and cognitive-motor development via affective parenting practices (lack of hostility and parental warmth) and depressive symptoms (Vásquez-Echeverría et al., 2022). Therefore, parental personality traits may not only influence parenting practices but also have a small potential influence on child development.

However, trait-based models are criticized for ignoring the situational variation in personality. Situational models, such as the cognitive affective processing systems model, argue that the social-environmental context activates different cognitive, affective and motivational processes such that the individual is driven towards a consistent pattern of behaviour in the particular context (Huprich & Nelson, 2015; Mischel & Shoda, 1995). For parents, parenting contexts may activate different

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cognitive, affective and motivational processes across individuals, which will function differently depending on previous developmental experiences and adjustment to parenthood (Belsky, 1984a; Mischel & Shoda, 1995). The cognitive-affective processes underlying parenting practices may both directly and indirectly affect child development via social learning, parenting and environmental factors such as socioeconomic status.

Reviews of psychological and neuroscience literature have identified four cognitive and affective processes which may be particularly important for parenting across cognitive, affective, behavioural and relational domains and child development. These processes are (i) Emotion, motivation and reward processes (ii) Empathy (iii) Emotion regulation (iv) Mentalization (Feldman, 2015; Feldman et al., 2019; Rajhans et al., 2019). Neuroscientific research is a helpful tool for capturing responses to stimuli which may occur outside of the individual's awareness, however interpretation relies on inference, psychological theories and behavioural measures to contextualise findings (Baker et al., 2022). Therefore, both forms of evidence were helpful when identifying cognitive and affective processes which may determine parenting and child development for later intervention development. The following paragraphs define and evaluate evidence for each cognitive affective process.

Emotion, motivation & reward processes are important in supporting the parent's feelings of reward and bonding towards their child, supported by the dopaminergic and oxytocinergic neuroendocrine systems (Rajhans et al., 2019). Behavioural and neuroscientific evidence has consistently demonstrated that children are a powerful appetitive stimulus to parents, with behavioural data demonstrating preference for and attentional prioritization of infant stimuli compared to adult faces in both parents and non-parents (Kringelbach et al., 2016; Thompson-Booth et al., 2014). Neuroimaging research repeatedly demonstrates activation of the motivational and

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reward circuitry in the brain in response to infant & child stimuli, suggesting salience and reward processing may underlie these attentional preferences in parents (Feldman, 2015; Feldman et al., 2019). Whilst theory and evidence highlight motivational and reward processes orient attention toward infant stimuli, limited evidence has demonstrated the influence of these processes on parenting practices and child development (Feldman, 2015). One neuroimaging study found that pre-schoolers raised by parents with greater network connectivity in the core-limbic network (thought to underlie these emotion, motivation and reward processes) during infancy exhibited more positive emotionality, readily employed simple regulatory strategies such as mimicking and displayed greater social engagement (Abraham et al., 2016). This forms early evidence of an association between emotion & reward processing underlying parenting and child developmental outcomes, however more research is needed to understand how these processes impact parenting and child outcomes.

Empathy refers to the parent's ability to understand and resonate with their child's emotions and is theorized as important for driving sensitive parenting (Rutherford et al., 2015; Feldman et al. 2019). Embodied simulation is an important component of these empathic processes, creating a shared experience and understanding of the child's emotional experience which aids parent-child attachment and bonding (Barba-Müller et al., 2019). There is a growing body of evidence which suggests a link between parent empathy and parent behaviour such as responsiveness in new mothers (Boorman et al., 2019) and sensitivity in mothers of school aged children (Borelli et al., 2020). In turn, parent empathy has been associated with children's outcomes such as attachment, emotion regulation and empathy (Abraham et al., 2016; Barnett et al., 1980; Borelli et al., 2020). Most of the evidence for a relationship between parent empathy and child outcomes is cross-sectional (e.g., Borelli et al., 2020) or focus on parenting of

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infants (Boorman et al., 2019), therefore greater understanding of the role of parent empathy on parenting and child outcomes across development is required.

Emotion regulation refers to the individual's ability to (i) notice (ii) appraise, and (iii) respond to their emotions (Armony & Vuilleumier, 2013). Parents' ability to (down)regulate their own emotion responses is key to supporting attentive and appropriate response to their child's needs and facilitating self-regulation for the child. (Hajal & Paley, 2020; Rutherford et al., 2015). Meta-analyses demonstrate parents with greater emotion regulation skills demonstrate more positive parenting (warmth, supportive) and less negative parenting (hostile, coercive and rejecting; Zimmer-Gembeck et al., 2022). Both maternal and paternal emotion dysregulation have been associated with lower emotion regulation (Binion & Zalewski, 2018; Li et al., 2019; Morelen et al., 2016) and adjustment (Camisasca et al., 2022) and greater emotional lability (Li et al., 2019), displays of sadness (Binion & Zalewski, 2018) and internalizing (Han et al., 2016) in children. Much of this research is cross-sectional (Bariola et al., 2012) and relies on self-report data of parent emotion regulation and child emotion regulation. Further observational and longitudinal research to evaluate the role of parental emotion dysregulation in the intergenerational transmission of child emotional functioning is required (Jugovac et al., 2022).

Mentalising is a socio-cognitive ability that refers to an individual's ability to understand themselves and in terms of intentional mental states. Mentalising underlies parents' reflective function, defined as the ability to reflect on and understand their child's and their own behaviour in terms of goals, feelings, needs and beliefs which motivate them (Camoirano, 2017; Luyten & Fonagy, 2015). Parent reflective function is associated with sensitive parenting and child attachment security (Camoirano, 2017; Zeegers et al., 2017) and early evidence suggests mentalisation-based parenting

interventions improve parent reflective function (Lo & Wong, 2022), parent-child interaction and child developmental outcomes such as emotion regulation and problem behaviour (Lavender et al., 2022). The effectiveness of mentalisation-based parenting interventions on child outcomes in early and middle childhood is yet to be established using robust Randomised Controlled Trial (RCT) designs and current evidence supporting interventions targeting parental reflective function on child behaviour is poor in quality (Midgley et al., 2021). Therefore, early evidence points to mentalising as an important determinate of parenting however further longitudinal and quality research understanding and evaluating the relationship between mentalising, parent reflective function, parenting and child development is required.

In summary, interdisciplinary evidence is emerging which supports the argument that both parent personality traits and cognitive and affective processes, such as emotion regulation and mentalising, determine parenting and child development. These personality traits and cognitive affective processes, programmed by genetic and developmental experiences (Belsky, 1984a; Condon et al., 2022; Day et al., 2020), are proposed to influence child development in three ways (Rutherford et al., 2015). First, directly via social learning processes where children observe and imitate parent's behaviour (Rutherford et al., 2015). Second, indirectly via the influence of personality on parenting styles. For example, parents who struggle with emotion regulation or do not view their child as having intentional mental states may be less responsive and sensitive to their child's needs (Rutherford et al., 2015). Third, these personality characteristics are influenced by and influence the familial environment through impacting co-parenting relationships and supportive relationships.

1.3.4 Characteristics of the child and family context

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In addition to parent's personality, Belsky (1984) highlighted the characteristics of the child and contextual influences (including the social, emotional and financial support available to the parent) on parenting and child development. Research has continued to support the independent influence of child characteristics, such as negative emotionality, on both parenting and child development (Speyer et al., 2022; Taraban & Shaw, 2018; Zarra-Nezhad et al., 2022). Similarly, research supports the influence of supportive social networks (Green et al., 2007; Lee et al., 2021), socioeconomic status (Liu et al., 2022; Taraban & Shaw, 2018) and co-parenting dynamics (Condon et al., 2022; Jean & Elizabeth, 2022; Stover et al., 2013, 2016) on both parenting and child developmental outcomes. Taraban and Shaw (2018) further identified culture, family structure, child stress response, genetics and emotion regulation as emerging areas which influence parenting and child development.

Alongside targeting parenting and its determinants, parenting interventions may indirectly impact parent outcomes and child development through improving aspects of the familial contexts. Similarly, the bi-directional influence of child characteristics on parenting and child development may moderate the impact of parenting interventions. Finally, the genetic transmission of parent characteristics to their child may also moderate the impact of parenting interventions. Therefore, it is important to bear these contexts in mind when developing and supporting parents.

Another determinant identified in the MDP is the parent's mental health status and experiences, including significant emotional and interpersonal difficulties (Belsky, 1984; Taraban & Shaw, 2018; Day et al. 2020). The following section defines significant emotional and interpersonal difficulties and outlines the potential impact of these difficulties on parenting and child development.

1.4 Significant Emotional and Interpersonal Difficulties and Parenting

Children of parents who experience significant emotional and interpersonal difficulties, including those with a diagnoses of personality disorder, are at increased risk for emotional and behavioural difficulties (Petfield et al., 2015; Steele et al., 2020). The diagnosis of personality disorder (defined in detail in chapter 2) is controversial, with debate ongoing about the language, classification and conceptualisation of the diagnosis (Anderson et al., 2014; Hopwood et al., 2018; Watts, 2019). The two main classification manuals for mental health difficulties currently use different approaches to classification. The Diagnostic and Statistical Manual of Mental Disorders (5th ed; DSM-5; [American Psychiatric Association, 2022](#)) uses a categorical approach featuring ten categories of personality disorder whereas the International Classification of Disease-11 (ICD-11; [World Health Organisation, 2018](#)) favours a dimensional approach that identifies core dysfunction and five trait domain specifiers. Furthermore, the term has received strong criticism for being pejorative, stigmatising and potentially misogynistic as it situates dysfunction within the individual rather than the wider societal and cultural contexts (Troup et al., 2022; Warner & Wilkins, 2004; Watts, 2019).

In addition to challenges and criticisms regarding the conceptualisation of personality disorder diagnoses, there are also barriers to accessing and engaging with mental health and parenting support for this population. Historically, there have been shortcomings in the treatment of people with a personality disorder diagnosis, with limited treatment availability, poor training of staff to support individual's needs and many experiencing exclusion from services as their needs are "too complex" (Snowden & Kane, 2003). Despite substantial improvements, there still remains inconsistency in the accessibility and availability of services (Dale et al., 2017; Evans et al., 2017), particularly around support for parents (Day et al., 2020). Often clinicians show

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reluctance to use the diagnosis because of the associated discrimination, stigma and remaining exclusion from generic mental health services (Rains et al., 2021; Troup et al., 2022). Furthermore, lack of resources and funding can often mean thresholds for acceptance to specialist personality disorder services are inconsistent, again leading to exclusion from services and support (Troup et al., 2022). As a result, many individuals who experience emotional and interpersonal difficulties associated with personality disorders do not receive a diagnosis and struggle to access support.

This PhD project recognises the complexity in the diagnosis and adopts the term *parents who experience significant emotional and interpersonal difficulties*.

Specifically, the term refers to parents who may struggle with managing strong emotions which can affect their parenting, who may struggle to trust others and maintain friendships and relationships, and parents who have experienced difficult or adverse events growing up, including invalidating or challenging relationships with their own parents. This non-diagnostic approach is particularly important when offering parenting support, as many parents may be requiring parenting support but perhaps not looking for mental health diagnosis or support (Day et al., 2020). Qualitative evidence indicates that support centred on parents' experiences may be more acceptable to parents experiencing significant mental health difficulties, reduce stigma and increase motivation for change due to the salience of the parenting role (Harries et al., 2023). Therefore, the term *significant emotional and interpersonal difficulties* aims to describe emotional and interpersonal experiences which include the experiences of parents who may be given a personality disorder diagnosis and is not used as a replacement of "personality disorder."

Many parents with significant emotional and interpersonal difficulties are highly motivated to provide positive parenting experiences for their children (Barnicot et al.,

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2022; Dunn et al., 2020; Eyden et al., 2016). However, the impact of emotional and interpersonal difficulties on parenting, their family environment and their child and the subsequent guilt can increase stigma, perpetuate negative cycles of conflict and distress and reduce support seeking (Day et al., 2020; Dunn et al., 2020; Harries et al., 2023). Parents with significant emotional and interpersonal difficulties have often experienced negative, harsh or neglectful caregiving in their own development (Eyden et al., 2016; Steele et al., 2019), affecting their ability to regulate their emotions and form trusting relationships (Luyten et al., 2020). As a result, parents with significant emotional and interpersonal difficulties often report greater inconsistent parenting behaviours, increased parenting stress and reduced confidence in parenting and high levels of stigma (Eyden et al., 2016; Steele et al., 2019).

Despite motivation to improve their situation, there are limited effective, evidence-based interventions to support parents with significant emotional and interpersonal difficulties and improve child emotional and behavioural outcomes. The number of parents experiencing significant emotional and interpersonal difficulties is unknown, however the prevalence of adult personality disorder diagnoses is high (with global estimates of around 7.8% [95% CIs 6.1- 9.5] of the population and 9.6% in high income countries such as the UK (Winsper et al., 2020). A number of these adults will be parents, with a recent census of Norwegian adult mental health services finding 37% of outpatients with personality disorder had a child under 18 years in their care (Ruud et al., 2019).

In addition to the high prevalence of parents with a personality disorder diagnosis, experiences of emotional and interpersonal difficulties are pervasive and persistent in nature and highly heritable (heritability coefficient=0.4-0.5 ; Torgeson et al. 2009). As a result, long term and complex inter-relations between parent and child

mental health outcome likely exist. Indeed, children of parents with a personality disorder diagnosis have more symptoms of mental health difficulties, including suicidal ideation, than children of parents with no diagnosis and parents with other severe mental health diagnoses such as depression (Petfield et al., 2015). Therefore, developing effective, evidence-based support for parents with significant emotional and interpersonal difficulties, including personality disorder diagnoses, is vital for improving child outcomes for many families.

1.5 Developing a novel intervention

1.5.1 Existing interventions

Children of parents with significant emotional and interpersonal difficulties represent a high-risk group for current and future behavioural and mental health difficulties. Developing parenting interventions which improve parent and child outcomes is vital for family functioning and child development. As highlighted, parents play an important role in child development, particularly prior to adolescence. Many one-to-one and group parenting interventions exist and show moderate effects on improving child behaviour (SMD= 0.46), which vary between parent reports (SMD=0.51) and observational data (SMD=0.62) (Mingebach et al., 2018).

Despite their effectiveness in community samples, the efficacy of non-specialised parenting interventions (interventions designed to improve child outcomes, delivered in the community and available to any parent regardless of need) have not been evaluated for parents with significant emotional and interpersonal difficulties. Furthermore, parents with significant emotional and interpersonal difficulties may benefit more from interventions which take account the potential impact of their difficulties on parenting and targets their barriers to accessing care. These include (i) support to more consistently implement positive parenting strategies and reduce

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parenting stress (Eyden et al., 2016; Steele et al., 2020; Stepp et al., 2011), (ii) content on different parenting concerns e.g. impact of their difficulties in emotion regulation on their children (Lumsden et al., 2018; Wilson et al., 2018), (iii) a trauma-informed intervention (Sweeney & Taggart, 2018) due to increased levels of adversity and trauma in the parents own childhood (Steele et al., 2020; Wilson et al., 2018; Zalewski et al., 2015), (iv) support to overcome different barriers to attending group interventions such as mental health stigma and lack of social support (Evans et al., 2017; Mytton et al., 2014; Troup et al., 2022). Developing an intervention that focuses on the additional needs and barriers experienced by parents with significant emotional and interpersonal needs may be necessary to support parents and their children.

Only a few studies have attempted to develop and evaluate support targeted to the needs of parents with significant emotional and interpersonal difficulties including personality disorders or symptoms. Four small scale uncontrolled experimental or qualitative studies (Gray et al., 2018; McCarthy et al., 2016; Renneberg & Rosenbach, 2016; Williams et al., 2018) and two feasibility RCT have been carried out thus far (Barnicot et al., 2022; Day et al., 2020) and two study protocols published (Feasibility RCT, Moran et al., 2022; Multi-centre RCT, Rosenbach et al., 2022). The majority of interventions focus on mothers with BPD and their infants aged under 3 years (Barnicot et al., 2022; Moran et al., 2022; Williams et al., 2018). The interventions evaluated were adapted DBT groups (e.g. Williams et al., 2018; Renneberg & Rosenbach, 2016; Moran et al., 2022), or add-on modules and training for clinicians working with parents with personality disorder (Gray et al., 2018; McCarthy et al., 2016). These interventions reported on parent outcomes, showing increase self-efficacy (Gray et al., 2018) and improved reflective function and mental health symptoms (Williams et al., 2018). No rigorous evaluation of child outcomes for these interventions have been carried out yet,

and the focus of the intervention evaluation was on the parent rather than child outcomes.

The two feasibility RCTs did evaluate parenting and child outcomes after two different targeted interventions for parents with significant emotional and interpersonal difficulties, including a six-session video-feedback intervention (Barnicot et al., 2022) and the Helping Families Programme, a 16-session psychoeducational home-based parenting intervention (Day et al., 2020). However, the video feedback intervention was developed for mothers of infants under 3 years, with feasibility RCT indicating small changes in maternal sensitivity, stress and confidence but no clear effects on behavioural parenting and child outcomes (Barnicot et al., 2022). In contrast, the Helping Families Programme targets children aged 2-11 years and feasibility evaluation demonstrated promising improvements in child behavioural outcomes, parent and caregiver satisfaction, confidence, and high acceptability (Day et al., 2020; Wilson et al., 2018). However, the Helping Families Programme is a one-to-one highly specialist and high-intensity intervention and may not be accessible or acceptable to parents and caregivers who already use other services or where the disruption in parenting is less severe.

1.5.2 Rationale for group-based and peer-led intervention

Stepped-care models where individuals are offered treatments with differing intensities provide an opportunity to improve efficiency and increase patient choice whilst retaining equivalent outcomes (Bower & Gilbody, 2005). Developing lower intensity, group-based support for parents and caregivers with significant emotional and interpersonal needs may increase access and reduce service cost whilst providing significant gain to these families. Parenting interventions are most commonly recommended for children under 11 years (NICE, 2017) and show efficacy in reducing

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child behaviour difficulties (Mingebach et al., 2018). Focusing on the age group 2-11 years offers an opportunity to intervene preventatively, prior to teenage years when most referrals to CAMHS services occurs (Smith et al., 2018), and provides families with skills to improve current behaviour and prevent chronic behavioural difficulties.

In addition, parents who have significant emotional and interpersonal needs are often socially isolated and stigmatised (Petfield et al., 2015). Group-format intervention offers the opportunity for normalising parenting experience and concerns and the possibility for these parents to develop social support networks with others with similar concerns (Day et al., 2012b; Williams et al., 2018). For these reasons, the following PhD aims to develop a group-based parenting intervention for parents with significant emotional and interpersonal difficulties and have concerns about their children's (aged 2-11 years) behaviour.

Furthermore, there is growing evidence for the acceptability, clinical effectiveness and cost-effectiveness of peer-led support for parents and families (Day et al., 2012b, 2012a, 2016; Michelson et al., 2014; Munns et al., 2016; Thomson et al., 2015). Non-specialised peer-led parenting interventions exist, including Empowering Parents Empowering Communities- Being a Parent (BaP-Standard). BaP-Standard is a well-established group-format parenting intervention consistent with NICE guidelines (NICE 2017) for parents and caregivers of children aged 2-11 who report child behavioural problems (Day et al., 2012b, 2012a; Thomson et al., 2015). A randomised control trial (n=116) comparing the standard Being a Parent intervention to waitlist control found significant improvements in child behavioural difficulties and reductions in ratings of parent behavioural concerns with medium to large effect sizes of $d=0.38-0.77$ (Day et al., 2012a). The trial also found increased positive parenting with a moderate effect size of $d=0.69$ compared to waitlist controls.

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Peer-led support may be particularly valuable for parents with significant emotional and interpersonal difficulties to increase social support and provide hope & validation (Barr et al., 2020). Peer-support workers are able to share their experiences to normalise and generate hope amongst peers and can also draw on their experiences of what works and what does not to guide their support (Day et al., 2016; Watson, 2019). This can be beneficial in encouraging strong partnerships characterised by mutual respect and trust, which may benefit individuals who fear stigma and child removal or may have a deep distrust of health systems due to historical and ongoing trauma such as parents with significant emotional and interpersonal difficulties (Munns et al., 2016; Tomfohr-Madsen et al., 2022).

Taken together, the effectiveness of existing non-specialised parenting interventions on child behaviour has not been evaluated for parents who experience significant emotional and interpersonal difficulties and may not meet their needs. Targeted parenting interventions for parents with personality disorder are in development, however these targeted interventions are not accessible for individuals who may not be receiving treatment or meet service thresholds (Troup et al., 2022). Group-format and peer-led support centred on parent's experiences rather than diagnosis may be particularly valuable for individuals who are stigmatised and do not trust professional support. Therefore, developing a group-format, peer-led parenting intervention targeting need of parents with significant emotional and interpersonal difficulties is vital for improving child and parent outcomes and family functioning and preventing the entrenchment of chronic behavioural and mental health difficulties.

1.6 Developing and evaluating a complex intervention

Parenting interventions are complex interventions targeting several distinct groups (parents/caregivers, children and parent facilitators). In addition, the recruitment

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of parents with significant emotional and interpersonal difficulties and retention in research can be challenging due to limited social support, multiple life stressors (Petfield et al., 2015), low service contact and increased stigma (McMurrin et al., 2010; Warner & Wilkins, 2004; Watts, 2019; Rains et al., 2021; Troup et al., 2022).

Developing and evaluating complex interventions is challenging due to these interacting and multiple components (Campbell et al., 2000; Skivington et al., 2021). Without rigor in the development and evaluation process, there may be low reproducibility of findings, challenges in applying research to clinical practice and research waste (Bauer & Kirchner, 2020; Chalmers & Glasziou, 2009; Grant et al., 2018). It is estimated that approximately 85% of healthcare research is wasted through utilizing inappropriate research designs with limited relevance to clinicians and patients (Chalmers & Glasziou, 2009), and fewer than 50% of clinical innovations are used in clinical practice (Bauer & Kirchner, 2020). Furthermore, evaluations of psychological interventions are often not reported with enough transparent detail to replicate them, leading to poor dissemination of effective intervention, over-estimation of intervention effects and additional research waste (Grant et al., 2018). Subsequently, guidelines to support the development, evaluation and reporting of complex interventions have been established.

This PhD follows Medical Research Council (MRC) framework for developing and evaluating complex interventions (Craig et al., 2013; Skivington et al., 2021). The MRC guidance is the most widely used in healthcare research showing applicability and clinical utility for a range of different contexts. It was systematically developed ensuring methodological rigor, whilst its iterative nature enables flexibility to address key uncertainties and encourages appropriate choice of research methods. Finally, its emphasis on implementation and stakeholder involvement ensures relevance to clinical practice (Bauer & Kirchner, 2020; Corry et al., 2013).

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The MRC framework outlines four phases for developing and evaluating complex interventions, namely; (1) intervention development or identification (2) feasibility testing, (3) evaluation and (4) implementation (See Figure 2; Skivington et al., 2021). These phases are non-linear and iterative with evidence acquired from multiple source points and assimilated across different phases. The MRC framework is a theory and evidence-centred complex intervention development approach, emphasizing the use of systematic reviews or other methods of evidence synthesis to guide intervention development or identification. The most recent MRC guidelines published by Skivington et al., (2021) propose that at each phase, six core elements should be considered; (i) context- the dynamic and multi-dimensional interaction between the physical, spatial, organizational, economic, social, political and cultural features of the system where the intervention is implemented (ii) programme theory- the theory behind how the intervention leads to its effect and under which conditions, (iii) stakeholder- inclusion of those targeted by and delivering the intervention, (iv) key uncertainties- engaging pragmatically with multiple uncertainties and offering flexible approaches to explore them, (v) intervention refinement- engagement of potential intervention users to inform refinements and (vi) economic evaluation and considerations.

In addition, the most recent guideline promotes mixed-methods and process evaluation to assess the fidelity and quality of the intervention, how the intervention may be implemented in wider context, clarify mechanisms of impact, and identify contextual factors which affect outcomes (Moore et al., 2015). In feasibility studies, mixed-methods and process evaluation are important in the ongoing refinement and development of both the intervention and trial design prior to a full RCT through evaluating trial and intervention acceptability and identifying potential barriers to

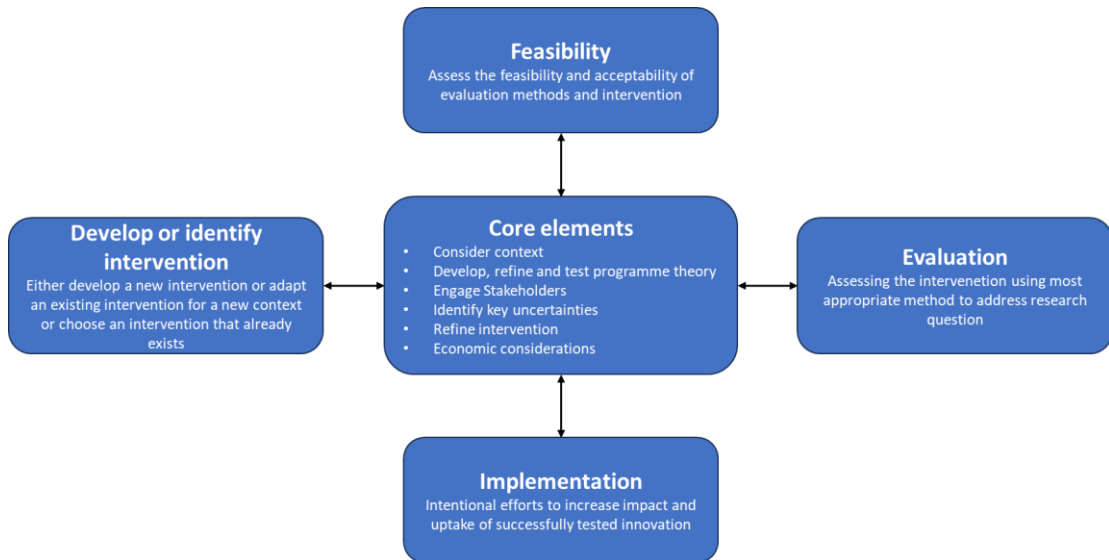


Figure 2. The MRC framework for complex intervention development and evaluation (Skivington et al., 2021)

research and treatment participation (Skivington et al., 2021). However, there is limited MRC guidance around the conduct of process evaluation (Craig & Petticrew, 2013; Skivington et al., 2021) and the epistemological contradictions of the positivist assumptions of effectiveness evaluation and constructionist and relativist assumptions of qualitative approaches can make mixed-methods evaluations challenging. This PhD research conducts a mixed-methods integration to evaluate the key uncertainties regarding trial methods and intervention and generates hypotheses for future process evaluation. The research adopts a convergent segregated approach, where quantitative findings and qualitative findings from the feasibility RCT are analysed separately and then integrated in the penultimate chapter. Finally, a critical realist epistemology is adopted in this PhD as it values both quantitative and qualitative data as empirical knowledge whilst also considering influence of context and PhD researcher’s assumptions on the data collected (Blackwood et al., 2010).

1.7 Aims and Objectives of PhD

The overall aim of this PhD was to develop and evaluate the feasibility and acceptability of a peer-led, group parenting intervention, Being a Parent-Enjoying Family Life (BaP-Enjoying Family Life), for parents who experience significant emotional and interpersonal difficulties and are concerned about their child's (aged 2-11 years) behaviour. This PhD is theoretically informed by Belsky et al.'s (1984) MDP model, adapted using updated research (Camoirano, 2017; Feldman, 2015; Feldman et al., 2019; Rutherford et al., 2015; Taraban & Shaw, 2018). Group-format, peer-led support may be valuable for parents with significant emotional and interpersonal difficulties in improving child behavioural outcomes and parent outcomes such as positive parenting and parent satisfaction, as well as increasing social support and intervention engagement. Therefore, this PhD choose to adapt a well-established peer-led group intervention, Being A Parent (BaP-Standard), for parents with significant emotional and interpersonal difficulties, following MRC guidance.

The MRC guidelines are well-established in guiding healthcare research on complex intervention development. The guidelines flexibility, emphasis on stakeholder involvement, implementation and use of theory and evidence can increase clinical utility, reduce research waste and support meaningful intervention development. Therefore, this PhD follows the MRC guidelines and presents activities undertaken during Phase 1 Intervention development, including systematic review of the impact of personality disorders on parenting (Chapter 2) and intervention development (Chapter 3). This PhD then presents the feasibility evaluation conducted following MRC framework's phase 2 guidance, including quantitative evaluation of the feasibility of trial methods and intervention acceptability using pre-specified parameters and indicators of preliminary intervention effectiveness (Chapter 4); Reflexive Thematic

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Analysis of participants lived experience of trial methods and intervention (Chapter 5); and integration of quantitative and qualitative findings to develop the research methodologies prior to a definitive evaluation (Chapter 6). The specific objectives were:

- 1) To conduct a mixed-methods systematic review to understand the impact of parental personality disorders on parenting and parenting experiences of parents of children aged 2-12 years (Chapter 2)
- 2) To adapt BaP-Standard into BaP-Enjoying Family Life (Chapter 3)
 - a. To identify intervention targets for BaP-Enjoying Family Life and develop the intervention's programme theory, incorporating systematic review findings and stakeholder perspectives
 - b. To conduct intervention refinement and adaptations, using the interventions programme theory, stakeholder perspectives and intervention targets
- 3) To establish the feasibility and acceptability of conducting a definitive Randomised Controlled Trial of BaP-Enjoying Family Life (Chapter 4)
 - a. To assess (a) the primary feasibility parameters for participant recruitment and retention and (b) secondary parameters for BaP-Enjoying Family Life acceptability and fidelity
 - b. To indicate preliminary estimation of treatment difference and obtain variance estimates for parent and child outcomes for future sample size calculations.
- 4) To conduct an in-depth qualitative analysis on a purposively sampled selection of parents to develop a fine grain understanding of parents/caregivers' subjective experience of trial and intervention procedures (Chapter 5)

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5) To integrate quantitative and qualitative findings to inform future research

(Chapter 6)

- a. To examine the acceptability of proposed trial methods, including randomisation
- b. To evaluate intervention implementation, possible mechanisms and the influence of participant and service factors on intervention implementation
- c. To propose direction for future intervention refinement
- d. To propose directions for future interventional research

Chapter 2 Systematic review

2.1 Chapter overview

The MRC framework for complex intervention development emphasises the importance of quality evidence synthesis using systematic review methods to guide intervention development, identify key challenges for the target population and ensure clinical utility and relevance based on existing knowledge (O’Cathain et al., 2019; Skivington et al., 2021). The aim of this chapter was to conduct a mixed-methods systematic review to understand the impact of parental personality disorders on parenting and parenting experiences of children aged 2-12 years. This chapter presents the rationale for the systematic review, then provides the systematic review method and findings. This chapter ends with a discussion of the key findings and the strengths and limitations of the evidence identified. The findings from this chapter identify the parenting challenges and support needs of the target population which informed the intervention development (Chapter 3) and trial methodologies for the feasibility evaluation (Chapter 4, 5 & 6)

2.2 Introduction

An improved understanding of how personality disorders may affect parenting can inform the development of specialised interventions to reduce the impact of significant emotional and interpersonal difficulties on parenting and protect and improve child developmental outcomes. As highlighted, the categorical diagnosis of personality disorder is controversial and actively debated (Rains et al., 2021; Troup et al., 2022; Watts, 2019). However, evidence has accumulated over the past 40 years, utilising a categorical approach to diagnoses (Bach & First, 2018; Watts, 2019; APA, 2022), whereas limited research focusing on the impact of experiencing significant emotional and interpersonal difficulties on parenting has not been conducted. Whilst

recognizing the diagnoses' limitations and complexities, this systematic review examines 40 years of research which is based on the preceding categorical model of personality disorders.

Personality disorder diagnoses are defined by enduring and pervasive patterns of experience and behaviour, manifesting as maladaptive cognitions and perceptions of self and other people; intense, labile or inappropriate emotional responses; and difficulties in interpersonal functioning and impulse control (APA, 2022). DSM-5-TR defines 10 different categories of personality disorder (APA, 2022). Each personality category is grouped into three clusters based on descriptive similarities: Cluster A (Paranoid, Schizoid, Schizotypal), Cluster B (Antisocial, Borderline, Histrionic and Narcissistic), Cluster C (Avoidant, Dependent and Obsessive-Compulsive). This categorical definition of personality disorders is used throughout this chapter.

2.2.1 Previous reviews & their limitations

Two previous systematic reviews (Eyden et al., 2016; Petfield et al., 2015) and one meta-synthesis (Steele et al., 2019) have been conducted on the impact of maternal Borderline Personality Disorder (BPD) symptoms on parenting across the four domains defined in Chapter 1. These reviews highlighted that maternal BPD diagnoses and traits are associated with lower sensitivity and emotional warmth; poorer emotion recognition; greater overprotection, intrusiveness, rejection and laxness; inconsistent discipline and frightened/disoriented parenting. Mothers with BPD also report greater parenting stress. It is unclear whether these findings extend to other personality disorder categories, or to fathers and whether these parenting patterns are consistent across the stages of child's development (Eyden et al., 2016). One review was conducted considering research on parents with any personality disorder diagnoses (Laulik et al., 2013). However, this study was conducted 10 years ago, and an updated review of

recent literature on personality disorders and parenting in mothers and fathers is required.

Initially, this review followed other reviews and aimed to synthesise research on parenting of children aged between 0-18 years old. However, parenting involves a series of dynamic, reciprocal behaviours and responses that change and adjust to meet the child's developmental need (Bronfenbrenner, 1977; Cabrera et al., 2014; Rutherford et al., 2015). Whilst the four parenting domains outlined in chapter 1 do not change across a child's developmental stage, the way parenting responses are used and the importance of the parenting response on the child evolve as the child develops and grows. For example, during infancy and toddlerhood, parenting sensitivity is important for fostering positive socioemotional outcomes, whereas in pre-school and school age children (2-12 years), parental structure and boundaries alongside sensitivity are required to facilitate social functioning (Belsky, 1984; Pinquart, 2017a, 2017b). As a result, measures of parenting are often restricted to specific child age ranges, and it is important to focus on the effects of parenting during specific developmental periods rather than attempt a synthesis across widely differing developmental periods.

Additionally, there is considerable heterogeneity in the parenting constructs measured across the 0-18 years developmental range, limiting the synthesis of findings in previous reviews. Petfield et al.'s (2015) systematic review separated synthesis of studies of parenting in mothers with BPD into two developmental groups: babies and young children and older children, although the specific age range was not reported. They identified a large body of research on babies and toddlers. Furthermore, the parenting constructs measured in this age-group (e.g., emotion recognition, activity structuring, interaction style) were different to those measured in older children (e.g., overprotection, mind-mindedness). This suggests synthesis of parenting research should

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focus on parenting within specific child developmental periods due to different research focus and different child developmental needs.

Clear delineation of the impact of personality disorders on parenting at specific child developmental stages is important for intervention development. Interventions should be developmentally informed to ensure positive parent and child outcomes (Stepp et al., 2011). This project aimed to develop an intervention for parents of children aged 2-11 years, due to (i) parenting interventions being recommended for this age group; (ii) the focus on parents of children under 3 years old for the majority of parenting interventions aimed at parents with significant mental health needs and personality disorders focus (Barnicot et al., 2022; Moran et al., 2022; Williams et al., 2018), and (iii) the opportunity to act preventatively, before chronic patterns become entrenched. Therefore, this review focused its synthesis on research of the parenting responses to early and middle childhood aged children in parents with personality disorders to aid identification of specific intervention targets.

Finally, the previous systematic reviews did not include qualitative studies of parental personality disorders. As highlighted in the introduction, mixed-methods research is increasingly important for intervention development to ensure clinical utility (Hamilton & Finley, 2019; Skivington et al., 2021), particularly in groups who have been historical excluded from services (Snowden & Kane, 2003). Quantitative research aims to provide valid, replicable, and generalizable findings which aim to represent the phenomena within a population. Integrating with qualitative research can both corroborate or question quantitative research and generate new concepts for investigation, encouraging clinical utility and acceptability through prioritising lived experience (Booth, 2001; Dixon-Woods et al., 2005; Hamilton & Finley, 2019). As this

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review was focused on intervention development, incorporating qualitative synthesis was justified to increase clinical utility and identify emerging targets for intervention.

This systematic review therefore addressed gaps in previous reviews by incorporating both quantitative and qualitative studies on parenting in parents of any gender with any personality disorder characteristics to investigate the research question:

How do personality disorder characteristics affect parenting practices and experiences in parents of children aged 2-12 years?

2.3 Method

2.3.1 Protocol and Registration

The systematic review protocol was registered prospectively on PROSPERO on 05/02/21, and can be accessed from:

https://www.crd.york.ac.uk/PROSPERO/display_record.php?RecordID=235103

2.3.2 Design

This review planned to use a convergent segregated approach where quantitative and qualitative findings were to be synthesised separately and simultaneously before being integrated (Lizarondo et al., 2020). A single search was conducted to identify relevant quantitative and qualitative studies. Unfortunately, an insufficient number of qualitative studies (n=1) were identified for planned meta-aggregation synthesis. Therefore, planned mixed-method synthesis was not possible. This review follows PRISMA (Page et al., 2021; See Appendix A for completed checklist) and ENTREQ (Tong et al., 2012) guidelines.

2.3.3 Search Strategy

This review's research question, search strategy and eligibility criteria were developed using the SPIDER framework (Cooke et al., 2012; Table 1).

Table 1. SPIDER framework to aid the development of systematic review search strategy and eligibility criteria

Sample	Parents with personality disorders or personality disorder traits/symptoms
Phenomena of Interest	Parenting and experience of parenting children aged 2-12 years
Design	Quantitative cross sectional or longitudinal studies, qualitative interviews/surveys
Evaluation	All reported outcomes/themes
Research type	Qualitative, quantitative or mixed methods

Search terms were:

1. (“personality difficult*”, “personality disorder*”, “personality pathology”)
2. AND (parent*, mother*, maternal, paternal, father*, caregiv*, guardian*)
3. AND (Interview*, Experience*, qualitative, “Qualitative research”)
4. OR (Quantitative*, Cross-sectional, “Cross sectional”, community, clinical, longitudinal, retrospective, cohort, observation*, “randomized controlled trial”, “Clinical Trial”, survey, questionnaire)

These terms were identified from prior reviews (Eyden et al., 2016; Rains et al., 2021) and MESH terms and subject headings identified from pilot searches. Searches were conducted on: Psych INFO, PubMed, Embase, and CINAHL on 16th February 2021. An updated search was conducted on 17th October 2022 (see Appendix B).

2.3.4 Eligibility criteria

Eligibility criteria are presented in Table 2 (see Appendix C for detailed criteria). Eligibility criteria were narrowed to parenting of children with a mean age between 2-12 years after the initial full text screening to reflect the refining of the research question from parenting across 0-18 years to parenting across early and middle childhood. The refinement was introduced after the initial search was conducted and prior to narrative synthesis and acknowledges that parenting requirements changes across child development to meet the child’s developmental needs and helps identify targets for developmentally sensitive parenting interventions.

Table 2. Systematic review eligibility criteria

Inclusion criteria	Exclusion:
1. Population:	1. Reviews, expert opinions, case studies, grey literature
a. Studies must identify personality disorders using a standard assessment procedure and must correspond to DSM or ICD diagnostic criteria.	2. Studies only collecting professional (Clinician/caseworker) report data
b. Study participants must identify as parents & provide caregiving role	3. Studies which combine data on participant personality disorders and other mental health
c. Parent must be 18 or older	4. Studies which combine personality disorder measures with other measures
d. Mean age of children in the study must be between the ages of 2-12 years at time of first assessment of parenting behaviour	5. Studies which only focus on a single trait/symptom of personality disorder (e.g., psychopathy, grandiosity)
2. Outcome: Parenting characteristics and/or experiences of parenting	6. Studies of treatment effectiveness or experience only
3. Settings: Clinical or community samples	7. Studies which report child removal or childcare choices e.g., vaccinations
4. Design: Qualitative or quantitative studies collecting primary data	8. Studies of parents of adult children (retrospective report)
5. Studies must be in English	
6. Studies published from 1980- 2021	

2.3.5 Study selection

All references from the initial search were downloaded onto Zotero and duplicates were removed. An independent second reviewer (JT) completed title and abstract screening for a randomly selected 8.7% (n= 514) of references, reaching 97.7% agreement (Cohen's K= 0.66), with remaining articles screened by the PhD researcher. A title and abstract screening tool, developed using the eligibility criteria (see Appendix D), was used to standardise screening and increase consistency between raters (Polanin et al., 2019). Full text articles were then retrieved and screened using the eligibility criteria, with 9.2% papers (n=22) screened by the second reviewer and 95.5% agreement was met (Cohen's K= 0.90). Authors of the original articles were not

contacted for further information. Discrepancies were resolved through discussions between both raters with input from supervisors.

2.3.6 Data extraction and Quality appraisal

Sample size, diagnosis (including co-morbidities and assessment tool), demographics and setting were extracted. Quantitative data extracted included design, eligibility criteria, control group, outcome measures, description of main results and effect sizes, and the researcher's conclusions. Data extraction was completed by the PhD researcher. Joanna Briggs Institute (JBI) quality appraisal tools (Lizarondo et al., 2020) were used to assess study quality as they are applicable for a range of methodologies (Ma et al., 2020). The second reviewer appraised 21.5% (n=4) of the included articles. Reliability between reviewer and second reviewer was assessed, reaching 80% agreement at an initial consensus meeting. Differences between reviewers in the interpretation of tool items and rating criteria were discussed, and studies were re-assessed for quality, leading to 94% agreement being met (Cohen's $K = 0.72$). All eligible studies, regardless of methodological quality, underwent data extraction and synthesis.

2.3.7 Data Synthesis

Quantitative data was synthesised using narrative synthesis. Themes were generated through combining the parenting constructs described in the studies across affective, behavioural, cognitive and relational domains, as informed by the work of Skinner (2005), to structure the results. Meta-analysis was not possible due to the level of heterogeneity in the definition and measurement of parent outcomes across studies. Planned synthesis of qualitative studies involved using meta-aggregation, however integration of quantitative and qualitative evidence was not possible as only one eligible

qualitative paper was identified, preventing synthesis of data from multiple sources to generate further insights.

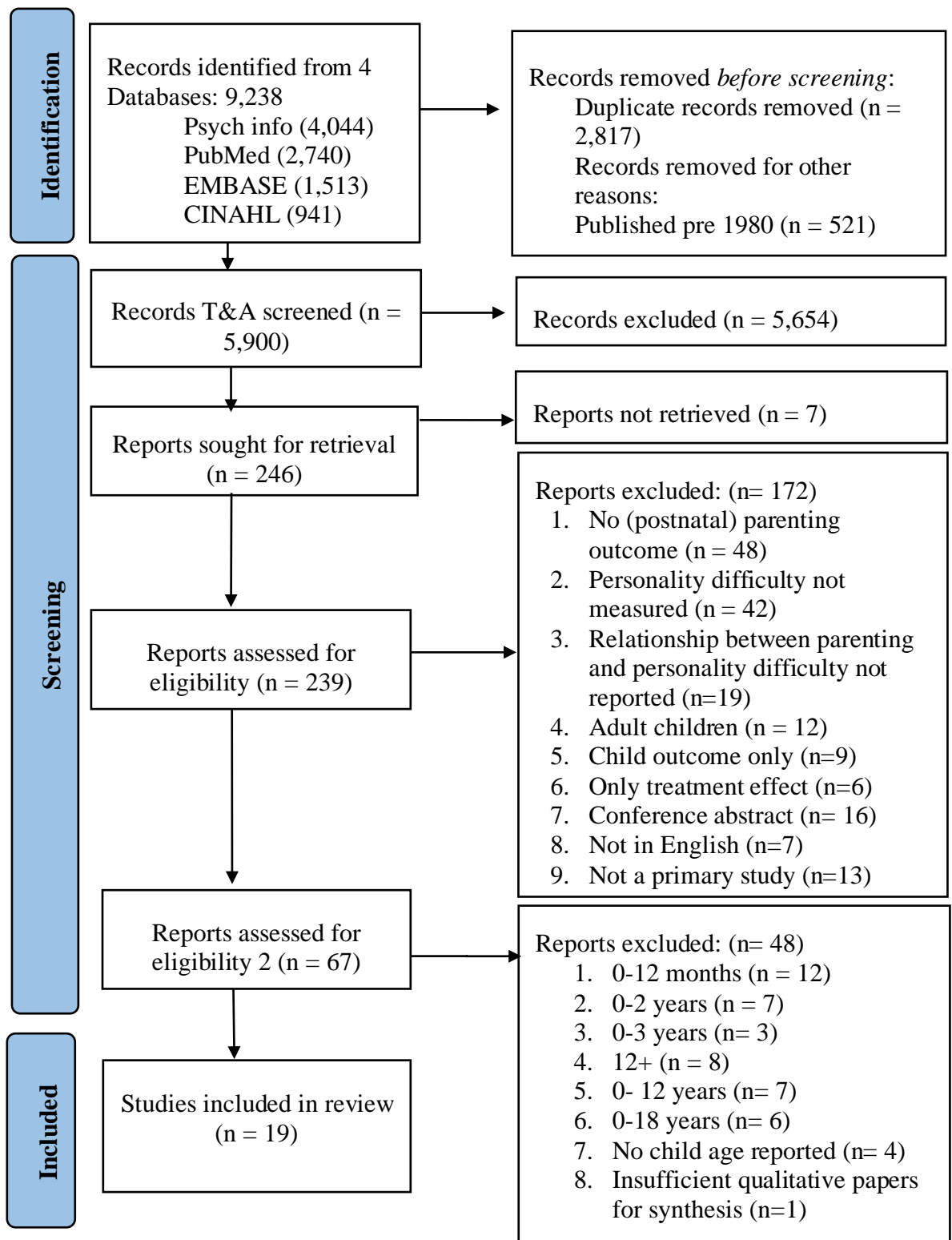
2.4 Results

2.4.1 Key studies included in the review

Figure 3 summarises the study screening process. The database search identified 9,238 records, with 5,900 records after duplicates were removed. A total of 5,655 articles were ineligible after title and abstract screening. Full-text screen (n=245) occurred in two stages, with articles first screened to identify eligible studies of parents of children under 18 years. Sixty-seven (quantitative n=61; qualitative n=6) eligible studies were identified at this stage. A further 47 articles were excluded for investigating parenting of infants or adolescents, leaving a final sample of 20 eligible papers (quantitative n=19, qualitative n=1). One qualitative paper (Wilson et al., 2018) was not sufficient for synthesis and was therefore excluded after full-text screening. Appendix E. contains additional information about articles identified as ineligible and reasons for ineligibility at full-text screening.

Nineteen quantitative studies were included in the review (see Table 3). Seven of the nineteen studies focused on BPD symptoms and traits only, an additional seven focused only on Antisocial Personality Disorder (ASPD) and the final six collected data on all personality disorder categories. Sixteen of nineteen used DSM-IV criteria to define personality disorders, and the remaining three papers used DSM-III-TR criteria. Nine studies focused on diagnoses, seven on symptoms and traits, and three studies focusing on both diagnoses and traits. Thirteen studies included only mothers (BPD k=7, ASPD k=4, all personality disorder diagnoses k=2), one study included fathers exclusively (ASPD only) and five included both mothers and fathers (ASPD k= 2; All

Figure 3. PRISMA flow diagram of study selection process and reasons for exclusion.



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Table 3. Summary of studies included in the systematic review

Author	Parent	Index child age	Sample recruitment	Parent MHA	Personality disorder	Mental health in sample	Outcomes	Outcome measures
Cross-sectional studies								
Bonfig et al. 2022	54 mothers, mean age= 31.23 years (SD= 6.05)	54 children aged 1.5- 3 years, M= 2.16 (SD= 0.57)	Clinical	MINI (<i>I</i>) IPDE BSL	DSM-IV BPD (Diagnosis)	25 mothers with research diagnosis of BPD (6 with co-morbid PTSD, 9 MDD, 7 anxiety disorder, 2 OCD); 29 control mothers with no BPD	Emotion dysregulation (SR) Parenting stress (SR) Child abuse potential (SR) Child behaviour and emotional problems (PR) Maternal sensitivity, intrusiveness, limit setting (O) Child involvement & withdrawal (O) Dyadic reciprocity & negativity (O) Cortisol, testosterone and oxytocin	DERS PSI CAPI CBCL CIB
Macfie & Kurdziel 2020 ^a	70 mothers, mean age= 32.41 years (SD= 5.04)	70 children aged 4-7 years, M= 5.37 (SD= 0.90)	Clinical & Community	SCID-II (<i>I</i>) PAI (<i>SR</i>) SCID-I (<i>I</i>)	DSM-IV BPD (Diagnosis and traits)	36 mothers with a research diagnosis of BPD, 34 mothers with no BPD	Child maltreatment (I, R) Child narrative representation (I- Story Stems)	MCMI SS records CNCS NCM
Trupe et al. 2018 ^a	70 mothers, mean age= 32.41 years (SD= 5.04)	70 children aged 4-7 years, M= 5.37 (SD= 0.90)	Clinical & Community	SCID-II (<i>I</i>) PAI (<i>SR</i>) SCID-I (<i>I</i>)	DSM-IV BPD (Diagnosis and traits)	36 mothers with a research diagnosis of BPD, 34 with no BPD diagnosis	Emotional availability (O: Story telling task) Child narrative representations (I- Story Stems) Child maltreatment (I, R)	EAS CNCS NCM MCMI SS records
LeMoine et al. 2018	102 fathers, mean age= 41.90 years (SD= 7.47)	102 children, aged 5-12 years, M= 8.96 (SD= 2.18)	Community	ASR (<i>SR</i>) CAARS (<i>SR</i>)	DSM-IV ASPD (Symptoms)	4% total sample had clinically sig rates of ASPD symptoms. 66% had ADHD	Child Disruptive behaviour disorders (PR) Child impairment (PR) Positive & Negative parenting (SR) Marital satisfaction (SR)	DBDRS IRS APQ PS DAS
Kluczniok et al., 2018	178 mothers, mean age= 38.8 years (SD= 6.0)	178 children, aged 5-12 years	Clinical & Community	IPDE (<i>I</i>) MINI (<i>I</i>) HAMD (<i>SR</i>)	DSM-IV BPD (Diagnosis)	88 rMDD only 28 rMDD & BPD 8 BPD only	Emotional availability (O: free play & puzzle task) Child psychopathology (I, PR)	EAS K-SADS CBCL

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Dittrich et al., 2018	114 mothers, mean age= 39.0 years (SD= 6.1)	114 children aged 5-12 years, M= 8.0 (SD= 1.8)	Clinical & Community	IPDE (I) MINI (I)	DSM-IV BPD (Diagnosis)	19 BPD 71 rMDD	Child abuse potential (SR) Parent difficulties in emotion regulation (SR) Parent maltreatment (I) Child emotional and behavioural problems (TR)	EBSK (German version of CAPI) DERs CECA TRF
Macfie et al., 2017 ^a	70 mothers, mean age= 32.41 years (SD= 5.04)	70 children aged 4-7 years, M= 5.37 (SD= 0.90)	Clinical & Community	SCID-II (I) PAI (SR) SCID-I (I)	DSM-IV BPD (Diagnosis and traits)	36 research diagnosis of BPD, 34 mothers with no BPD	Maternal sensitivity (O: Puzzle solving task) Maternal autonomy support (O) Maternal hostility (O) Maternal fearful/disoriented behaviour (O) Role-reversal (O)	Qualitative ratings of parent-child interaction at 54 months
Robinson et al., 2016	75 mothers, mean age= 41.3 years (SD= 9.54)	75 sons, aged 7-11 years, M=8.8 years (SD= 0.97)	Community	PDQ-4 PPI-R	DSM-IV ASPD (Symptoms)	Mean antisocial personality traits= 1.31 (SD= 2.13)	Poor monitoring (SR) Inconsistent discipline (SR) Positive parenting (SR) Parental involvement (SR) Child callous-unemotional traits (PR) Child narcissism (PR) Child impulsivity (PR)	APQ Antisocial Process screening device
Schacht et al., 2013	39 mothers, mean age= 35 years (SD= 6.68)	39 children, age 3.25 - 5 years M= 4.25 years (SD= 7.76)	Community (Birth cohort)	SCID-II SCID-I BDI-II	DSM-IV BPD (Diagnosis)	20 mothers with BPD research diagnosis 19/20 also met criteria for other PDs. 19 mothers with no depression or PD	Child false belief task (x4; L) Child affective labelling (L) Child understanding causes of emotion (I) Maternal mind-mindedness (I)	Causes of emotion interview-modified. Maternal Mind-mindedness interview
Bornovalova et al., 2013	1240 mothers and 1185 fathers, no age reported	2,520 children (same-sex twins), aged 11 years	Community (Birth cohort)	SCID (I) FH-RDC (I) FISC (I)	DSM-III-R ASPD (Symptoms)	76 mothers (6.1%) and 338 fathers (28.5%) reported 3 or more symptoms of ASPD	Problematic parenting (SR) Marital quality (SR, average score across both parents) Child disruptive behaviour disorders (I)	PEQ CRQ MRQ DISC-R

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Harvey et al., 2011	182 mothers, mean age= 31.52 years (SD= 6.86) 126 fathers, mean age= 36.46 years (SD= 7.39)	184 children, aged 3 years at screen and 3-4 years at first home visit	Community (screened for child externalising)	MCMIII (I)	DSM-IV all PD (symptoms)	Percentage parents with base rate score ≥ 75 on MCMIII ^b	Parental laxness (SR) Parental over reactivity (SR) Parental warmth (O: free play, clean up and forbidden object task, A: home recordings) Negative affect (O, A) Laxness (O, A, SR) Marital conflict (SR) Child externalising (PR)	PS Global rating scale CPS-Violence BASC-PRS
Wilson & Durbin, 2012	145 mothers, mean age= 37 (SD= 5); 145 fathers, mean age= 39 years (SD= 6)	145 children aged between 3-6 years, M= 4.5 years (SD= 0.92)	Community	IPDE (SR)	DSM-IV all PD (symptoms)	Mean symptoms ^c	Parent-child interaction: social bids, influence bids, responsiveness to bids (O: three mother-child and three father-child tasks)	Parent-child interaction coding scheme
Van Santvoort et al., 2014	24 fathers, 98 mothers, mean age= 40.01 years (SD= 5.97)	122 children, aged 8-12 years, M= 10.3 years (SD= 1.37)	Clinical	Clinician diagnosis BSI (SR)	DSM-IV or ICD-10 All PD (Diagnosis)	42 parents had one mental illness (13 with personality disorder- 10 BPD and 3 NOS) 80 parents had comorbidity, 70 of which were across Axis I and Axis II (32 had BPD; 38 had other personality)	Parental competence (SR) Parent-child interaction (SR) Child-parent interaction (CR) Family functioning- support and communication (SR) Child temperament (PR) Child perceived competence (CR) Child Psychosocial problems (PR) Child cognitions about parent mental illness (CR)	PSI PCIQ VGP Self-perception profile SDQ 4 questions developed by study on child feeling worry, guilt, shame & loneliness
Kim-Cohen et al., 2006	1116 mothers, mean age= 33 years (SD= 5.83)	1116 children aged 5 years	Community (birth cohort)	DIS (I)	DSM-IV ASPD (symptoms)	217 mothers reported one or more symptoms of ASPD; 165 reported lifetime	Child psychopathology (PR) Socio-demographics (SR) Family environment (SR, O) Parenting (SR, O)	CBCL HOME MAST Global rating scale applied

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						depression only; 152 reported ASPD symptoms and lifetime depression; 572 reported no ASPD or depression		to mother- child interaction. Interview about child's misbehaviour 3 questions on discipline
Stewart et al., 2006	146 families; Father mean age= 44 years; mother mean age= 42 years	146 children aged 10-12 years, M= 11.4 years (SD= 0.79)	Communit y	SCID (I) Severity measure (SR)	DSM-IV ASPD (symptoms)	Not reported	Paternal child neglect (CR)	Child Neglect Questionnaire
Famularo et al., 1992	91 mothers, mean age= 33.75 years	91 children aged 5-12 years (no mean reported)	Communit y (hospital and courts)	SCID (I)	DSM-III-R all PD (Diagnosis)	PD diagnosed in 64.81% maltreatment mothers (n=54) and 29.73% control mothers (n=37)	Child maltreatment (R)	SS & Hospital records
Cohort studies								
Russotti et al., 2022	122 mothers, mean age= 24.86 years	122 children, aged 1 year at T1, 2 years at time 2 and 3 years at time 3	Clinical	DIS-IV (I) BDI-II	DSM-IV ASPD (Diagnosis)	21.3% (n=26) MDD-only; 13.1% (n=16) ASPD-only; 34.4% (n=42) comorbid 31.1% (n=38) no MDD or ASPD	Negative parenting (O) Maternal Efficacy (SR) Parenting stress (SR) Maternal sensitivity (CR) Child emotional/behavioural problems (PR & OR)	SCIPD (time 2) MEQ (T2) PSI (T2) MBQ (T2) CBCL (T3)
Davies et al., 2012	201 mothers, age not reported	201 children, T1 aged 1.5- 2.5 years M= 2 years (SD= 1.69)	Communit y	DIS-V (I)	DSM-IV ASPD (symptoms)	Mean symptoms of: ASPD= 3.19 (SD=1.91); Substance use= 2.29 (SD=3.78), mood difficulties= 3.88 (SD=4.33) and	Diminished maternal responsiveness (O: free play & clean up task, SR) Interparental aggression (SR, I) SES (SR) Child disruptive behaviour (PR)	AAPI (T1) IFIRS (T1) CTS-2 (T1) CPS (T1) IDI (T1) CBCL (T1, time 2)

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						anxiety= 7.08 (SD=6.80)	Child emotional reactivity to conflict (I with mothers) Child temperament (L) Child cortisol reactivity (L)	Child temperament battery (T1)
DeMulder et al., 1995	89 mothers, T1 mean age= 32.7 years (SD= 4.25)	89 children T1 mean age 2.65 years (SD= 0.61) time 2: 5.54 years (SD= 0.61) time 3: 9.26 years (SD= 1.12)	Community	SCID (T1-3; I) SADS-L (T1-3; SR) PDE (time 3; I)	DSM-III-R all PD (Diagnosis)	PD diagnosed in 54% of unipolar depressed (n=39), 70% of bipolar depressed (n=23) and 19% of no mood disorder (n= 27) mothers	Maternal engaged parenting (O: mother and child participating in doctor visit, story time and teaching task, mealtime and free play) Maternal Critical/Irritable parenting (O)	Global coding scale (T1-3)

Notes.

Parent Mental Health Assessment: ASR= Adult Self Report form. BDI-II= Beck Depression Inventory- II. BSI= Brief Symptom Inventory. CAARS= Connors Adult ADHD Rating Scale- Short version. DIS= Diagnostic Interview Schedule. FH-RDC= Family History- Research Diagnostic Criteria. FISC= Family Informant Schedule and Criteria. IPDE= International Personality Disorder Examination. MCMI-III= Million Clinical Multiaxial Inventory- III. MINI= Mini International Neuropsychiatric Interview. PAI= Personality Assessment Inventory. PDE= Personality Disorder Examination. PDQ-4= Personality Disorder Questionnaire-4. PPI-R= Psychopathic Personality Inventory- Revised. SADS-L= Schedule for Affective Disorders and Schizophrenia- Lifetime scale. SAPAS= Standardised Assessment of Personality- Abbreviated Scale. SCID-I= Structured Clinical Interview for Axis I. SCID-II= Structured Clinical Interview for Axis II.

Outcome measure: AAPI= Adult and Adolescent Parenting Inventory. PS= Arnold O'Leary Parenting Scale. APQ= Alabama Parenting Questionnaire. BASC-PRS= Behaviour Assessment System for Children- Parent Report Scale. BPVS-II= British Picture Vocabulary Scale (2nd eds.). CAPI= Child Abuse Potential Inventory. CBCL= Child Behaviours Checklist. CECA= Childhood Experiences of Care and Abuse interview. CIB= Coding Interactive Behaviours. CNCS= Child Narrative Coding System. CPS= Conflict and Problem-Solving scale CRQ= Child Rearing Questionnaire. CTS-2= Conflict Tactics Scale- 2. DAS= Dyadic Adjustment Scale. DBDRS= Disruptive Behaviour Disorders Rating Scale. DERS= Difficulties in Emotion Regulation Scale. DISC-R= Diagnostic Interview Schedule for Children and Adolescents- revised. EAS= Emotional Availability Scale. EBSK= Eltern-Belastungs-Screening zur Kindeswohlgefährdung. HOME= Home Observational Assessment of the Environment. IDI= Interparental Disagreement Interview. IFIRS= Iowa Family Interaction Rating Scales. IRS= Impairment Rating Scale. K-SADS= Kiddie Schedule of Affective Disorders and Schizophrenia. MAST= Michigan Alcohol Screening Test. MBQ= Maternal Behaviours Q-set. MCMI= Maternal Child Maltreatment Interview. MRQ= Marital Relationship Questionnaire. MEQ= Maternal Efficacy Questionnaire. NCM= Narrative Coding Manual. PCIQ = Parent-Child Interaction Questionnaire. PEQ= Parental Environment Questionnaire. PSI= Parenting Stress Inventory. SCIPD= System for Coding Interactions in Parent Child Dyads. SDQ= Strengths and Difficulties Questionnaire. SCQ= Social Communication Questionnaire. TRF= Teacher Report Form. VGP= Vragenlijst voor Gezinsproblemen (Family Problems Questionnaire).
CR= Child Report. I= Interview. O= Observation. PR= Parent Report. R= Records. SR= Self-Report. TR= Teacher Report, ,

^a Uses the same sample.

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^b Mothers: 17.0% Schizoid, 3.3% Schizotypal, 19.2% Paranoid; 9.9% Borderline; 13.2% Antisocial; 14.3% Avoidant; 18.1% Dependent. Fathers: 31.0% Schizoid; 3.9% Schizotypal; 11.8% Paranoid, 7.9% Borderline; 17.3% Antisocial; 25.2% Avoidant; 18.1% Dependent

^c Mothers: Paranoid= 1.32, Schizoid= 1.13, Schizotypal= 1.13, Antisocial= .53, Borderline= 1.81 Histrionic= 2.26, Narcissistic=2.88, Avoidant= 2.61, Dependent= 1.61, OCPD=2.80. Fathers: Paranoid= 1.56, Schizoid= 1.32, Schizotypal =1.55, Antisocial =.76, Borderline= 1.70, Histrionic= 2.09, Narcissistic=3.35, Avoidant= 2.71, Dependent= 1.35, OCPD=2.49

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personality disorder diagnoses $k=3$). Of the nineteen studies, six studies used multi-methods to capture parenting outcomes, with five studies collecting both observational and self-report data, and one study collecting social service records and interview data on parenting outcomes. Fifteen of the studies also collected data on child outcomes.

Here a written summary of demographics across studies is presented, and Appendix F includes the demographics of parents for each study. Twelve studies were carried out in the USA, four in Germany, two in the UK, and one in the Netherlands. Nine out of the thirteen studies that reported parent ethnicity, and five of the six studies that reported child ethnicity, had a predominantly White/Caucasian/European sample (between 60-98.5%). Three studies did not report on the ethnicity of parent or child. There was low proportion of Asian (0.5%-4%) and Latinx (between 1-23.1%) parents and children across all studies in which ethnicity was reported. Samples ranged in terms of socioeconomic status (SES) and reporting of SES, typically measured as a combination of education, income and occupation. Six studies recruited a low SES sample, three recruited a diverse SES sample, four reported on middle-high SES samples and six studies were unclear in defining the SES of their sample. Although four of the six reported on individuals with an average-to-high level of education or intelligence. Between 31.6%-100% of samples were either living with the child's parent, married or had a partner. The number of children was reported in three of the nineteen studies, and fourteen of the nineteen studies reported child gender with one study focusing solely on male only children.

2.4.2 *Quality appraisal*

Of the sixteen cross-sectional studies, overall methodological quality was fair (15/16 scored 5/8 'yes' or more; See Table 4). The JBI manual encourages justifying

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why articles were given a rating of unclear during quality appraisal (Lizarondo et al., 2020), therefore this section justifies why unclear was given. Eligibility criteria was

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Table 4. Quality appraisal of studies included in the systematic review

Cross-sectional studies								
Author	Q1. Were the criteria for inclusion in the sample clearly defined?	Q2. Were the study subjects described in detail?	Q3. Was the exposure measured in a valid and reliable way?	Q4. Were objective, standard criteria used for measurement of the condition?	Q5. Were confounding factors identified?	Q6. Were strategies to deal with cofounding factors stated?	Q7. Were outcomes measured in a valid and reliable way?	Q8. Was appropriate statistical analysis used?
<u>Bonfig et al., 2022</u>	Y	N	UC	Y	N	Y	Y	Y
<u>Macfie & Kurdziel, 2020</u>	N	N	Y	Y	Y	Y	Y	Y
<u>Trupe et al., 2018</u>	UC	Y	Y	Y	Y	Y	Y	Y
<u>LeMoine et al., 2018</u>	Y	Y	Y	N	Y	Y	Y	Y
<u>Kluczniok et al., 2018</u>	Y	N	Y	Y	Y	Y	Y	Y
<u>Dittrich et al., 2018</u>	Y	N	Y	Y	Y	Y	Y	Y
<u>Macfie et al., 2017</u>	N	N	Y	Y	Y	Y	UC	Y
<u>Robinson et al., 2016</u>	Y	Y	Y	Y	Y	Y	Y	Y
<u>van Santvoort et al., 2014</u>	Y	Y	Y	UC	N	N	UC	UC
<u>Schacht et al., 2013</u>	Y	Y	Y	Y	Y	Y	UC	Y
<u>Bornovalova et al., 2013</u>	Y	N	UC	Y	Y	Y	Y	UC
<u>Harvey et al., 2011</u>	Y	Y	Y	Y	Y	Y	UC	Y
<u>Wilson & Durbin, 2012</u>	N	Y	Y	N	Y	Y	Y	Y
<u>Kim-Cohen et al., 2006</u>	Y	UC	Y	Y	Y	Y	UC	Y
<u>Stewart et al., 2006</u>	UC	Y	Y	N	Y	Y	UC	Y
<u>Famularo et al., 1992</u>	Y	N	Y	Y	Y	N	Y	Y

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Cohort											
Author	Q1. Were the two groups similar and recruited from the same population?	Q2. Were the exposures measured similarly to assign people to both exposed and unexposed groups?	Q3. Was the exposure measured in a valid and reliable way?	Q4. Were confounding factors identified?	Q5. Were strategies to deal with confounding factors stated?	Q6. Were the groups/participant free of the outcome at the start of the study (or at the moment of exposure)?	Q7. Were the outcomes measured in a valid and reliable way?	Q8. Was the follow up time reported and sufficient to be long enough for outcomes to occur?	Q9. Was follow up complete, and if not, were the reasons to loss to follow up described and explored?	Q10. Were strategies to address incomplete follow-up utilized?	Q11. Was appropriate statistical analysis used?
<u>Russotti et al., 2022</u>	Y	Y	Y	Y	Y	N	Y	Y	N	UC	Y
<u>Davies et al., 2012</u>	Y	Y	Y	Y	Y	N	UC	Y	Y	Y	Y
<u>DeMulder et al., 1995</u>	Y	Y	UC	N	N	N	N	UC	N	N	Y

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outlined sufficiently for 69% of studies, and was unclear for Trupe et al., (2018) and Steward et al., (2006) as both studies present some exclusion criteria but did not report and clearly define inclusion criteria e.g., low socio-economic sample, intact families. The sample demographics were described in sufficient detail for 50% of studies, and were unclear for Kim-Cohen et al., (2006) as the study carried out cross-sectional analysis from a cohort study and it was unclear whether the demographics cited were collected at the same time point. Exposure (personality disorder) was measured in a reliable and valid way for 88% of studies, but was unclear for Bornovalova et al., (2013) who did not explain why they defined antisocial behaviour by 3 or more symptoms of ASPD; and Bonfig et al., (2022) who did not report reliability for their assessment of personality disorder, nor whether they conducted mental health assessment for their control participants.

Objective and standard criteria were used in 67% of studies, with Van Santvoort et al., (2014) not clearly defining how parents were referred or identified for the preventative support group for parents with mental illness. Confounds were identified in 88% and dealt with in 88% of studies. Outcomes were measured using reliable and valid measures for 63% of studies, with five studies rated unclear for using one or more non-validated measures alongside validated measures (e.g., Macfie et al., 2017; Kim-Cohen et al., 2006; Van Santvoort et al., 2014; Harvey et al., 2011, Schacht et al., 2013). Appropriate statistics were used in 88% of studies, with a lack of clarity around the use of correction for multiple comparisons in the remaining studies.

The quality of the three cohort studies included in the review was mixed, with two studies scoring 9/11 and the other scoring 3/11. Russotti et al. (2022) were unclear about the use of strategies to address incomplete follow up, however employed a missing at random assumption to account for loss, in order to follow up statistically.

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Davies et al., (2012) used validated measures for all outcomes except one child outcome measure, leading to an unclear rating. The reliability of DeMulder et al.'s (1995) measurement of personality disorder was unclear and there was no justification of why they examined parenting behaviour from early childhood to pre-adolescence, resulting in uncertainty on whether the length of follow up was long enough for their outcome of interest.

2.4.3 Narrative summary of key findings across reviews

Table 5 summarise the key findings across affective, behavioural, cognitive and relational domains. The table shows there was inconsistency in the measurement and inclusion of different personality disorders and fathers. For fathers, there was only one study for each parenting construct, therefore synthesis based on parent gender was not possible. Similarly, for different personality disorder categories, there was often only one study per parenting construct which considered other PDs to BPD or ASPD, therefore synthesis across personality disorder category was also not possible.

2.4.3.1 Affective parenting constructs

Positive affective parenting constructs. Four studies assessed maternal sensitivity (Bonfig et al., 2022; Kluczniok et al., 2018; Macfie et al., 2017; Russotti et al., 2022), three assessed parental warmth (Davies et al., 2012; Harvey et al., 2011; Kim-Cohen et al., 2006 see Table 5), two assessed parental responsiveness (Davies et al., 2012; Wilson & Durbin, 2012) and one study assessed maternal emotional availability (Trupe et al., 2018). Sensitivity and emotional availability were assessed for mothers with BPD diagnoses only, whereas warmth and responsiveness were investigated across all personality disorders, as well as ASPD traits. Overall, only

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Table 5. Summary of key findings & specific findings organised by parenting construct for individual studies included in systematic review.

Construct	Personality disorder category	Finding	Quality
Affective parenting construct			
Sensitivity (N=4)	Mothers with BPD	Mixed findings	High
Macfie et al., 2017	BPD (Diagnosis and traits) and current mood disorder	Mothers with BPD were less sensitive than control mothers (BPD M= 3.56 (SD= 1.42); Control M=4.88 (SD= 1.61) $F(1,65)=11.64, p<.01, \eta^2=.15$). Maternal sensitivity correlated with affective instability ($r= -.31, p<.01$), identity disturbance($r= -.30, p<.05$) and negative relationships($r= -.38, p<.01$).	
Kluczniok et al. 2018	BPD (Diagnosis) and rMDD	rMDD, not BPD, predicted lower maternal sensitivity: rMDD & sensitivity ($b= -.369$ [95% CI= $-.640$ to $-.018$], $p= .019$); BPD & sensitivity ($p >.05$).	
Russotti et al., 2022	ASPD and MDD	No significant difference between mothers with comorbid ASPD & MDD and mothers with MDD only. Control mothers demonstrated significantly greater maternal sensitivity ($b=.25, [SE=.10]$), $p=.006$) compared to mothers with co-morbid ASPD and MDD.	
Bonfig et al. 2022	BPD diagnosis	Mothers with BPD also showed significantly less sensitivity ($U=502.50, Z= 2.43, p =.045$) compared to mothers without BPD.	
Warmth (N=3)	Mothers: Co-morbid ASPD^a and depression, cluster A traits. Fathers: no relationship	Unclear due to low quality, possible relationship in mothers but not fathers	Poor^a
Kim-Cohen et al. 2006	Depression and ASPD (1 or more symptoms)	Mothers with comorbid ASPD & depression expressed significantly less warmth ($M= -0.29, SD=1.10$) than mothers with depression only ($M= 0.02, SD= 0.97; t(1003)=2.61, p<.01$); but not those with antisocial personality symptoms only ($M= -0.19, SD= 1.08; p>.05$).	
Harvey et al., 2011	Cluster A, Borderline, Antisocial, cluster C (symptoms), anxiety, depression and substance abuse	Cluster A ($r= -.34, p<.001$), Borderline ($r= -.29, p<.001$), Antisocial ($r= -.18, p<.001$) and Cluster C ($r= -.23, p<.001$) personality disorder symptoms were negatively correlated with audio recorded warmth in mothers after controlling for education. No relationship found in fathers. Trimmed regression models found Cluster A personality traits were a significant independent predictor of maternal video and audio warmth ($B= -.37, SE= .11, \beta= -.38, p<.001$; Model Adjusted $R^2= .11, p<.001$).	
Davies et al., 2012	ASPD (symptoms, diagnosis & impairment)	Maternal ASPD symptoms ($M= 3.19, r= -.02$), diagnosis ($M= 0.87, r= -.03$) and level of impairment ($M= 1.53, r= -.14$) were not significantly correlated with maternal warmth.	

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Responsiveness (N=2)	Mothers: Paranoid, ASPD^a Mother & Fathers: BPD, Histrionic	Negatively associated with parental responsiveness	Moderate -to-high
Wilson & Durbin 2012	All personality disorder (symptoms)	Found significant zero-order correlation of Paranoid ($r=.29, p<.01$), Antisocial ($r=.34, p<.001$), borderline ($r=.26, p<.01$) and histrionic ($r=.19, p<.05$) symptoms and response bids in mothers. For fathers, only borderline was sig correlated with response to bids ($r= -.24, p<.05$). Regression models: Paranoid symptoms were independently associated with lower quality responsiveness by mothers ($b=-.05, se=.02, t(220)= -2.68, p=.008$), but were unrelated for fathers ($p=.941$). Antisocial symptoms were associated with lower quality responsiveness by mothers ($B= -.08, SE= .03, t(220)= -3.24, p=.001$), but bore no relation to responsiveness by fathers. BPD and histrionic PD were associated with lower quality parental responsiveness to the child (BPD: $t(221) = -3.28, p = .002$; HPD: $t(221) = -2.41, p= .017$)	
Davies et al. 2012	ASPD (symptoms, diagnosis & impairment)	Responsiveness was not directly related to ASPD symptoms, diagnosis or impairment. Latent difference score analysis found maternal antisocial behaviour was a predictor of interparental aggression ($b=0.41, p<.05$), and in turn interparental aggression predicted diminished maternal responsiveness ($b=.30, p<.05$).	
Emotional availability (N=1)	Mothers with BPD	No relationship identified	High
Trupe et al. 2018	BPD (Diagnosis & Trait) & Lifetime MDD	No significant difference was observed in prevalence of BPD diagnoses across 4 categories of emotional availability. Mothers in the high functioning emotional availability cluster reported significantly lower scores on borderline feature of negative relationship compared to the low functioning cluster (HF Mean= 7.90 (5.91); LF Mean= 15.00 (3.03). $F(3,36)= 3.03, p<.05$).	
Hostility (N=3)	Mothers with BPD, other PD	Increased parental hostility	Moderate
Macfie et al., 2017	BPD (Diagnosis and traits) & Current mood disorder	Mothers with BPD were more hostile than controls (BPD $M= 3.06$ (SD= 1.55); Control $M= 2.12$ (SD= 1.49) $F(1,65) =5.92, p<.05, \eta^2=.08$). Hostility correlated with affective instability ($r= .31, p<.01$), identity disturbance ($r= .36, p<.01$) and negative relationships ($r= .44, p<.01$).	
Kluczniok et al. 2018	BPD (Diagnosis) & rMDD	Regression models showed BPD & IQ, but not rMDD and the interaction of rMDD and BPD, were significant individual predictors of maternal hostility. BPD: $B= -.602$ (95% CI = -1.05 to -.158); $\beta= -0.218, p<.01$; IQ: $B= .026$ (.010 - .043), $\beta= 0.243, p<.01$	

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DeMulder et al., 1995	All PD (diagnoses), bipolar & unipolar depression	In mothers with no depression diagnosis (n=27): critical/irritable behaviour was positively correlated with Schizoid ($r = .40, p < .05$) & Paranoid ($r = .45, p < .05$) personality disorder symptoms at T1 only. In mothers with bipolar depression (n=23): no significant correlations. In mothers with unipolar depression n=39: critical/irritable behaviour was correlated with ASPD symptoms at T1 ($r = .35, p < .05$), and Paranoid personality disorder symptoms ($r = -.34, p < .05$) and self-defeating symptoms ($r = -.33, p < .05$) at time 3.	
Negative affect (N=3)	Mothers: Co-morbid ASPD and depression, cluster A, ASPD and BPD symptoms. Fathers: no relationship	Increased negative affect	Moderate-to-high
Kim-Cohen et al., 2006	MDD and ASPD (1 or more symptoms)	Comorbid ASPD & MDD mothers expressed significantly more negativity ($M = 0.38, SD = 1.15$) than mothers with MDD only ($M = 0.13, SD = 1.03; t(1003) = 2.28, p < .05$) and ASPD only ($M = 0.14, SD = 1.07; t(1003) = 2.37, p < .05$).	
Harvey et al. 2011	Cluster A, Borderline, Antisocial, cluster C (symptoms), anxiety, depression and substance abuse.	Cluster A (Audio: $r = .24, p < .001$, Video: $r = .24, p < .01$) and Borderline ($r = .23, p < .001$) personality disorder symptoms were positively correlated with audio and video recorded negative affect in mothers. No significant correlation was found in fathers. No correlation was found between any personality disorders and video, or audio rated negative affect after controlling for parental education. Regression models found that no personality or other psychopathology were significant independent predictors of aggregate video and negative affect scores, although overall model including all 7 diagnoses were significant ($R^2 = .06, p < .01$)	
Bonfig et al., 2022	BPD diagnosis ^a	Significant group-by-emotion-by time interaction were found ($F(1,52) = 4.56, p = .037, \eta_p^2 = .081$) with post-hoc tests showing significantly lower positive affect at t1 and t2 ($p < .01$) and more negative affect at t1 ($p < .05$) for mothers with BPD compared to control mothers.	
Over-reactivity (N=1)	Parents with BPD, cluster A^a	Increased Over-reactivity	High
Harvey et al. 2011	Cluster A, Borderline, Antisocial, cluster C (Symptoms), anxiety, depression and substance abuse	BPD traits were positively correlated with self-reported over-reactivity in mothers ($r = .22, p < .01$). No significant correlations were reported in fathers. Trimmed regression model found cluster A ($B = -.21, se = .11, \beta = -.21, p < .05$) and borderline ($B = .17, se = .12, \beta = .20, p < .05$) personality traits and anxiety ($B = .23, se = .11, \beta = .23, p < .05$) were significant independent predictors of self-reported over-reactivity. All three co-efficient became non-significant when FDR correction applied. The overall model including all diagnoses was significant (Model $R^2 = .06, p < .01$).	

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Intrusiveness (N=1)	Mothers with BPD	Greater intrusiveness	Moderate
Bonfig et al. 2022	BPD diagnosis	Mothers with BPD showed more intrusiveness ($U=203.0$, $Z = -2.82$, $p= .025$) compared to control mothers.	
Fearful & disoriented response (N=1)	Mothers with BPD	Increase fearful and disoriented responses	Poor^a
Macfie et al., 2017	BPD (Diagnosis and traits) & Current mood disorder	Mothers with BPD showed more fearful/disoriented behaviour than controls (BPD $M=1.46$ ($SD=1.23$); Control $M=1.09$ ($SD=0.38$), $F(1,65)=4.34$, $p<.05$, $\eta^2=.06$). Maternal fearful/disoriented behaviour was positively correlated with identity disturbance ($r=.29$, $p<.05$)	
Behavioural parenting constructs			
Negative and positive parenting practices (N=4)	Maternal ASPD symptoms	Greater Negative, but not less positive parenting behaviour	Moderate -to-high
LeMoine et al. 2018	ASPD (Symptoms)	Paternal ASPD symptoms significantly correlated with negative parenting ($r= .540$, $p<.01$). No correlation found between ASPD traits and positive parenting	
Robinson et al. 2016	ASPD (Symptoms)	No correlation found between maternal ASPD symptoms and positive parenting. ASPD symptoms significantly correlated with inconsistent discipline ($B=.51$, $p<.01$)	
Russotti et al., 2022	ASPD & MDD (Diagnoses)	Control mothers displayed less negative parenting compared to mothers with co-morbid ASPD and MDD ($\beta=-.29$, $b=-.70$ [$SE=.28$], $p=.01$). There was no significant difference in negative parenting for co-morbid mothers compared to MDD-only mothers ($p=.07$). Among covariates, maternal education predicted negative parenting. ($\beta=-.21$, $b=-.13$ [$SE=.06$], $p=.04$)	
Kim-Cohen et al. 2006,	Depression and ASPD (1 or more symptoms)	Comorbid mothers used more negative parenting practices ($M=0.37$, $SD=1.52$) than depression only ($M=0.04$, $SD=0.95$, $t(1076)= 2.33$, $p<.05$), but not ASPD only ($M=0.19$, $SD=1.25$). No significant difference in positive parenting between Depressed only ($M=-0.07$, $SD=1.08$), ASPD only ($M=-0.20$, $SD=1.16$) or Co-morbid ($M=-0.22$, $SD=1.13$) mothers	
Engagement and involvement (N=3)	Maternal ASPD symptoms Correlational relationship with other PD categories	Reduced parental engagement and involvement	Low and high
DeMulder et al. 1995	All PD (Symptoms), Bipolar & unipolar depression	Mothers with no depression($n=27$): engaged behaviour was positively correlated with Schizotypal PD symptoms ($r=.67$, $p<.001$) at time 2, and Schizoid ($r=.38$, $p<.05$) personality disorder symptoms at time 3.	

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		<p>Bipolar depression mothers n=23: engagement was correlated with Obsessive Compulsive ($r=.59, p<.001$) and Dependent ($r=.49, p<.05$) personality disorder symptoms at T1, and Borderline (time 2: $r=.44, p<.05$; time 3: $r=.59, p<.001$) and Dependent personality disorder symptoms at (time 2: $r=.43, p<.05$, time 3: $r=.46, p<.05$) at time 2 and time 3.</p> <p>Unipolar depression n=39: Engagement was correlated with Paranoid ($r= -.55, p<.001$), Schizoid ($r=-.58, p<.001$), Schizotypal ($r= -.47, p<.001$), antisocial ($r=-.52, p<.001$), and Avoidant ($r=-.34, p<.05$) personality disorder symptoms at T1, and Schizoid (time 2: $r=-.43 p<.01$; time 3: $r=-.40 p<.05$) & Schizotypal PD symptoms (time 2: $r=-.52, p<.001$; time 3: $r=-.37 p<.05$) at time 2 & time 3.</p> <p>Antisocial personality disorder traits were negatively correlated with parental involvement ($B=-.31, p <.01$)</p> <p>There was significantly less involvement in fathers with 3 or more ASPD symptoms ($M=48.40, t=2.42, p<.05$) compared to fathers with <3 ASPD symptoms ($M=50.68$)</p>	
Robinson et al., 2016	ASPD (Symptoms)		
Bornovalova et al (2013)	ASPD (3 or more symptoms)		
Poor monitoring (N=1)	Maternal ASPD symptoms	Greater poor monitoring	High
Robinson et al., 2016	ASPD (Symptoms)	Maternal ASPD symptoms were correlated with poor monitoring ($B= .29, p<.05$)	
Parental laxness (N=1)	Maternal BPD and cluster A symptoms	Increased lax parenting	High
Harvey et al., 2011	Cluster A, Borderline, Antisocial, cluster C (Symptoms), anxiety, depression and substance abuse	Cluster A ($r= .38, p<.001$), borderline ($r= .40, p<.001$), Antisocial ($r= .28, p<.001$) and Cluster C ($r=.21, p<.01$) personality disorder traits were correlated with self-reported laxness in mothers, but not in video laxness after controlling for education. In fathers, Cluster A ($r= .23, p<.01$) and Cluster C ($r= .21, p<.05$) personality disorder traits were correlated with self-reported laxness. Trimmed regression models found Cluster A ($B= .30, SE= .11, \beta= .25, p<.01$) and borderline ($B= .25, SE= .11, \beta= .25, p<.01$) personality traits were significant independent predictors of self-reported laxness, with antisocial and substance abuse also included in the model (Model $R^2= .17, p<.001$).	
Autonomy Support (N=1)	Mothers with BPD	Decreased Autonomy supportive parenting	Moderate
Macfie et al., 2017;	BPD (Diagnosis and traits) & Current mood disorder	Mothers with BPD showed less autonomy support (BPD $M= 3.58 (SD= 1.52)$; Control $M= 4.71 (SD= 1.64)$, $F (1,65)= 6.15, p<.05, \eta^2=.09$) compared to controls. Maternal autonomy support negatively correlated with identity disturbance ($r= -.26, p<.05$) and negative relationships ($r= -.28, p<.01$).	

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Influence (control) (N=1)	Narcissistic and OCPD symptoms in mothers and fathers	Increased attempts to influence child	Moderate
Wilson & Durbin 2012	All PD traits	In regression models, Narcissistic ($b = .08$, $SE = .04$, $t(221) = 2.01$, $p = .046$) symptoms were independently associated with more parental influence bids. OCPD ($B = .09$, $SE = .04$, $t(220) = 2.47$, $p = .014$) was also independently associated in mothers, with no relationship found for fathers. Parents who reported more OCPD symptoms made fewer social bids to older children ($B = -.11$, $se = .06$, $t(219) = -2.04$, $p = .04$), with no effect found for younger children ($p = .39$)	
Limit setting (N=1)	Mothers with BPD	Reduced limit setting	Moderate
Bonfig et al. 2022	BPD diagnosis	Mothers with BPD showed less limit setting ($U = 502.50$, $Z = 2.60$, $p = .036$) compared to mothers without BPD.	
Maltreatment (N=6)	Mothers with any PD, BPD, co-morbid ASPD symptoms & depression	Mixed findings	Moderate-to-high
Bonfig et al. 2022	BPD diagnosis	Mothers with BPD reported increased child abuse potential ($M = 120.4$ ($SD = 42.4$), $t(41.5) = 8.17$, $p < .001$) compared to mothers without BPD ($M = 38.37$ ($SD = 29.0$)).	
Macfie & Kurdziel 2020.	BPD (Diagnosis & traits)	Children whose mothers had BPD experienced more overall maltreatment (75%, $p < .001$, Cramer's $V = .57$), more sexual abuse (17%, $p < .05$, $V = .30$) more physical abuse (25%, $p < .05$, $V = .26$), and more neglect, (69%, $p < .001$, $V = .55$) than controls (overall maltreatment = 53%, physical abuse = 6%, neglect = 15%)	
Dittrich et al., 2018	BPD (Diagnosis) and rMDD	Maternal BPD and rMDD were not directly associated with abuse potential. Maternal BPD was indirectly linked to child abuse potential via difficulties in emotion regulation ($B = 12.92$, $S.E. = 5.70$, $\beta = 0.119$, $p = 0.023$, BCa 95% CI [1.76; 24.09]) and rMDD ($B = 7.55$, $S.E. = 3.50$, $\beta = 0.090$, $p = 0.031$, BCa 95% CI [0.69; 14.41]).	
Stewart et al. 2006	ASPD (symptoms), substance use disorder & Internalising	ASPD symptoms correlated with global ($r = .22$, $p < .01$), and emotional ($r = .27$, $p < .01$) and supervision ($r = .23$, $p < .01$) neglect in fathers. ASPD symptoms in mothers were correlated with global and all subscales of paternal child neglect (Global $r = .37$, $p < .001$), physical neglect ($r = .35$, $p < .001$), emotional neglect ($r = .34$, $p < .001$), supervision ($r = .38$, $p < .001$) and educational neglect ($r = .33$, $p < .001$). In regression models, maternal ASPD symptoms were significant independent predictor of paternal global neglect ($B = 2.177$, $t(145) = 2.195$, $p = .030$), physical neglect ($B = .847$, $t(145) = 2.237$, $p = .027$), and educational neglect ($B = .496$, $t(145) = 2.379$, $p = .019$).	

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Kim-Cohen et al. 2006	Depression and ASPD (1 or more symptoms)	Children of comorbid ASPD & depression mothers had increased odds of harm (n=113, 33,95%) than mothers with depression only (n=64, 19.4%; t(1074)=2.28, p<.05) and antisocial personality symptoms only (n=81, 16.2%; t(1074)=2.37, p<.05). No difference found in agency involvement or child separated from family or reported child neglect.	
Famularo et al., 1992	Any personality disorder (Diagnosis)	Increased odds of mothers being diagnosed with personality disorder in maltreatment (64.81%) compared to control group (29.73%; Odds ratio= 4.35 (95% CI= 1.77, 10.70), p= .001)	
Relational parenting constructs			
Parent-child interactions (N=4)	Mothers with BPD, Parent with any personality disorder. ASPD symptoms.	Lower quality of parent-child interactions, less reciprocity and more negative states. ASPD symptoms are positively associated with parent-child conflict.	Low, moderate -to-high
Bonfig et al. 2022	BPD diagnosis (6 with co-morbid PTSD, 9 MDD, 7 anxiety disorder, 2 OCD)	Within the dyad, mothers with BPD and their children showed significantly less reciprocity (U=552.50, Z = 3.36, p = .007) and more negative states (U=180.50, Z = -3.48, p=.006) compared to non-BPD controls. CIB total score correlated negatively with borderline symptom severity (r= -0.57, p=.003), emotion dysregulation (r= -0.45, p=0.25), depression (r=-0.56, p=.004) and child abuse potential (r=-0.44, p=.029). No sig correlations found for history of childhood trauma, parenting stress or child internalizing or externalizing, or in the control group. Oxytocin reactivity did not mediate maternal BPD on dyadic reciprocity. However, there were significant indirect effect of maternal BPD on dyadic negative states via cortisol reactivity ($\beta = 0.08$, CI95 % [-.174; -.003]) and testosterone ($\beta = -0.12$, CI 95% [-.243; -.022]).	
Macfie & Kurdziel 2020	BPD (Diagnosis and traits)	Found a significant indirect effect of maltreatment between mothers' total borderline features and children's representation of the caregiver-child relationship (b = -.02, SE = .01, 95% CI [-.04, -.001]). There were also significant indirect effects for all borderline feature subscales: affective instability (b = -.03, SE = .02, 95% CI [-.09, -.002]); identity disturbance (b = -.05, SE = .03, 95% CI [-.13, -.002]); negative relationships (b = -.06, SE = .03, 95% CI [-.14, -.005]); and self-harm (b = -.06, SE = .04, 95% CI [-.16, -.006])	
Bornavolova et al (2012)	ASPD symptoms (3 or more)	There was significantly more conflict in mothers with 3 or more ASPD symptoms (M= 53.05, t(1239)= -2.69, p<.01) compared to mothers with <3 ASPD (M= 49.2).	

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Van santvoort et al. 2014	Any PD (Diagnosis), Axis-I disorders	Children of parents with a PD reported significantly lower quality of interaction with their parents (M= 96.48 (SD= 13.66), $t(121) = -2.10, p < .05, OR = 1.55,$) than children without a parent with PD (M= 102.23). There was no difference in parent reported interaction with child.	
Role reversal (N=1)	Mothers with BPD	Positively associated with role reversal	Moderate-to-high
Macfie et al., 2017	BPD (Diagnosis and traits) & Current mood disorder	Mothers with BPD showed more role reversal than controls (BPD M= 3.06 (SD= 1.45); Control M=1.74 (SD= 1.61) $F=15.41, p < .001, \eta^2 = .19$). Role reversal correlated with affective instability ($r = .44, p < .001$), identity disturbance ($r = .45, p < .01$), negative relationships ($r = .42, p < .001$).	
Cognitive parenting constructs			
Maternal mind-mindedness (n=1)	Mothers with BPD	Negative association (non-sig when controlling for depression)	Poor^a
Schacht et al. 2013	BPD, other PD (Diagnosis) and depression	Significantly less (n= 46%), of the comments used by mothers in the BPD group to describe their children were mind related compared to control group (n= 68%, $t(37) = 3.025, p = .005$). Multivariate analyses were non-significant ($p = .07$) when controlling for maternal depression.	
Parenting stress (n=4)	Mothers with any personality disorder symptoms and diagnosis, co-morbid ASPD and depression, BPD	Positively associated with parenting stress	Low and moderate-to-high
Kim-Cohen et al., 2006	Depression and ASPD (1 or more symptoms)	Comorbid ASPD & MDD mothers reported increased stress (M= 0.71, SD= 1.28) than mothers with MDD only (M= 0.42, SD=0.95; $t(1074) = 2.14, p < .05$) and ASPD only (M= 0.07, SD=1.08; $t(1074) = 4.79, p > .001$).	
Van santvoort et al. 2014	Any PD (Diagnosis), Axis-I disorders	Parents with personality disorder diagnosis reported significantly more parenting stress (M=38.55, SD=13.00, $t(121) = 2.06, p < .05, OR = 1.62$) than parents without PD (M=33.32, SD= 12.74)	
Bonfig et al. 2022	BPD diagnosis ^a	Mothers with BPD reported increased parenting stress (Mean= 148.64 (SD=31.1), $t(52) = 5.06, p < .001$) compared to mothers without BPD (Mean= 109.41 (SD=25.9)).	
Russotti et al., 2022	ASPD & MDD diagnoses	Mothers with comorbid MDD/ASPD and MDD-only did not demonstrate significantly different levels of parenting stress. Mothers with ASPD-only reported significantly less parenting stress ($\beta = -.23, b = -31.0 [SE = 11.0], p = .005$;) than mothers with comorbid MDD/ASPD. Control mothers demonstrated less parenting stress ($\beta = -.44, b = -43.6$	

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[SE=9.0], $p < .001$) compared to mothers with comorbid MDD/ASPD. No significant difference between the four groups on maternal efficacy. Covariate analysis indicated baseline childhood externalizing symptoms predicted greater parenting stress ($\beta = .22$, $b = 31.7$ [SE=12.9], $p = .01$) for mothers.

*Used non-validated measures

parental BPD and histrionic and maternal paranoid and ASPD symptoms were negatively associated with parental responsiveness, with low quality and mixed findings in other studies preventing clear conclusions from being drawn.

Four studies of moderate-to-high quality investigated parental sensitivity and reported contradictory findings. Macfie et al., (2017) found mothers diagnosed with BPD were less sensitive compared to mothers without a BPD diagnosis when statistically controlling for current mood disorder. This finding was replicated by Bonfig et al., (2022). However, Kluczniok et al., (2018) found that a maternal diagnosis of remitted Major Depression Disorder (rMDD), rather than coexisting BPD, better predicted lower maternal sensitivity. Indeed, Russotti et al., (2022) found that mothers with co-morbid ASPD and MDD demonstrated less sensitivity than control mothers, but no differences were found between mothers with MDD-only. These contrasting findings may be due to differences in age. For example, Bonfig et al. (2022) and Russotti et al. (2022) included children aged 1.5-3 years whereas Macfie et al. (2017) and Kluczniok et al. (2018) included children aged 4-7 years and 5-12 years respectively. Alternatively, the findings may be due to the use of different measures of sensitivity, diagnoses and statistical handling of co-morbid depression. Both Kluczniok et al. (2018) and Russotti et al. (2022) more rigorously controlled for the role of depression history in their study design, increasing the studies' quality and adding weight to their findings.

Two out of three studies found that there was less observed warmth in mothers with co-morbid ASPD and depression symptoms (Kim-Cohen et al., 2006) and mothers with cluster A personality disorder traits (Harvey et al., 2011). No relationship was found in fathers, although it should be noted warmth was only assessed using audio not video recordings for fathers but both audio and video means for mothers (Harvey et al., 2011). However, both studies used non-validated measures of warmth, increasing the

risk for bias and meaning the results should be treated with caution. In contrast, Davies et al., (2012) measured observed maternal warmth using a validated measure and found no significant independent correlations between maternal warmth, and ASPD symptoms. Davies et al.'s (2012) findings were correlational and did not control for comorbid maternal depression, therefore symptoms of depression may explain contradictory results.

Two well-designed, moderate-to-high quality studies on personality disorders and parental responsiveness found a negative relationship, which may be moderated by gender and personality disorder categories and mediated by inter-partner aggression. Specifically, Wilson & Durbin (2012) found maternal paranoid and ASPD symptoms were associated with lower quality of observed maternal responsiveness but not paternal responsiveness; whereas BPD and histrionic personality disorder symptoms were associated with lower quality parental responsiveness in both mothers and fathers. Davies et al., (2012) found that maternal ASPD symptoms were only indirectly related to diminished maternal responsiveness via increased interparental aggression. Finally, in a high-quality study, no relationship was found between maternal emotional availability and BPD diagnoses (Trupe et al., 2018).

Negative affective parenting constructs. Three studies assessed hostile and critical parenting responses in mothers only (DeMulder et al., 1995; Kluczniok et al., 2018; Macfie et al., 2017), three assessed negative affect in mothers and fathers (Bonfig et al., 2022; Harvey et al., 2011; Kim-Cohen et al., 2006), one assessed observed fearful and disoriented parenting in mothers (Macfie et al., 2017), one investigated self-reported over-reactive parenting in mothers and fathers (Harvey et al., 2011) and one investigated intrusiveness in mothers (Bonfig et al., 2022). Overall, greater parental hostility was associated with maternal BPD diagnoses and traits; greater negative affect

with maternal ASPD, cluster A and BPD symptoms and diagnoses; greater over-reactivity with parental BPD and cluster A symptoms; and greater intrusiveness and fearful and disoriented responses in mothers with BPD diagnoses.

A relationship was identified between maternal BPD and hostility in both cross-sectional studies, controlling for current mood disorder (Macfie et al., 2017) and rMDD (Kluczniok et al., 2018). In a low-quality cohort study, positive correlations across different personality disorder symptoms (see Table 5) and critical and irritable behaviour were identified which varied over time and whether mothers were diagnosed with depression, bipolar depression or received no depression diagnosis (DeMulder et al., 1995). Methodological limitations require DeMulder et al.'s (1995) findings be treated with caution, and replication is necessary to characterise the relationship between parental hostility and personality disorders with varied co-morbidity.

For negative affect, mothers with co-morbid ASPD and depression showed more observed parenting negativity than mothers with only depression or ASPD symptoms (Kim-Cohen et al., 2006). Further, ASPD, cluster A and BPD symptoms were correlated with observed negative affect in mothers but not fathers (Harvey et al., 2011). Harvey et al., (2011) found no categorical personality disorder symptoms independently predicted negative affect in regression models but the overall model, including all personality disorder categories, anxiety, depression and substance misuse, was significant. Bonfig et al. (2022) measured self-reported affect before and after mother-child interaction and identified significantly lower positive affect pre- and post-parent-child interaction, and greater negative affect pre-interaction in mothers with BPD diagnosis compared to control mothers. Bonfig et al. (2022) did not control for the effects of co-morbid diagnoses, thus cannot distinguish between whether PD or general psychopathology may be responsible for this effect. All studies were moderate or high quality and

indicate general psychopathology (including personality disorder and co-morbid mood disorders) may predict greater parental negativity, rather than an independent effect of personality disorders.

Mothers with BPD diagnoses showed more fearful and disoriented parenting compared to controls (Macfie et al., 2017). However, Macfie et al., (2017) used a non-validated measure of fearful and disoriented parenting responses in mothers with BPD, reducing the robustness of the findings. For over-reactive parenting, trimmed regression models including BPD, cluster A personality disorder symptoms and anxiety symptoms significantly predicted self-reported over-reactivity in parents (Harvey et al., 2011). There were no significant independent predictors of self-reported over-reactivity once a correction for multiple tests was applied, suggesting no independent effect of any personality disorder categories on parental over-reactivity. Mothers with BPD also showed greater intrusiveness compared to control mothers (Bonfig et al., 2022), although the sample was small and could not control for confounds such as neighbourhood adversity.

2.4.3.2 Behavioural parenting constructs

Positive and negative parenting practices. Four moderate-to-high quality studies assessed negative and positive parenting (Kim-Cohen et al., 2006; LeMoine et al., 2018; Robinson et al., 2016; Russotti et al., 2022), with one study considering inconsistent discipline separately to negative and positive parenting (Robinson et al., 2016). Positive parenting included parenting constructs such as positive reinforcement of behaviour and involvement, whereas negative parenting included measures of over-reactivity, laxness, monitoring and inconsistent discipline (LeMoine et al., 2018; Robinson et al., 2016). All four studies focused on ASPD symptoms and found ASPD symptoms were associated with negative parenting and inconsistent discipline, but not

positive parenting, in both mothers (Robinson et al. 2016) and fathers (LeMoine et al., 2018). This relationship may be stronger when the mother has co-morbid depression (Kim-Cohen et al., 2006). Although, in a smaller sample, Russotti et al., (2022) found the relationship only approached significance when comparing negative parenting in mothers with co-morbid ASPD and MDD compared to mothers with MDD only. Maternal education was a significant co-variate in predicting negative parenting (Russotti et al., 2022).

Parental control. One study investigated monitoring and supervision by mothers with ASPD symptoms (Robinson et al., 2016); one assessed limit-setting in mothers with BPD (Bonfig et al., 2022); another investigated personality disorder symptoms and parental laxness (Harvey et al., 2011). One study focused on autonomy support in mothers with a BPD diagnosis (Macfie et al., 2017); and one study focused on influence bids and parent personality disorder symptoms (Wilson & Durbin, 2012). Study quality across the four studies was moderate-to-high. However, the heterogeneity in measurement of constructs associated with parental control limits inter-study comparisons. Overall, maternal BPD diagnoses and symptoms were associated with greater lax and decreased autonomy supportive and limit setting parenting; parental narcissistic and OCPD symptoms were associated with great attempts to influence child; and cluster A symptoms associated with increased lax parenting.

BPD symptoms and cluster A personality disorder symptoms were significant independent predictors of self-reported laxness in parents (Harvey et al., 2011). The overall regression model, including ASPD and substance abuse, was also found to be significant, suggesting that co-morbidity adds to the independent effects of personality disorder symptoms on self-reported laxness. Similarly, mothers with BPD showed less limit-setting compared to mothers without BPD (Bonfig et al., 2022). There was also a

positive correlation between ASPD symptoms and poor monitoring (Robinson et al., 2016). Narcissistic and Obsessive-Compulsive personality disorder symptoms were significant independent predictors for observed parental influence bids (Wilson & Durbin, 2012). Significantly less autonomy support was found in mothers with BPD compared to controls (Macfie et al., 2017). Autonomy support was correlated with identity disturbance and negative relationships.

Engagement and involvement. Three studies measured parental engagement and involvement (Bornovalova et al., 2013; DeMulder et al., 1995; Robinson et al., 2016), with two of the three studies focussed on ASPD symptoms and one study focusing all personality disorder symptoms. Overall, a relationship was found between ASPD symptoms and lower parental involvement (Bornovalova et al., 2013), and maternal engagement (Robinson et al., 2016). In a low-quality cohort study, correlational relationships were found between observed maternal engagement and involvement, and greater symptoms across different personality disorder diagnoses (DeMulder et al., 1995; see Table 5). The strength of the correlation varied across the child's development and by maternal depression status. DeMulder et al., (1995) did not use a validated measure of parental engagement, and replication is required.

Maltreatment. Six studies investigated the relationship between maternal personality disorders and maltreatment (Famularo et al., 1992; Kim-Cohen et al., 2006; Macfie & Kurdziel, 2020), neglectful parenting practices (Stewart et al., 2006) and abuse potential (Bonfig et al., 2022; Dittrich et al., 2018). One moderate quality study identified increased odds of personality disorder diagnoses in a sample of mothers with court-substantiated cases of child maltreatment compared to controls (odds ratio 4.35, CI 1.77-10.70; Famularo et al., 1992), with another moderate-to-high quality study finding mothers with BPD showed increased child abuse potential compared to controls

in a small clinical sample (Bonfig et al., 2022). Two moderate quality studies also identified a greater likelihood of children experiencing maltreatment or harm in families where the mother had BPD diagnosis compared to no diagnosis (Macfie & Kurdziel, 2020) or co-morbid depression and ASPD symptoms compared to depression only and ASPD symptoms only (Kim-Cohen et al., 2006). However, for these two studies using community recruited samples, it was unclear whether the parent with a personality disorder was more likely to be the perpetrator. Indeed, Macfie & Kurdziel (2020) found that whilst children of mothers with BPD experienced more maltreatment, mothers with BPD were the perpetrator in only 47% of cases in this community sample.

A high-quality study identified an indirect effect of maternal BPD on child abuse potential via parental emotion regulation difficulties (Dittrich et al., 2018). Mothers with BPD had less emotional awareness, clarity, regulation strategies and acceptance of emotional responses which in turn was associated with increased abuse potential. In addition, Stewart et al. (2006) found that maternal, but not paternal ASPD symptoms were a significant independent predictor of paternal child neglect.

2.4.3.3 Relational parenting constructs

Five studies investigated parent-child relationship, with one study specifically focusing on role reversal. Overall, the studies found that parents with ASPD symptoms showed parent-child interactions that were characterised by significantly more conflict (Bornovalova et al., 2013). Children of parents with personality disorders reported significantly lower quality interaction with their parent compared to children with a parent without a personality disorder (Van Santvoort et al., 2014). No difference was found in parent-reported quality of interaction with their child. However, Van Santvoort et al.'s (2014) study was of low quality and results should be treated with caution. Additionally, in a moderate-to-high quality study, Bonfig et al., (2022) found that

mothers with BPD and their children showed significantly less reciprocity and more negative states compared to controls. There was a significant indirect effect of maternal BPD on dyadic negative states via cortisol reactivity and basal testosterone. The researchers interpreted these hormonal responses as indicative of parent-child interactions which result in less reward and relief of stress in mothers with BPD. Maltreatment also mediated the relationship between BPD symptoms and mother-child relationship quality in a moderate quality study (Macfie & Kurdziel, 2020). Finally, role-reversal was greater in parent-child interactions where mothers had BPD compared to mothers without (Macfie et al., 2017). Role-reversal was correlated with the BPD features of affective instability, identity disturbance and negative relationships.

2.4.3.4 Cognitive parenting constructs

Four studies investigated parenting stress and found that mothers with personality disorder symptoms and diagnoses reported increased stress compared to mothers without personality disorder symptoms (Bonfig et al., 2022; Kim-Cohen et al., 2006; Russotti et al., 2022; van Santvoort et al., 2014). Russotti et al., (2022) found no difference between parenting stress in mothers with co-morbid ASPD and MDD, and MDD only; whereas mothers with ASPD-only reported significantly less stress than mothers with co-morbid ASPD and MDD, suggesting MDD may be driving this effect. Co-variate analysis indicated that baseline childhood externalising (aged 1 years old) predicted greater parenting stress, highlighting the influence of child variables on parenting too. Russotti et al.'s (2022) findings contrast with Kim-Cohen et al. (2006), who found that mothers with co-morbid ASPD and MDD reported increased stress compared to mothers with MDD only. Kim-Cohen et al., (2006) defined ASPD based on mothers reporting 1 or more symptoms, whereas Russotti et al. (2022) used a clinical sample, perhaps explaining these contradictory findings.

One moderate-to-high quality study investigated maternal mind-mindedness in parents of children aged 2-12 years and found that mothers with BPD described their children with mind-related comments significantly less compared to the control group (Schacht et al., 2013). This relationship was no longer significant when controlling for maternal depression.

2.5 Discussion

This systematic review investigated the impact of personality disorder diagnoses and symptoms on the parenting of parents of 2–12-year-old children, summarising research from 19 studies. This review originally aimed to synthesise and integrate qualitative findings with quantitative research; however, this was not possible due to an insufficient number of eligible qualitative studies. This review addresses limitations of previous reviews by focusing on all personality disorder diagnoses and parenting during early and middle-aged childhood (2-12 years) to focus synthesis on parenting constructs relevant to intervention development for parents of children aged 2-11 years.

The literature summarised in this review varies in methodological quality, is heterogenous and, for most parenting constructs, there are too few studies to make inter-study comparisons and draw firm conclusions about the impact of personality disorder characteristics at a categorical and general classification level. Nevertheless, the studies included can form an early understanding of the potential influences of personality disorder characteristics on parenting and highlight avenues for further research. The following discussion will first summarise the key findings across affective, behavioural, cognitive and relational parenting domains. The main limitations of the literature reported are then considered, followed by a summary of implications for intervention development and future research.

2.5.1 Summary of key findings

For affective parenting constructs, the evidence reviewed here supports an association between personality disorders and negative affective parenting constructs in mothers (hostility, negativity, over-reactivity), between BPD and maternal hostility. There were less robust findings regarding the extent to which personality disorders affected positive affective parenting constructs (warmth, sensitivity), with only parental (both mothers and fathers) responsiveness consistently associated with personality disorder characteristics. Inter-partner conflict and history of depression were important mediating variables. For behavioural parenting constructs, preliminary evidence suggested that parental personality disorder symptoms in both mothers and fathers are associated with greater laxness; more influence; less involved parenting; and increased negative parenting behaviours such as harsh discipline, but not necessarily less positive parenting behaviours such as praise. Maternal BPD diagnosis was associated with less autonomy support, and children of mothers with personality disorder diagnoses and symptoms were more likely to experience maltreatment and neglect. However, it was unclear whether personality disorder characteristics independently increased the risk of perpetration of maltreatment and neglect by the parent experiencing personality disorder symptoms. Instead, studies indicated that emotion dysregulation and co-morbidity may increase risk for perpetration.

For cognitive parenting constructs, mothers with BPD use less mind-related comments than controls. Mothers with personality disorder diagnoses also reported higher parenting stress compared to mothers without diagnosis or symptoms, with qualitative research indicating parents feel helpless to improving their situation (Wilson et al., 2018). Finally, the parent-child relationships of parents with personality disorder were also characterised by higher levels of conflict and negativity; lower quality interactions in both mothers and fathers; and more role-reversal in mothers, with no

studies on role reversal reported in fathers. Cortisol and oxytocin reactivity analysis potentially highlight different physiological responses to parent-child interaction, with mothers with BPD showing maintained cortisol reactivity (an indicator of physiological stress) which indirectly predicted negative dyadic states and a reduction in oxytocin across parent child interaction (Bonfig et al., 2022). This finding indicates mothers with BPD may experience more physiological stress and less reward than control mothers in parent-child interactions.

Previous reviews have highlighted a relationship between maternal BPD and lower sensitivity, responsiveness & warmth (e.g., Eyden et al., 2016; Petfield et al., 2015; Steele et al., 2019). The current review's mixed findings around the relationship between parental personality disorder and positive affective parenting such as warmth and sensitivity deviates from previous reviews. One explanation may be that the research on maternal sensitivity summarised previously focused on parenting in infancy. Parenting behaviour evolves across development to meet the child's needs (Bronfenbrenner, 1977; Cabrera et al., 2014; Rutherford et al., 2015). Thus, the divergence between previous reviews and the current mixed findings suggest that the age of the child may be an important factor in the relationship between personality disorder and affect-related parenting constructs and highlights the importance of studying the impact of personality disorders on parenting longitudinally.

In agreement with Eyden et al., (2016), these findings suggests that parents with personality disorder do not lack desire to care for their children. However, these parents may experience greater stress with lower capacity to regulate stress, alongside co-morbidity and challenging co-parenting/partner relationships (Bonfig et al., 2022; Harvey et al., 2011; Russotti et al., 2022; Wilson et al., 2018). In turn, greater parenting stress may increase the likelihood of negative affect and parenting behaviours and

challenging parent-child relationships. This interpretation is supported by qualitative research, finding that parents with personality disorders experience uncertainty and distress around how to respond to daily challenges of parenting (Wilson et al., 2018). Research indicates that negative affect can influence parents' ability to interpret their child's behaviour, impacting their ability to use positive discipline strategies during stress and engage with the child positively (Maliken & Katz, 2013). Therefore, targeting negative affect and improving emotion regulation of negative affect may be particularly important for this population.

Finally, the low number of studies investigating concepts related to cognitive parenting constructs such as self-efficacy (Bornstein et al., 2018), and the cognitive-affective processes underlying parenting such as parental emotion regulation (Rutherford et al., 2015) is surprising. There was only one study which considered parental mentalising in parents of 2–12-year-olds (Schacht et al., 2013). Meanwhile, there is extensive literature on the difficulties in mentalising experienced by individuals with a personality disorder (Fonagy & Bateman, 2008; Luyten et al., 2020) and the potential importance of mentalising for sensitive, responsive parenting (Camoirano, 2017). A small number of studies have investigated adult cognitive and affect processing in parents with personality disorder diagnoses (e.g., Binion & Zalewski, 2018). However, these studies were excluded at full text level as they did not measure the cognitive or affective process e.g. emotion regulation in the context of parenting and child stimuli, using instead a general measure (Zhang et al., 2023). Future research is necessary to establish how personality disorder characteristics affect the underlying cognitive and affective processes which support parenting.

2.5.2 Limitations of the evidence

There are three core limitations of the literature reviewed and this systematic review which must be addressed in future research; (i) conceptualisation of parenting and personality disorder; (ii) handling co-morbidity and (iii) methodological variation and constraints. Firstly, the literature reviewed varies considerably in the definition and measurement of parenting constructs, preventing inter-study comparison, synthesis of parenting across age groups (0-18 years) and undermining clear conclusions about the impact of personality disorders on parenting. For example, LeMoine et al., (2018) combined over-reactivity, laxness, inconsistent discipline & poor monitoring into negative parenting, whereas Harvey et al., (2011) considered laxness and over-reactivity separately and Stewart et al., (2006) included poor monitoring as an aspect of child neglect. Similarly, some studies focused on symptoms from all categories of personality disorder in community samples and others on specific personality diagnoses (e.g., BPD). No studies directly compared parenting across all personality disorder categories. The heterogeneity in operationalising personality disorders here may reflect the wider debate in the conceptualisation of personality disorders (Anderson et al., 2014; Hopwood et al., 2018; Widiger & Samuel, 2005). It is a limitation of this systematic review that the search strategy did not include terms such as “complex emotional needs” or “significant emotional and interpersonal difficulties”, referring to individuals who may have received a “personality disorder diagnosis” or may have comparable needs. Similarly, including child-related search terms may have captured additional research on the impact of personality disorders on parenting. The findings synthesised here can be used as a starting point from which to consider the impact of core features of personality (self and interpersonal) dysfunction and trait-specific difficulties across the different levels of impairment on parenting as researchers shift to a more dimensional model of personality disorders and significant emotional and interpersonal difficulties.

Relatedly, studies varied in their handling of co-morbidity, preventing delineation of the influence of personality disorders and other mental health diagnoses on parenting and parent's experiences. Personality disorders are often associated with one or more mental health disorders (Newton-Howes et al., 2010; Tyrer, 2015; Tyrer et al., 2015), and recruiting individuals with a personality disorder diagnosis and without co-morbidity or history of other mental illness may be challenging (Kluczniok et al., 2018). It is possible that the cumulative effects of co-morbidity on parental functioning and stress accounts for some of the variance in parental care rather than personality disorder characteristics themselves. Further work needs to be undertaken to delineate the role of personality disorders vs. general psychopathology on parenting.

There are also several methodological limitations of the research reviewed here. First, most of the research was carried out with North American and northern European samples of white ethnicity. This indicates a potential cultural bias which may limit the generalisation of existing findings to other cultural and national contexts. Secondly, there was heterogeneity in the reporting and statistical handling of demographics and socioeconomic status within the studies. Only 53% of papers described sample demographics with sufficient detail to identify potential confounds and aid interpretations of generalisability and representativeness of the findings, with nearly all studies neglecting to report the number of children for whom the parent was caring. Number of children has been shown to impact on parenting stress & confidence (Hickey et al., 2019), parental emotional and cognitive stimulation (Lehmann et al., 2018) and parental neural responses to their children (Maupin et al., 2015). Greater consideration of demographic confounds are therefore required.

Third, there is a significant bias in studies towards focusing on maternal parenting only, replicating the wider parenting literature (Cabrera et al., 2014). All

studies of BPD focused on maternal parenting, and tended to focus on affective parenting constructs e.g., sensitivity. Personality disorder diagnoses, in particular BPD, have been criticised for being potentially misogynistic and pathologizing of female emotions (Shaw & Proctor, 2005; Troup et al., 2022; Warner & Wilkins, 2004; Watts, 2019). The lack of investigation of other personality disorder and research in fathers may reflect bias and perpetuate stigmatising and misogynistic practices and assumptions about mothers with BPD. This bias in turn may prevent exploration of alternative explanations for varied results, such as the impact of trauma, co-parent relationship quality or co-morbidity. Considering the familial, intergenerational and systemic factors at play in the diagnosis of personality disorders and the associated impacts on child outcomes is also important when developing supportive interventions.

Fourth, 40% of the studies did not use validated measures for all outcomes collected and replication of findings with validated measures is vital to ensure that researchers are investigating what they set out to. Fifth, there was a lack of multi-method and multi-respondent designs, with only four studies using multi-methods to capture data on parenting outcomes. Multi-method designs using self-report, observational and interview assessments and multi-respondent designs such as both parent and child-report are important for parent populations where self-report bias is likely due to stigma and fear of judgement (Morsbach & Prinz, 2006). Finally, the current review only identified one eligible qualitative study (Wilson et al., 2018) and could not conduct qualitative synthesis. The other qualitative studies identified during the search focused on early infancy or were indiscriminate regarding child age. This highlights a dearth in understanding and need for research on parent's experiences of raising early and middle childhood and adolescent children whilst also experiencing personality disorder symptoms. Further qualitative research could also explore

children's experience to develop awareness of children's needs and inform intervention development (Clavering & McLaughlin, 2010; Woodgate et al., 2017).

2.5.3 *Clinical implications and summary*

The review identifies relationships between personality disorder characteristics and increased negative affect, hostility and parenting stress, reduced parental involvement and negative parenting practices. This synthesis does not indicate an absence of positive parenting skills such as warmth and praise, rather greater negative affect and inconsistent parenting practices. Negative affect may be a particularly important target for parenting interventions as it disrupts the ability to use positive parenting strategies and positively engage with children (Maliken & Katz, 2013). Supporting parents to cope with their negative feelings whilst parenting may help reduce negative parenting practices. Furthermore, using a strength-based framework to support and enhance consistent use of existing positive parenting skills and affect may positively impact parent and child outcomes. Experiential learning models which offer parents opportunities to reflect on their parenting and problem solve challenges in implementing positive strategies may be more helpful in increasing use of positive parenting than skills-based, didactic or educational workshops.

The increased levels of parenting stress suggests that the importance of developing interventions that target specific parenting-related distress, rather than personality disorder symptoms alone, may benefit parents and children. Currently, there is not enough strong evidence to suggest that clinical interventions should vary based on categorical diagnoses or personality disorder traits. Rather exploring the parent's needs and experiences whilst experiencing personality disorder symptoms but without attributing them to their personality disorder symptoms may be incredibly important for engaging parents with support (Wilson et al., 2018).

The influence of co-morbidity suggests that interventions should also consider the impact of other mental health difficulties, general functioning and transdiagnostic features such as emotion dysregulation. Indeed, emotion dysregulation and inter-partner aggression were found to mediate the relationship between personality disorder and parenting outcomes such as maltreatment and responsiveness (Dittrich et al., 2018; Davies et al., 2012). Parenting support which improves emotion dysregulation and co-parental relationship may therefore be important for this population. The age of the child should also be considered when planning interventions, as the impact of personality disorders on parenting may vary across development, indicated by the differences in the current review and past reviews of parenting across all age ranges.

Overall, the studies reviewed here begin to shed light on impact of personality disorders on parenting of 2–12-year-olds. Future longitudinal research should be carried out to assess the impact of personality disorder on parenting overtime and to identify causal vs. correlational relationships. More qualitative research on parenting experiences in early and middle childhood whilst also experiencing personality disorder symptoms is needed to understand, corroborate or question quantitative research and generate new concepts for investigation. Consideration of transdiagnostic factors (e.g., emotion dysregulation), co-parent relationship quality and the cumulative effects of co-morbidity would also aide understanding and fit with the newer conceptualisations of personality disorders in the ICD-11 and DSM-5's alternative model.

2.6 Chapter summary

This chapter presents a systematic review of the impact of personality disorder characteristics on parenting of children aged 2-12 years. This chapter provides systematic evidence synthesis emphasized in MRC framework as important for defining the target population and informing intervention development and evaluation. The key

findings from this review were (1) there is a relationship between personality disorder characteristics and parenting of children aged 2-12 years, particularly increased negative affect & hostility, inconsistent parenting behaviour, increased parenting stress and distress and conflict in the parent-child relationship (2) there is insufficient evidence to suggest that intervention should vary based on personality disorder categories (3) co-morbidity, emotion dysregulation and inter-partner relationships should be considered as potential contextual influences on interventions. Unfortunately, qualitative synthesis was not possible as part of this mixed-methods systematic review, with qualitative research not focusing on experience of parenting of 2–12-year-olds. The following section integrates these key findings from systematic review with theoretical and empirical research on parenting and parenting interventions, qualitative research on the experience of parents with personality disorders and stakeholder involvement to outline the development of BaP-Enjoying Family Life .

Chapter 3 Development of Being a Parent-Enjoying Family Life

3.1 Chapter summary

The systematic review demonstrated that parents with a personality disorder diagnoses or traits show greater negative affect, inconsistent parenting behaviour, greater parent-child conflict and role-reversal, and higher levels of parenting stress compared to parents without a diagnosis or traits. Interventions which focus on parent's coping and support to enhance parents use of positive parenting strategies may be particularly useful for this population. This chapter brings together learning from chapters 1 (theoretical foundation of parenting interventions and methodological guidance in intervention development) and 2 (relationship between personality disorder characteristics and parenting) to outline the development of BaP-Enjoying Family Life.

BaP-Enjoying Family Life was developed as a novel peer-led, group-format parenting intervention for parents with significant emotional and interpersonal difficulties who are concerned about their child's (aged 2-11 years) behaviour. This chapter follows the MRC framework for intervention development, supplemented by work from O'Cathain et al.'s (2019) group and the GUIDED (Duncan et al., 2020) checklist on reporting intervention development in health research. The chapter first reports the rationale for selecting BaP-Standard for adaptation and justifies the use of MRC framework to guide intervention development. Then the methods and actions taken to develop the intervention are defined. Third, the programme theory is articulated, including intervention targets and group process and peer-facilitation skills which guided intervention adaptation and development. Finally, the intervention content and delivery are described.

3.2 Introduction

3.2.1 Rationale for selecting BaP-Standard for adaptation

Many evidence-based parenting interventions exist with established efficacy in improving child emotional and behavioural difficulties (Mingebach et al., 2018; Wilson et al., 2012). Evans et al., (2019) outline that assuming effective interventions will work across different populations is problematic as they often do not consider intervention context and additional needs of the population. Equally, assuming effective approaches cannot be transported into different populations is also contentious and may lead to research waste, high research costs of developing a completely new intervention and ethical dilemmas of subjecting participants to unnecessary research when appropriate interventions already exist. Adapting existing interventions can increase likelihood of intervention uptake and implementation and reduce research waste where there is robust evidence that the mechanisms targeted by the intervention are relevant. Therefore, this PhD chose to adapt an existing, evidence-based parenting intervention.

There is growing evidence for the acceptability, clinical and cost-effectiveness of peer-led parenting and mental health support (Barr et al., 2020; Day et al., 2012b; Huang et al., 2020; January et al., 2016; Munns et al., 2016; Tomfohr-Madsen et al., 2022). Peer-led support can facilitate respect, trust and mutual identification which can normalize parenting and mental health concerns, support engagement with interventions and offer hope of change (Tomfohr-Madsen et al., 2022; Watson, 2019). Peer-led delivery may be particularly valuable for parent's with significant emotional and interpersonal difficulties in (i) increasing social support (Barr et al., 2020) (ii) reduce stigma (Watson, 2019) and, (iii) provide hope for change and validation (Barr et al., 2020; Watson, 2019). In addition, peer-led delivery may be more acceptable to parent's who can be distrustful of services due to historical and ongoing trauma and negative experiences of care (Munns et al., 2016; Tomfohr-Madsen et al., 2022).

Being a Parent (BaP-Standard) is a well-established, effective peer-led group-format parenting intervention for child behavioural difficulties and was identified as an appropriate candidate for adaptation to BaP-Enjoying Family Life. BaP-Standard is currently delivered in the community by local hubs developed and supported by the Empowering Parents Empowering Communities (EPEC) team in over thirty local authorities in the UK (Day et al., 2022). A Randomised Controlled Trial (RCT; $n = 116$) comparing BaP-Standard to waitlist control found significant improvements in child behavioural difficulties and reductions in parent-rated behavioural concerns with medium-to-large effect sizes of $d = 0.38-0.77$; Day et al., 2012b, 2012a). Positive parenting also increased significantly greater than waitlist (effect size $d = 0.69$). The intervention was rated as highly acceptable by participants and had a 92% completion rate. A subsequent scaling and implementation quasi-experimental study evaluated the impact of BaP-Standard on a national scale, delivering 128 groups across 15 sites over an 18 month duration (Day et al., 2022). The study found statistically significant and clinically meaningful improvements across parent's concerns about their child, wellbeing, behaviour and goals, similar to the original RCT.

Second, BaP-Standard is an intervention that lends itself to being adapted. It has been delivered, evaluated and adapted to support other target populations (e.g. Homeless parents- Bradley et al., 2020; Perinatal populations- Harwood et al., 2022; Parents in conflict- Kearney et al., 2020; Parents of teenagers- Michelson et al., 2014), demonstrating that it can be successfully adapted and delivered to different groups. Prior to commencing this project, BaP-Standard was already being delivered to clinical populations by the Helping Families team by a clinician and one Parent Group Leader. A proof-of-concept study where BaP-Standard was delivered by a specialist clinician and a peer-facilitator to a group of parents with mental health concerns and renamed

EPEC-Recovery was conducted prior to the current PhD research. Twenty-nine parents were offered EPEC-Recovery via recruitment from mental health services. Twenty-six accepted the intervention, with a 76.9% completion rate. Of those who completed, 70% provided pre-post intervention data. These parents reported satisfaction with EPEC-Recovery and improved parental confidence. Preliminary outcome analysis indicated positive impacts on parental wellbeing, child concerns and parent goals. However, feedback from attendees and parent group leaders who delivered EPEC-Recovery identified further adaptations and modifications were required to meet the target needs of the population. Furthermore, the project was delivered to parents with varied mental health needs, and it was important to get a greater understanding of the target population's needs and challenges for intervention development (O'Cathain et al., 2019; Skivington et al., 2021)

Taken together, a growing body of evidence identifies BaP-Standard as an acceptable, clinically effective and adaptable peer-led intervention for parents and children, indicating that it is an appropriate candidate for supporting parents with significant emotional and interpersonal difficulties. However, without adaptation, BaP-Standard may not be as effective for parents/caregivers with significant emotional and interpersonal needs due to (i) higher levels of inconsistent parenting styles and parenting stress in these parents and caregivers (Chapter 2, Eyden et al., 2016; Steele et al., 2020), (ii) different parenting concerns e.g. impact of their mental health on their children (Dunn et al., 2020; Wilson et al., 2018), (iii) high levels of adversity and trauma in the parents/caregivers own childhood (Boucher et al., 2017; Steele et al., 2020), increasing the need for trauma-informed intervention (Sweeney & Taggart, 2018) and (iv) different barriers to attending group interventions such as mental health stigma and lack of social support (McMurran et al., 2010; Petfield et al., 2015; Rains et

al., 2021). Therefore, adaptation of BaP-Standard content and delivery methods to support the additional needs and overcome barriers experienced by parents and caregivers with significant emotional and interpersonal difficulties is vital,

3.2.2 Rationale for adapting interventions using the MRC framework

There is currently no over-arching guidance for adapting complex interventions (Evans et al., 2019). However, many guidelines for developing and evaluating complex intervention exist. As outlined in the introduction, this PhD follows the MRC framework (Skivington et al., 2021) for developing and evaluating complex interventions. The MRC framework outlines that to develop a complex intervention or adapt an intervention to a new population, it is important to (i) identify the relevant evidence base (Chapter 2); (ii) identify and develop an appropriate programme theory, supplemented by evidence from stakeholders; and (iii) model processes and outcomes (e.g., pre-trial economic evaluations; Skivington et al., 2021). Grounding the intervention development on well-tested theory can guide operational procedures for intervention content and delivery, help determine which components of the intervention and context are important in influencing outcomes and creates a foundation upon which further intervention development hinges (Corry et al., 2013). Furthermore, incorporating stakeholder perspectives reduces the risk of research waste by ensuring interventions are relevant to and implementable in clinical practice (Bauer & Kirchner, 2020).

Nevertheless, the MRC framework alone may be insufficient to develop Being a Parent-Enjoying Family Life. Implicit within its strengths as a flexible approach is that the framework does not offer a detailed methodological guide to developing and reporting intervention development (Corry et al., 2013; Datta & Petticrew, 2013). Instead, the framework points to other guidelines for designing the intervention (e.g. O’Cathain et al., 2019) and reporting all aspects of intervention development e.g.

GUIDED (Duncan et al., 2020). O’Cathain et al.’s (2019) guidance was funded and developed by the MRC and NIHR using evidence from a review of published approaches to intervention development, qualitative interviews with stakeholders and a consensus exercise involving two e-Delphi studies. The 14-item GUIDED checklist for reporting intervention development was systematically developed by the same group of researchers under the same MRC funding through a consensus exercises involving three e-Delphi studies and a workshop. Following O’Cathain et al.’s (2019) guidance and the GUIDED checklist can enhance quality and lead to greater transparency and reproducibility in intervention research. Furthermore, the TIDIER checklist refers to reporting of interventions for clinical trials to enable replication (Hoffmann et al., 2014), and is also used in this PhD project. The following section describes the methods used for adapting the BaP-Standard manual to BaP-Enjoying Family Life, developed based on MRC framework and supplemented by O’Cathain et al.’s (2019) and Duncan et al.’s (2020) guidance. Appendix G report completed GUIDED checklist to ensure clear reporting of intervention development.

3.3 Method for adapting BaP-Standard to BaP-Enjoying Family Life

Intervention development was dynamic, involving many iterative cycles of generating ideas, getting feedback from stakeholders, considering the existing theory and literature (including Chapter 2’s systematic review findings), implementing potential solutions, assessing acceptability of solutions and returning to idea generation, as suggested by MRC framework. Table 6 provides a summary of the different components of planning and timeline based on O’Cathain et al.’s (2019) guidance. This section describes the key actions which occurred at each stage.

Planning the development process: The development of BaP-Enjoying Family Life was conducted in collaboration with researchers from King's College London and practitioners from the Empowering Parent's Empowering Communities (EPEC) teams and Helping Families teams at Centre for Parent and Child Support, South London and Maudsley NHS trust. The EPEC team supports the delivery, development and implementation of a series of peer-led parenting interventions in South London, nationally and internationally. The Helping Families team is a National and Specialist Children and Adolescent Mental Health service that provides a one-to-one, home-based intervention for parents with complex mental health difficulties (Helping Families Programme, Day et al., 2020) and consultancy, training and support for teams working with families affected by parent mental health, predominantly in South London. Both teams have expertise in parenting, parental mental health, clinical interventions and peer-led support. The development and delivery of the intervention was funded by South London and Maudsley NHS trust, and research costs by King's College London. Planning the development stage involved the PhD researcher building collaborative partnerships between key stakeholders within the three organisations and creation of a timeline for development and evaluation.

Stakeholder involvement: Stakeholder involvement was key in the intervention development process, as encouraged by MRC framework (Skivington et al., 2021). The adaptation of BaP-Standard relied on an active partnership between the PhD researcher and parents who may receive the intervention, deliverers of the intervention and those that developed the original intervention. Stakeholder involvement followed guidance published by National Institute of Health Research (NIHR) and the UK standards for public involvement's (November, 2019) statement on effective public involvement for health and social care research. The statement encourages flexibility; inclusive

opportunities for public involvement across research and governance; clear communication and sharing of findings; learning opportunities; assessment of impact; and collaborations that are characterised by respect and value all contributions. The NIHR developed a series of resources to support Patient Public Involvement (PPI) which were used to plan and support stakeholder involvement for this project (National Institute for Health Research, December 2019). These resources aim to increase PPI involvement and reduce tokenism, where PPI involvement is perfunctory and not valued as equally important as other pieces of information. Appendices H and I outlines PPI planning for this PhD, created following the PPI toolkit developed by Bagley and colleagues (2016) and the Public Involvement Impact Assessment Framework (PiiAF; Popay and Collins, 2014). PPI activities included consultations related to trial methods, informing chapter 4 feasibility evaluation design.

For intervention development, multiple consultations were conducted with five groups of stakeholders: (1) BaP-Standard's original intervention developers (Prof. Crispin Day, Clinical Psychologist, and Charlotte Wilson, Mental Health Nurse); (2) Clinical Leads of EPEC and Helping Families Team (Jo Nicoll, Occupational Therapist, and Dr Joanna Gibbons, Clinical Psychologist); (3) Supervisors of the BaP-Standard group (two Clinical Psychologists, one Occupational Therapist), (4) Four Parent Group Leaders (PGLs) who had delivered the BaP-Standard group to clinical populations, including one PGL with lived experience of mental health difficulties, and (5) Six parents who experienced mental health difficulties who attended EPEC-Recovery. Appendix J outlines the stakeholder meetings and outcomes in greater detail.

Review of published evidence: A rapid search and review of systematic reviews on parenting and personality disorder and qualitative research was conducted early on in intervention development. Findings were summarised and discussed with

stakeholders. Gaps in the reviews synthesized were used to identify the research question and design of the systematic review outlined in chapter 2.

Programme theory: The programme theory was articulated using theory, evidence and stakeholder consultation. This PhD used the Multiple Determinants of Parenting model (Belsky, 1984a; Taraban & Shaw, 2018), outlined in Chapter 1, to develop the theoretical framework to understand how significant emotional and interpersonal difficulties may impact the parent, parenting and child development (Appendix K). Findings from several systematic reviews (including Chapter 2), synthesis of qualitative studies and consultations with stakeholders were incorporated with the theoretical framework to identify intervention targets and guide adaptations to the BaP-Standard manual. The key features of intervention impact and delivery were identified from (i) theories of group cohesion and development (Burlingame et al., 2018; Malhotra & Baker, 2023; Wilberg & Karterud, 2001); (ii) theories of peer-support (Watson, 2019); (iii) research and evaluation of the Helping Families Programme (Day et al., 2020), and; (iv) BaP-Standard (Day et al., 2012a, 2012b; Thomson et al., 2015) and Being a Parent-together (Kearney et al., 2020) programme theories.

Understand context: The PhD researcher immersed themselves with the delivery and content of BaP-Standard through observing and then supervising the intervention in non-clinical and clinical population. Supervising the intervention helped familiarize the PhD researcher with the delivery and facilitation procedures and requirements. This observation and immersion allowed the PhD researcher to fully understand the context of the intervention, an important part of MRC framework (Skivington et al., 2021). The PhD researcher kept notes throughout this observation and immersion process and was able to use their experience of observing the interventions to refine the questions they asked of stakeholders. The PhD researcher is

not a parent; therefore, their observations are limited in their ability to understand fully parent's experience of the intervention. The stakeholder consultations were vital in reducing any bias and identifying blind spots of the PhD researcher to ensure the clinical utility and relevance of the intervention to the target population.

Designing and refining the intervention: This process involved iterative cycles of engaging with the programme theory, stakeholder feedback and observation notes to identify areas for development and make content and delivery adaptations. The BaP-Standard intervention manual was read and interrogated with the three key uncertainties:

- What content and delivery methods of BaP-Standard fit well with proposed programme theory?
- What content and delivery methods need adapting & refining to align with programme theory?
- What content and delivery methods needs adding to meet the needs of the target population in line with the programme theory?

Then, the PhD researcher developed session plans in two batches (session 1-5 then sessions 6-10) in collaboration with intervention developers, supervisors and PGLs. The session plans were refined based on stakeholder suggestions. After approximately three cycles of feedback and edits, the session plans were developed into manual content. The manual was sent to intervention developers and the service leads for further feedback. Finally, training material for PGLs invited to deliver the BaP-Enjoying Family Life intervention for the trial was developed in collaboration with the intervention developers and supervisors, focusing on new content and empowering and developing PGL's group facilitation skills. Training was conducting using a goal-based and

strengths-focused approach with a mixture of didactic, role play and group-based discussion.

3.4 Intervention development outputs

There were two key outputs from the intervention development stage: BaP-Enjoying Family Life programme theory and intervention manual. The following sections will first outline the BAP-Enjoying Family Life programme theory development, considering the five areas for change and delivery methods hypothesised as important in facilitating intervention engagement and change in intended outcomes. Second, the adaptation of BaP-Standard for delivery with parents with significant emotional and interpersonal difficulties and concerns about their child is outlined.

3.4.1 BaP-Enjoying Family Life programme theory

The BaP-Enjoying Family Life programme theory (See Figure 4) was influential in guiding BaP-Standard adaptation by identifying possible targets for change and mechanisms of BaP-Standard which need to be maintained (Evans et al., 2019; O’Cathain et al., 2019; Skivington et al., 2021). Five areas for change were identified using MDP outlined in chapter 1 and evidence synthesis, including findings from systematic review (Chapter 2). Intervention targets were selected if there was evidence of: (1) contribution to child socioemotional development and difficulties (intended outcome) (2) evidence of variation in parents with significant emotional and interpersonal difficulties compared to parents without significant emotional and interpersonal difficulties and, (3) existing intervention strategies to address the key target (i.e., are modifiable, discussed later in this chapter). These areas of change were used to guide content and delivery adaptations to BaP-Standard for BaP-Enjoying Family Life manual.

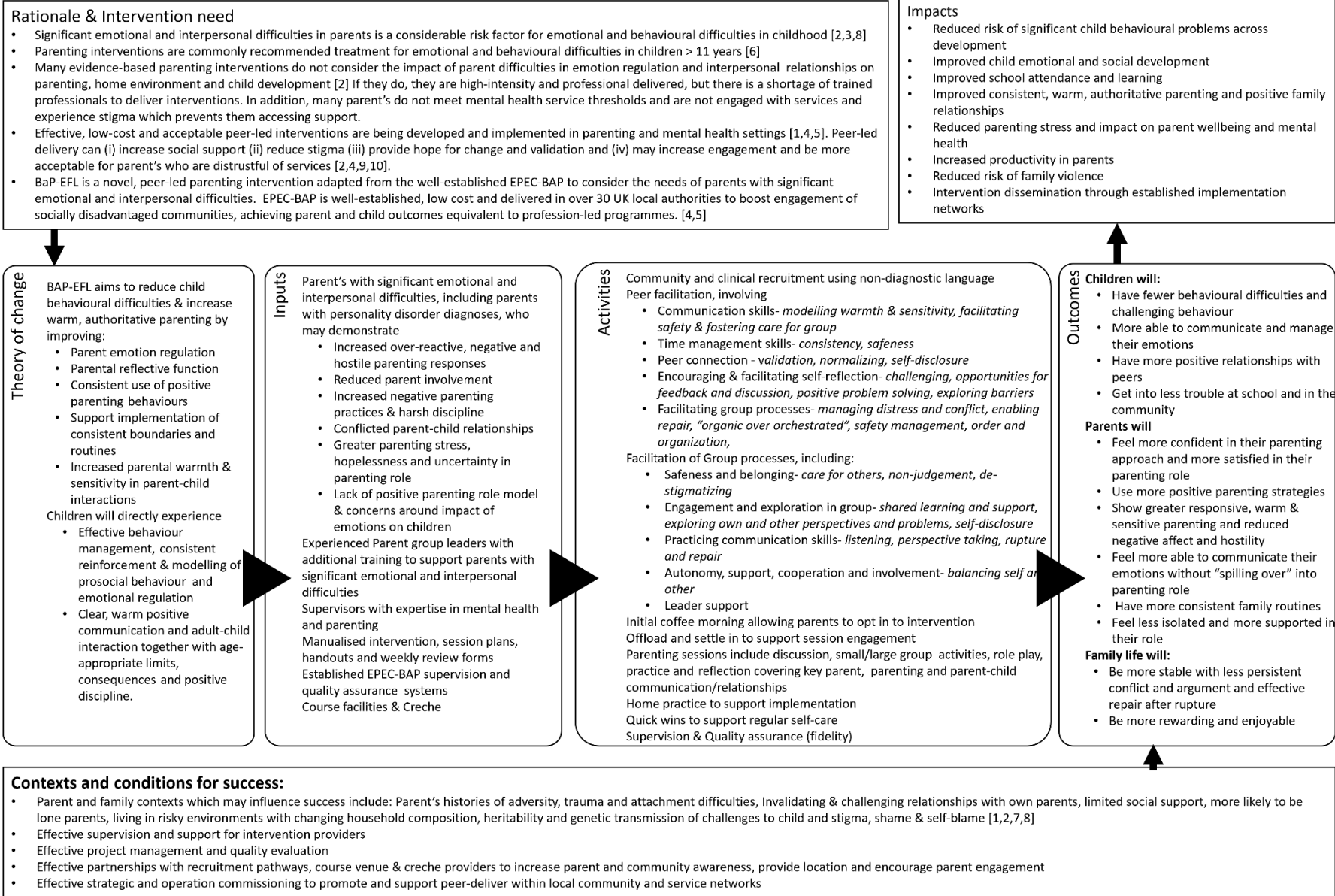


Figure 4. Being a Parent-Enjoying Family Life Intervention programme theory.

[1] Barr et al., 2020 [2] Bee et al., 2014 [3] Campbell et al., 2020 [4] Day et al., 2012 [5] Day et al., 2022 [6] NICE, April 2018 [7] Petfield et al., 2015 [8] Steele et al., 2019 [9] Tomfohr-Madsen et al., 2022 [10] Watson 2019

In addition to intervention content, there is a growing recognition that the implementation of an intervention does not only depend on its content, but also on how it is delivered and participant engagement with the intervention content (Ginsburg et al., 2021; Walton et al., 2020). Engagement refers to both whether the participant can understand and perform the required skills and whether the individual can put the skill into practice in daily life (Walton et al., 2020). The peer-led and group-format of BaP-Standard were hypothesised to be beneficial to increasing access, acceptability and engagement with parenting support for parents with significant emotional and interpersonal difficulties. However, it was important to fully define and consider what peer-facilitation and group processes would be particularly important for parents with significant emotional and interpersonal difficulties and whether any new skills or processes be introduced. Therefore, the programme theory also articulates the key components of peer-facilitation and group processes hypothesised to facilitate access, acceptability and engagement with support, defined in Figure 4 and the section below.

Finally, the programme theory highlights the parent, child and family context. Whilst the parent, child and family context will be unique to the individual and not a direct target of intervention, it is important to consider how the individual's context may shape their interaction with the course content and delivery methods (Skivington et al., 2021). Important aspects of context included greater number of parents with histories of adversity and trauma and invalidating or challenging relationships with their own parents (Steele et al., 2020). Quantitative systematic reviews show a strong relationship between invalidating parenting and the development of personality disorder

characteristics (Boucher et al., 2017; Steele et al., 2020). Qualitative evidence finds parent's often link their parenting difficulties to traumatic or challenging early childhood experiences and parenting (Dunn et al., 2020; Wilson et al., 2018), indicating trauma could be a target for intervention. However directly targeting these traumatic experiences in the intervention may be incredibly distressing and potentially retraumatizing for parents who are looking for parenting support. In addition, some parents may not identify traumatic experiences in their past, and trauma-focused content may be invalidating for these parents. Therefore, the intervention takes a trauma-informed approach over trauma-focused treatment for these parents and considered the impact of individual histories of trauma throughout intervention development.

The following section justifies the five areas hypothesised to lead to changes in child outcomes where a parent has significant emotional and interpersonal difficulties. Then the key peer-facilitation and group processes hypothesised in the programme theory to support parent's engagement with the intervention content are defined.

3.4.1.1 Areas for change in the BaP-Enjoying Family Life intervention

Parent Emotion Regulation. Parent emotion regulation refers to the ability of parents to manage the experience and expression of their emotions in caregiving contexts. As highlighted in chapter 1, this ability is key in helping parents downregulate their emotional responses to respond to their child's needs and emotions and facilitate their child's emotion regulation development through social learning processes (Hajal & Paley, 2020; Rutherford et al., 2015). Individuals who experience significant emotional and interpersonal difficulties often experience emotion dysregulation and struggle to recognise and acknowledge unwanted emotions (Barnicot et al., 2022; Binion & Zalewski, 2018). Studies of parents with personality disorders have found self-report difficulties in emotion regulation indirectly mediate the relationship between maternal

BPD characteristics and greater punitive and minimizing responses to infant displays of negative emotions (Kiel et al., 2017) and lower infant emotion regulation (Gratz et al., 2014). In chapter 2, emotion dysregulation was highlighted as a mediator in the relationship between personality disorder and parenting outcomes such as maltreatment in parents of 2–12-year-olds. The systematic review also identified that parents with personality disorder show greater negative affect (e.g., hostility, negativity, irritability) in parenting responses to their children, suggesting problems down-regulating negative emotional responses to their children. Improving parent emotion regulation can decrease parent negative affect and enable parents to employ positive parenting strategies and positively engage with their children (Maliken & Katz, 2013).

In further support, the rapid synthesis of qualitative research indicated mothers with BPD described intense emotions which they struggled to contain during parenting (Dunn et al., 2020), and had concerns about the impact of their emotion dysregulation, how to repair after an argument and role-reversal on their children (Zalewski et al., 2015). This led to mothers describing either putting on a façade that everything is okay or having to use a high level of control. Similar experiences of overwhelm by strong emotions, shame around their challenges and concerns on the impact of their emotions were found in fathers with BPD (Lumsden et al., 2018). Supporting parent emotion regulation was also emphasized by stakeholders. In the focus group with parent group leaders who delivered BaP-Standard in a clinical setting (See Appendix J), they described the importance of an increased focus on emotion regulation strategies early in the sessions for these parents, replicating findings from Hajal and Paley's (2020) review. Therefore, targeting parent emotion regulation was highlighted in both quantitative and qualitative research and stakeholder involvement as important for the

target population and has the potential to reduce parent expression of negative affect and increase consistent use of positive parenting strategies.

Strategies to improve parental emotion regulation are grounded in psychological theories of emotion regulation which argue that individuals have the ability to influence which emotions they have and when they have them through employing attentional, cognitive and behavioural responses (Gross, 2015; Kobylińska & Kusev, 2019).

Strategies used in evidence-based emotion-focused parenting interventions include: (i) supporting awareness of parent's emotions; (ii) exploring how beliefs and reactions to emotions were shaped by their experiences of their family of origin; (iii) self-care skills; and (iii) emotion-focused practical problem solving (Day et al., 2020; Hajal & Paley, 2020; Havighurst et al., 2020, 2022). When adapting BaP-Standard to BaP-Enjoying Family Life, the PhD researcher looked for content and delivery opportunities where parents could practice noticing, acknowledging and choosing how to respond to their emotions, and added content to increase parent emotional awareness, self-care, and emotion focused problem solving. BaP-Standard includes some content that examines the influence of experience of family of origin on emotion regulation, and this was enhanced in BaP-Enjoying Family Life to give parents more time on this topic.

Parental Reflective Function. Parental reflective function refers to the ability of parents to reflect and understand their child and their own behaviour in terms of goals, feelings, needs and beliefs which motivate them (Camoirano, 2017; Luyten et al., 2017a, 2020). Reflective function is a component of mentalising (Luyten et al., 2020). Disruptions in mentalising ability are thought to underlie interpersonal difficulties and the core symptoms of personality disorders (Euler et al., 2021; Fonagy & Bateman, 2008). Furthermore, mentalisation-based treatments show effectiveness in treating personality disorders (Stoffers-Winterling et al., 2022). In the wider parenting literature

including infants and adolescents, Steele et al., (2020) found that parents of 0-19 year olds who were high in personality disorder features had poor reflective functioning and showed increased parenting stress and competence and negative perceptions of parent-child relationship. Chapter 2 reported inconclusive evidence of a relationship between personality disorder characteristics and parent reflective function in parents of 2–12-year-olds due to low quality and low number of studies investigating this relationship. However, the large body of evidence accumulating to indicate a role of disruptions in mentalising in interpersonal difficulties (Euler et al., 2021; Fonagy & Bateman, 2008) and impact of parent reflective function on child outcomes (Camoirano, 2017; Zeegers et al., 2017) meant considering parent reflective function as a potential intervention target for individuals with significant emotional and interpersonal difficulties was warranted.

Furthermore, stakeholder involvement emphasised the importance of time for parents to reflect and understand the motivations behind their parenting styles and responses, where they may have been learnt and understanding their challenges and their child's needs in the BaP-Enjoying Family Life intervention. Indeed, qualitative interviews with practitioners with experience working with individuals with BPD described parents as having limited insight into their behaviour and the impact on their children, with parent's sometimes struggling to "put themselves into their children's shoes" (Wilson et al., 2018; Zalewski et al., 2015). This lack of insight may reflect low Parental Reflective Function. In contrast, qualitative studies of parents with BPD demonstrate their insight into the motivations underlying their behaviour, with parents describing a legacy of abuse and negative parenting experiences which impacted their relationship with their child and led them to want to parent differently (Dunn et al., 2020; Zalewski et al., 2015). This suggests parents with significant emotional and

interpersonal difficulties can reflect on how their past experience influence current parenting responses, rather than in-the-moment intentions behind parenting responses and their child's behaviour. For both practitioners and parents in our stakeholder groups, parenting groups were described as helpful in giving parents insight into their own internal world so they could be more mindful of what's going on underneath (Renneberg & Rosenbach, 2016; Wilson et al., 2018). Therefore, based on stakeholder feedback and qualitative studies and the wider evidence for the efficacy of mentalization-based treatments for personality disorders, giving parents the opportunity to reflect on the intentions and motivations for current parenting practices and child behaviour was seen as important for BaP-Enjoying Family Life .

Interventions to support parent reflective function are in their infancy of development. Reflective function is amenable to change, with a recent meta-analysis indicating effectiveness of mentalisation-based parenting interventions at improving parent reflective function (Lo & Wong, 2022). The effectiveness of mentalisation-based parenting interventions on child outcomes in early and middle childhood is yet to be established using robust RCT designs and current evidence supporting interventions targeting parental reflective function on child behaviour is poor in quality (Midgley et al., 2021). Therefore, adopting a mentalisation-focused approach was not recommended, however activities to enhance parent reflective function were considered. BaP-Standard includes content which supports parents to reflect on intentions and motivations behind their and their child's behaviour. This content was enhanced throughout BaP-Enjoying Family Life intervention and emphasised in the intervention delivery by encouraging peer-facilitators to model exploring emotions and intentions with group discussions.

Warmth and Sensitivity. Warmth and sensitivity refers to parents' attentive, appropriate and consistent responsiveness towards their child, including expression of

positive emotion, affection and admiration (Belsky, 1984a; Skinner et al., 2005). Consistent warm and sensitive parenting is important across development (Guttentag et al., 2014), with warm and sensitive parenting associated with less child internalizing and externalising difficulties (Pinquart, 2017a, 2017b). In the wider literature on parenting in parents with personality disorder characteristics, Stepp et al., (2011) hypothesised that mothers with BPD may inaccurately perceive their children's emotions and invalidate the emotions of their children as a result of their own difficulties understanding their feelings and their childhood experiences of parental invalidation. Indeed, previous systematic reviews and meta-syntheses indicate that warm & sensitive parenting is reduced in mothers with BPD (Eyden et al., 2016; Laulik et al., 2016; Petfield et al., 2015; Steele et al., 2019). This would suggest that strategies to increase warmth and sensitive parenting and in turn child emotion processing and challenging behaviour would be beneficial for parents with significant emotional and interpersonal difficulties and their children.

Nevertheless, the systematic review in chapter 2 identified low quality and mixed evidence that personality disorder characteristics influenced parental warmth and sensitivity in parents of 2–12-year-olds. Much of the research cited in the previous systematic reviews included studies of parents of infants, where sensitivity and warmth has been more widely researched. Instead, in parents of 2-12 years, moderate-to-high quality evidence suggests that personality disorder characteristics were associated with less responsiveness and greater hostility, negative affect, and over-reactive or fearful and disoriented responses. This would suggest focusing on reducing negative affect in this group would be beneficial. However, parents who are experiencing significant emotional and interpersonal difficulties are likely to be highly stigmatized and communication focused on the risk of hostile responses on offspring wellbeing may

further stigmatise and reduce engagement (Lannes et al., 2021). As outlined, the intervention aimed to reduce negative affect and hostility through supporting parental emotion regulation. Building on and reinforcing consistency within existing strengths may be more effective and beneficial to parent wellbeing (Waters & Sun, 2016). Indeed, stakeholder consultations with practitioners and parents emphasized the importance of defining and practicing warmth and sensitive responses and emotion-focused communication skills for this group. Therefore, BaP-Enjoying Family Life will target parental warmth and sensitivity through strategies which attempt to promote warm and sensitive responding.

Evidence-based strategies to improve parental warmth and sensitivity are well articulated within the parenting intervention literature. Video-based interventions are popular and effective at increasing warmth and sensitivity (Barnicot et al., 2022), however may not be acceptable if delivered in a group format (Balldin et al., 2018). Emotion-focused parenting interventions offer effective strategies to support warm and sensitive parenting interventions. Havighurst et al., (2020) reviewed evidence from 50 studies of emotion-focused parenting interventions and found that focusing on emotion-related processes is important, particularly when parents and children experience emotion dysregulation. Emotion-focused parenting intervention strategies aim to increase parent's emotional awareness and regulation, support parents and children to communicate emotions, and promoting parent's skills in supporting child emotion regulation. Therefore, BaP-Standard was reviewed, considering where emotion-focused parenting strategies were being used already, where these strategies could be adapted and enhanced and where new strategies could be introduced.

Positive Parenting Strategies. Positive parenting strategies including positive and negative reinforcement of behaviour and developmentally appropriate support of

the child's independence (McCabe, 2014; Skinner et al., 2005). Chapter 2 identified parents with personality disorder characteristics show greater negative parenting strategies such as harsh discipline, but not necessarily less positive parenting strategies such as praise. This suggests parents with significant emotional and interpersonal difficulties already have the positive parenting tools to support child development, but perhaps do not always use them. High levels of stress and low confidence in knowing how to respond perhaps leads to this inconsistency (Eyden et al., 2016). Indeed, qualitative research indicates that parent's with personality disorders often lack confidence in their parenting (Dunn et al., 2020; Wilson et al., 2018; Zalewski et al., 2015), experience distressing interactions with their child and feel helpless of how to respond (Wilson et al., 2018) and often do not have a positive parenting model growing up to learn from (Dunn et al. 2020; Zalewski et al., 2015). The lack of parenting model growing up led parents to do the opposite to what their parents did whilst growing up, and parents describe often struggling to find a middle ground (Dunn et al., 2020). Stakeholder feedback with parents who have previously attended BaP-Standard highlighted the benefit of learning positive parenting strategies such as descriptive praise over labelling with their children. Therefore, a psychoeducational intervention which teaches, supports and praises parents for what they already do and improves parents' confidence in consistently implement recommended parenting practices would be particularly beneficial for this population (Stepp et al., 2011).

Behavioural parenting interventions aim to break coercive cycles by shifting parent's attention from children's problematic behaviour to their desirable ones, using strategies such as praise, clear instructions, logical consequences, planned ignoring and timeout (Jugovac et al., 2022). Behavioural parenting interventions can give parents strategies and techniques which are developmentally appropriate and help establish

clear expectations of children's behaviour. These strategies are effective at reducing child challenging behaviour through using positive and negative reinforcement. Therefore, BaP-Standard was reviewed, considering what behavioural parenting strategies were being delivered already, whether they could be adapted or refined and where new strategies could be introduced. Furthermore, facilitation of discussions on the barriers to implementing positive parenting strategies was encouraged.

Consistent Boundaries and Routines. Consistent boundaries and routines refer to clarity and enforcement of expectations and consequences (Skinner et al., 2005; Stepp et al., 2011). Chapter 2 identified that parents with personality disorders show less monitoring, autonomy supportive, engaged and involved parenting, and greater lax and influencing parenting responses. This indicates inconsistent patterns of parenting behaviours, rather than challenges in one behavioural parenting construct. Stepp et al., (2011) highlights that mothers with BPD may have difficulty maintaining stable and nurturing environments and consistent routines. Providing rationale and skills such as problem solving around the challenges to establishing consistent boundaries and routines may be important for parents with significant emotional and interpersonal difficulties. In agreement, stakeholder and qualitative findings highlight the importance of supporting and reinforcing consistency in boundaries and routines, particularly in a group of parents who may not have experienced these parenting skills growing up (Stepp et al., 2011; Dunn et al., 2020). Evidence-based strategies to establish consistent boundaries and routines are also found in behavioural parenting interventions.

Taken together, the BaP-Enjoying Family Life intervention aimed to target parent emotion regulation and reflective function to reduce negative affective parenting and increase understanding of the motivations behind both parent and child behaviour. The intervention also aimed to increase warm and sensitive parenting, use of positive

parenting strategies such as reward and praise and establish consistent boundaries and routines to support parent's use of skills shown to improve challenging child behaviour.

3.4.1.2 Facilitation and group processes core to intervention

Group processes and cohesion were identified as possible determinants of the intervention and its intended effect. Group interventions have been found to be effective compared to treatment as usual in both parenting interventions (Mingebach et al., 2018) and personality disorder treatment literature (McLaughlin et al., 2019). Evidence synthesis identified group cohesion as a potential moderator of the intervention's effect. Group cohesion is defined as the sense of connection or bond between group members, with meta-analytic evidence demonstrating group cohesion to be a reliable predictor of group outcomes (Burlingame et al., 2018). In group treatments for patients with personality disorders, group cohesion has been shown to mediate the relationship between interpersonal distress and group attendance (Ogrodniczuk et al., 2006). In addition, Burlingame et al.'s (2018) meta-analysis found the cohesion-outcome association was strongest when member interaction was encouraged by group leaders.

Evidence synthesized from the wider literature, stakeholder consultation and BaP-Standard's process models (Appendix L) helped identify the key function and processes important for the group. Group delivery gives participants the opportunity to practice core parenting and communication skills and explore new ideas with peers (Kearney et al., 2020; McLaughlin et al., 2019; Rosendahl et al., 2021), challenge negative appraisals of others and increase trust (Alldredge et al., 2021; McLaughlin et al., 2019) and may be less intense than individual therapy for some patients, improving engagement and access (Ogrodniczuk et al., 2006). The BaP-Together (for co-parent conflict) process of change evaluation (Kearney et al., 2020) emphasised the importance

of shared experience of learning, a safe and non-judgmental environment, peer support and connection in facilitating intended outcomes. Therefore, the programme theory of BaP-Enjoying Family Life identified safeness and belonging, engagement and exploration, practicing communication skills, cooperation, involvement and leader support of the group as core processes supporting group cohesion.

Peer facilitation was highlighted as important for encouraging engagement with intervention content and method (Watson, 2019). Core facilitation skills identified from BaP-Standard manual and supervision were organized into four domains: (i) Communication (active listening, reflective listening, body matching, appropriate eye contact and clarifying), (ii) Peer connection (validation, self-disclosure), (iii) Time Management (moving on questions, minimal encouragers), and (iv) Encouraging self-reflection (challenging, feedback from discussions, negotiating skills). Through consultation with stakeholders and reviewing interventional research on peer support, personality disorder and parenting interventions (Day & Harris, 2013; Watson, 2019), no additional facilitation skills were identified as necessary for PGLs. However, it was anticipated that PGLs would use these communication skills at a greater frequency throughout the intervention to facilitate group processes and support cohesion for a group of parents who find interpersonal relationships challenging. Facilitation of group processes was hypothesised to involve managing distress and conflict in the group, allowing for rupture and repair, ensuring safety through returning to the group agreement and the importance of order, organization and group boundaries. Training was developed to help PGLs practice managing challenging conversations using their existing communication skills, peer connection and to encourage self-reflection, outlined in greater detail below.

3.4.2 Adaptation of BaP-Standard to BaP-Enjoying Family Life

With the programme theory in mind, BaP-Standard was reviewed with three key questions in mind: (i) what content and delivery already address intervention targets and do not need amending for the target population? (ii) what content and methods need adapting or refining for the target population and proposed intervention to align them with the conceptual model and intervention targets? and (iii) what content and methods need adding to meet the needs of the target population? Adaptations may involve content modifications that amend core intervention components at a surface-level (e.g. changing language) or deep-level (e.g. altering the content's intended outcome to ensure the intervention fits the cultural values; Evans et al., 2019). Stirman et al., (2013) developed a coding system for intervention adaptation, including content-adaptations (modifications to content), context-modifications (way the intervention is delivered), and training modifications (modification to way staff are trained). Adaptation of BaP-Standard to BaP-Enjoying Family Life involved content, delivery and training modifications. This section will first outline content-adaptations, then context-adaptations and finally training adaptations.

3.4.2.1 Intervention content

Session structure: Review of BaP-Standard identified a lack of consistent focus on parent emotion regulation and reflective function throughout the session, with stakeholder feedback from PGLs suggesting emotion regulation strategies should be introduced earlier on to generate consistent practice and implementation. This led to an adaptation of the session structure of BaP-Enjoying Family Life sessions. Each session began with parents briefly noticing and naming how they are feeling (called an “offload”), before practicing a different emotion regulation or mindfulness strategy to “settle in” to the group. Each session ends with a short goal setting exercise focused on self-care (“quick win”), alongside the BaP-Standard home practice activity related to

content of the session. Offload, settle in and quick win were concepts adapted from the evidence-based Helping Families Programme intervention (Day et al., 2020). These adaptations aimed to improve parent's emotion regulation and reflective function through encouraging parents to practice noticing and acknowledging their feelings and giving them tools to respond. In turn, increasing parent emotion regulation and reflective function was hypothesised to reduce negative affective responses and improve parent responsiveness, warmth and sensitivity to their children's needs, leading to a reduction challenging child behaviour. In addition, offload, settle ins and quick wins aimed to (i) reinforce positive coping and strengths focus; (ii) facilitate group cohesion through normalizing parent's feelings; (iii) reduce stigma; and (iv) increase motivation through celebrating small achievements. Finally, the repetitive structure aimed to support parents to (i) implement self-care and emotion regulation in their daily routines through regular practice; (ii) model the benefit of consistency in routines; and (iii) encourage safety by helping parents know what to expect.

Content adaptations: Alongside changes to the session structure, specific adaptations to content were made (Table 7 outlines BaP-Standard and BaP-Enjoying Family Life core content and Appendix M links content to intervention target for BaP-Enjoying Family Life). Adaptations include one additional session, a greater focus on recognising and managing emotional triggers, and practical and emotional problem solving. The additional session was included based on stakeholder feedback from PGLs identifying a need for more time to cover the course content for parents who experience significant emotional and interpersonal difficulties. The additional session was used to separate emotion-focused parenting content to a session on parent's emotions (Session 2), aiming to improve emotion regulation abilities through improving parent's ability to notice and name their feelings and apply practical and emotional coping skills to

Table 7. Core content of BaP-Enjoying Family Life and BaP-Standard by session.

	BaP-Enjoying Family Life	BaP-Standard
Session	Topics	Topics
Introduction	Coffee morning <ul style="list-style-type: none"> • Introduction to facilitators, intervention and group members • Exploring parenthood • Quick wins Home practice: Quick wins	Coffee morning <ul style="list-style-type: none"> • Introduction to facilitators, intervention and group members • Exploring parenthood
Session 1:	Being a parent <ul style="list-style-type: none"> • Group agreement • Goals, strengths, motivators and cheerleaders • Taking care of ourselves • Good enough vs. perfect parent Settle in: Distraction Home practice: Soothe and re-energize box	Being a parent <ul style="list-style-type: none"> • Group agreement • Goal setting • Taking care of ourselves • Good enough vs. perfect parent
Session 2:	My Feelings <ul style="list-style-type: none"> • Naming feelings • Noticing feelings • Feelings as parents • Expressing feelings • Firefighting (practical and emotional problem-solving technique) Settle in: Spotlight of attention Home practice: Noticing and naming feelings	Feelings <ul style="list-style-type: none"> • Remembering what it was like to be a child • Acknowledging, accepting and expressing feelings
Session 3:	My Child's Feelings <ul style="list-style-type: none"> • My feelings and my child's feelings • Pushing away feelings • Acknowledging feelings • Don't vs. saying what you want Settle in: Positive Talk/Affirmations Home practice: Naming child's feelings; Saying what you want	Play and Listening <ul style="list-style-type: none"> • Non-directive play ("special time")
Session 4:	Child-led play <ul style="list-style-type: none"> • Remembering and the importance of play • Non-directive play • Barriers to child-led play Settle in: Soothing Breathing Home practice: Child-led play	Valuing my Child <ul style="list-style-type: none"> • Avoiding labels and describing behaviour • Using descriptive praise to change behaviour

Session 5:	Celebrating my Child <ul style="list-style-type: none"> • Avoiding labels and describing behaviour • Using descriptive praise to change behaviour Settle in: Progressive Muscle relaxation Home practice: Descriptive praise	Understanding Children's behaviour <ul style="list-style-type: none"> • Understanding children's behaviour in response to needs • Discipline • Commands, consequences, rewards and star charts
Session 6:	Understanding Children's behaviour <ul style="list-style-type: none"> • Understanding parents and children's needs • Needs and behaviour • Competing and changing (developmental) needs • Withdrawing attention • Reconnecting with your child Settle in: Mindfulness Home practice: Withdrawing attention	Discipline strategies <ul style="list-style-type: none"> • Understanding boundaries • Time out, ignoring and saying no • Household rules
Session 7:	Boundaries and Routines <ul style="list-style-type: none"> • Understanding boundaries • Saying No • Commands • Rewards • Barriers to establishing boundaries • Family agreement Settle in: Relaxing place Home practice: Family agreement	Listening <ul style="list-style-type: none"> • Parental communication styles • Open and closed questions • Reflective listening
Session 8:	Communication <ul style="list-style-type: none"> • Parental communication styles • Warm assertive communication • Listening/not listening • Reflective listening Settle in: Compassionate memory Home practice: Reflective listening	Review and support <ul style="list-style-type: none"> • Coping with stress • Reviewing the course & knowing where to get support • Ending and celebration
Session 9:	Review and support <ul style="list-style-type: none"> • Safety plan • Reviewing the course and goals • Celebrating achievements Settle in: Compassion towards others	

problem solve daily crises through a strategy called firefighting (adapted from Helping Families Programme; Day et al., 2020). Session 3 focused predominantly on child-focused emotion-related parenting skills to help foster curiosity and reinforce parental warmth and sensitive responding to their child's needs.

In addition, more time was given to the topic of understanding children's needs behind behaviour and considering needs across development, encouraging and facilitating parental reflective function. BaP-Enjoying Family Life retained the BaP-Standard positive parenting strategies of consequences, rewards and planned ignoring. However, time-out was removed from BaP-Enjoying Family Life as a parenting strategy. A recent mixed-method study of time-out found that of 297 parents surveyed, 57.91% of parents reported using time-out (Canning et al., 2021). Parents who did not use time-out reported using time-in or other parenting techniques such as reasoning. Parents who were taught time-out from "scientific sources" e.g. clinicians were more likely to find time-out acceptable than non-scientific sources. Seventeen parents were interviewed to understand why they chose not to use time out, with parents reporting time-out as punitive, harmful or ineffective as children do not learn to self-regulate and the strategy fails to deal with the unmet needs leading to challenging behaviour. In addition, time out was viewed as contradictory to parent's values such as connection with child. Finally, negative experiences of authoritarian parenting growing up also explained avoidance of using the strategy. Therefore, time out was removed as parents with significant emotional and interpersonal difficulties are more likely to have experienced authoritarian parenting upbringings (Boucher et al., 2017; Dunn et al., 2020; Zalewski et al., 2015), and the strategy gave contradictory message to the intervention's promotion of parental warmth and connection.

Similarly, planned ignoring has been recently criticized by emotion-focused parenting approaches as it encourages ignoring of emotion expressions, which contradicts strategies of emotion acceptance, noticing and naming of child's emotions and understanding and responding to the need behind the behaviour (Havighurst et al., 2020). Indeed, stakeholder consultation highlighted a concern that teaching ignoring as

a parenting strategy would be potentially re-traumatising for parents who have experienced a high level of invalidation and potential emotional neglect as a child. However, social learning theory describes benefits of using both positive and negative reinforcement to communicate expected behaviour. In addition, emotion-focused strategies may positively reinforce the challenging behaviour if the behaviour is motivated by a need for attention. Therefore, Havighurst et al., (2020) suggest that implementing emotion validation prior to planned ignoring can model emotional awareness whilst communicating expectations for behaviour to the child. In addition, reconnecting after conflict is important for both parent and child in regulating emotions, positively reinforcing desirable behaviour or the absence of undesirable behaviour (Havighurst et al., 2020; Jugovac et al., 2022; Rutherford et al., 2015). Based on this empirical evidence and stakeholder consultation, planned ignoring was adapted to withdrawing attention, with an emphasis on reconnecting with the child once the challenging behaviour had stopped.

Finally, as described earlier in the chapter, parents with significant emotional and interpersonal difficulties experience greater negative affect and hostility towards their children. Parents may have had limited experiences of warmth and sensitive responding to their needs. Therefore, the BaP-Enjoying Family Life intervention includes a number of self-reflective and experiential learning activities on what warm and sensitive parenting looks like, adapted from the Helping Families Programme (Day et al., 2020). This content aimed to support and increase parents use of warm, assertive and sensitive communication.

3.4.2.2 Intervention delivery

Minimal adaptations were made to intervention delivery of BaP-Enjoying Family Life. Both BaP-Standard and BaP-Enjoying Family Life interventions are peer-

led, facilitated by two highly trained and accredited parent-group leaders (PGLs). PGLs receive supervision every two weeks with a mental health clinician with expertise in parenting whilst they are facilitating the group (typically session 1, 3, 5 and 8/9). There is also a pre-group supervision meeting where PGLs set themselves facilitation goals and areas for development, discuss roles, responsibilities, concerns and expectations for the group and supervision space, and go through practical considerations for running the groups (e.g., completion of attendance records, text/email reminders, weekly review form, creche, refreshments etc.). During the intervention, supervisors observe half of an intervention session and then provide a reflective hour-long supervision space. Supervision is strengths-based and focuses on encouraging self-reflection. Supervisors may offer feedback on teaching and skills observed and ask reflective questions such as “what did you do in the session & what was the effect on the learner?” and/or “what went well and anything you’d like to try doing differently?” No differences were made to supervision of BaP-Standard and BaP-Enjoying Family Life.

Additional delivery methods which were introduced to BaP-Enjoying Family Life were focused on supporting PGLs to model and facilitate parent emotion regulation, reflective function, consistent boundaries and routines and group cohesion. These methods were (i) Emphasis on parent’s noticing and acknowledging their feelings after tasks or if describing challenges (target: parent emotion regulation) (ii) explore barriers to the implementation of parenting skill by exploring parent’s feeling and child’s feeling (target: parent emotion regulation and reflective function) (iii) Encourage parents to set quick wins, review quick wins in the group and offer praise for completion (Target: parent emotion regulation, consistent routines, group cohesion) (iv) refer back and use settle in activities to manage emotions in the group (Target: parent

emotion regulation) (v) refer back to manual content and messages (vi) model warm, sensitive communication (target: Warmth & Sensitive parenting).

Both groups were adapted to be administered face-to-face or online to assess the acceptability of each delivery method. Face-to-face groups were administered for 2 hours in community venues with an accessible creche. Online groups were run via Zoom. The length of the online groups differs between the two groups. BaP-Standard runs for 120 minutes in person and 90 minutes online based on feedback from Patient Public Involvement (PPI) on the importance of reducing screen time for parents. BaP-Standard content remains the same for both online and in-person groups with shorter discussion-based activities online to account for the shortened delivery time. Online BaP-Enjoying Family Life groups were run for two hours based on PPI feedback on the importance of group discussion for the target population and to ensure time to deliver additional content. A 10-minute break reduced the screen time for parents.

3.4.2.3 Intervention training and adherence

Parent group leaders for BaP-Enjoying Family Life previously attended a BaP-Standard course and successfully completed an accredited training programme including 60 h of workshops, a written portfolio and supervised practice (Day et al., 2012b). PGLs delivering Being a Parent-Enjoying Family Life intervention received an additional one-and-a-half day training on the new manual, intervention theory and facilitation skills. Intervention adherence is supported by supervisors and a weekly review form.

3.5 Discussion

BaP-Enjoying Family Life intervention development was completed at the end of November 2021. An intervention manual, session plans, supervisory material, fidelity

measure (see Appendix P) and training protocol was developed ready for feasibility evaluation. O’Cathain et al., (2019) highlight that the decision to progress to feasibility testing may be partly informed by practicalities such as time and by data saturation i.e., stakeholders begin to suggest few refinements. Progression to the evaluation phase was appropriate at this time as the number of key uncertainties around intervention acceptability and recruitment had become saturated, with limited new uncertainties arising and a growing need to address key uncertainties before further intervention refinement could be made. The following section evaluates the impact of stakeholder involvement in this process and identifies the key uncertainties remaining after intervention development.

3.5.1 Impact assessment of stakeholder involvement

Stakeholder involvement was key in developing the BaP-Enjoying Family Life intervention, both in developing the programme theory and identifying areas of BaP-Standard which required further adaptation. The PIIAF (Appendix I) which was consulted when planning PPI and stakeholder involvement highlights the importance of assessing the impact of public involvement in research. Unfortunately, developing a summative impact assessment which collected data to evaluate the impact of PPI was beyond the scope of this PhD project. This is a limitation of the project as stakeholder and PPI consultations were informal and consultations were held on an as-required basis rather than regular meetings, therefore heavily shaped by the PhD researchers perceived need. This may impact the clinical utility of the intervention as things outside of the PhD researcher’s awareness may not have been consulted upon. To reduce the impact of the researcher’s assumptions on stakeholder consultations, the PhD researcher ensured to use open questions and feedback to generate ideas, particularly in the early consultations, and used later consultations to ask more specific questions.

Nevertheless, stakeholder and PPI consultation was hugely influential in the intervention development and trial methods. Stakeholder contributions directly led to and supported changes including the decisions to (i) increase the number of sessions from nine to ten in order to go through content at a slower pace and give extra time for additional and adapted content; (ii) increase the focus on parent's emotions early on in sessions; (iii) training on facilitation skills on group containment and mental health; (iv) introduce warm, authoritative parenting and firefighting activities and increase the emphasis in the course on emotion-focused communication, and (v) the decision to keep the two peer-deliverers format rather than introduce a clinician.

3.5.2 Key uncertainties after intervention development

In addition to the impact of stakeholder involvement, there remained several key uncertainties around the intervention that were appropriate to address through a feasibility study (Chapters 4, 5 and 6). First the acceptability of the intervention content and delivery to parents with significant emotional and interpersonal difficulties must be established, in particular the peer-facilitation and group format. Secondly, whether it is feasible to deliver the intervention and if the intervention is delivered as intended in both online and delivery formats is also vital to assess and trouble shoot any issues which arise as part of the feasibility evaluation. A fidelity measure was developed to evaluate whether the intervention was delivered as intended, described in chapter 4 and included in Appendix P. Barriers and facilitators of intervention implementation and the influence of context are identified and considered in the mixed-methods integration in chapter 6. Finally,, the feasibility and acceptability of trial methods in evaluating the BaP-Enjoying Family Life intervention, including initial estimates of intervention effect, was important for indicating whether further investigation and development is warranted and clinically useful.

3.6 Chapter summary

This chapter describes the development of Being a Parent-Enjoying Family Life, a peer-led group-format parenting intervention for parents with significant emotional and interpersonal difficulties and concerns about their child's (aged 2-11 years) behaviour. First, BaP-Standard was determined an appropriate candidate for adaptation due to the well-established evidence-base for intervention acceptability and effectiveness, previous demonstrations of adaptability and implementation in different populations and potential acceptability for the target population. Intervention development followed MRC guidance (Skivington et al., 2021) supplemented by guidance from O'Cathain et al., (2019) and Duncan et al., (2020). The use of this guidance ensures reproducibility of methods and clinical utility through emphasis on the importance of stakeholder involvement, iterative development and consideration of context to encourage clinical utility. The seven iterative processes that made up the method for adaptation of BaP-Standard to BaP-Enjoying Family Life were also outlined. Fourth, the programme theory was articulated, identifying five areas of change based on stakeholder consultation and evidence synthesis. The interventions and family contexts were also considered throughout, although not a target of the intervention. Finally, the adaptations to the intervention's structure, content, delivery and training were described and stakeholder contribution and remaining key uncertainties identified. The following chapter presents the rationale and findings of a quantitative feasibility evaluation of trial methods and initial indicators of intervention effect to identify whether research on the intervention is feasible and warranted.

Chapter 4 Feasibility Randomised Controlled Trial of Being a Parent-Enjoying Family Life

4.1 Chapter outline

This chapter presents the quantitative evaluation of the feasibility and acceptability of conducting a mixed methods RCT comparing Being a Parent-Enjoying Family Life to the well-established BaP-Standard in a sample of parents with significant emotional and interpersonal difficulties. The preceding chapters have established the rationale for developing group-based and peer-led parenting support for this population (Chapter 1), highlighted current understanding of the impact of personality disorder characteristics on parenting (Chapter 2) and outlined the adaptation of BaP-Standard into the new intervention BaP-Enjoying Family Life (Chapter 3). As described, the MRC framework highlights that the feasibility and acceptability of the intervention and the proposed trial methodologies should be examined prior to a definitive trial of intervention effectiveness. This chapter presents the rationale for the selection of trial methodologies, the methods undertaken, and the quantitative findings of the feasibility trial. Finally, the findings will be compared to the pre-specified feasibility criteria to indicate whether progression to a full-scale RCT is recommended.

4.2 Introduction

BaP-Enjoying Family Life is a novel peer-led, group-based intervention derived from the well-established BaP-Standard. The MRC framework recommends the feasibility and acceptability of the intervention and the proposed trial methodologies should be examined prior to a definitive trial (Skivington et al., 2021). Feasibility trials support clinical utility and reduce research waste by exploring key uncertainties relating to the feasibility and acceptability of the intervention and proposed trial methods using a sample often underpowered to detect clinical effectiveness. The study uses pre-defined

progression criteria relating to the planned research design. These pre-defined criteria are useful for evaluating key uncertainties about the intervention and research methods, identifying whether or not to proceed with a full-scale evaluation and highlighting whether changes need to be made to design and intervention prior to full-scale trial (Skivington et al., 2021; Eldridge et al., 2016). The aim of this chapter is to report a quantitative examination of the feasibility and acceptability of the RCT trial methods and intervention, and to provide initial estimates of likely intervention effects to identify whether a definitive evaluation of BaP-Enjoying Family Life is warranted, feasible and if any further development and refinements required. This introduction first presents the rationale for selection of trial methods and second the key uncertainties the feasibility study aims to address.

4.2.1 Rationale for trial methods

The novelty of the intervention required a feasibility study to evaluate trial design and methods and indicate the sample size required for a definitive evaluation of intervention effectiveness. Randomised Controlled Trials (RCTs) are considered the gold standard for evaluating interventions because of the standardized, controlled conditions, reduction of bias through masking and randomisation to an intervention or a control arm (Bauer & Kirchner, 2020; Blackwood et al., 2010; Minary et al., 2019). Randomisation using a 1:1 ratio ensures all participants have an equal chance of receiving one intervention or another, and theoretically ensures similarity between baseline characteristics (Minary et al., 2019). The high level of control leads to high internal validity and is hypothesised to objectively establish cause and effect (Blackwood et al., 2010; Minary et al., 2019). However, the high level of control can lead to low external validity i.e., limited assessment of the relevance and transferability

of the intervention effects from highly controlled experimental conditions to real-world use.

There are different types of RCT designs which increase or decrease internal and external validity and can answer slightly different types of research questions. A pragmatic RCT was identified as most appropriate for feasibility evaluation, comparing BaP-Enjoying Family life to an active control intervention of BaP-Standard. Pragmatic RCT's are designed to determine whether an intervention works, describe how it is used and utilize less stringent eligibility criteria. In comparison, explanatory RCTs use strict eligibility criteria and attempt to address whether the intervention works and how it works (Minary et al., 2019). A pragmatic design increases external validity and reduces research waste by supporting recruitment of a more heterogeneous group that more closely reflects clinical practice. This was appropriate for the early phase of development where there were uncertainties about the recruitment approach, target outcome and a high likelihood of co-morbidity in the target population (Chapter 2, [Day et al., 2020](#); [Tyrer et al., 2015](#); [Winsper et al., 2020](#)).

The use of an active control arm comparing BaP-Enjoying Family Life to the well-established BaP-Standard intervention was also identified as the most appropriate choice based on research and stakeholder feedback. Randomisation to a waiting-list or placebo control group was identified by stakeholders (Appendix J) as potentially unacceptable to individuals who are often underserved by clinical services and are seeking support. Low acceptability of randomisation may affect trial participation. Indeed, a recent meta-analysis found an association between randomisation and drop-out in clinical trials of individuals with personality disorders (Iliakis et al., 2021). In addition, RCTs are based on the assumption of equipoise (there is uncertainty about the relative benefits and harms of tested treatments) and ethical concerns arise when

participants are prevented access to treatment which may help them (Blackwood et al., 2010; Cristea et al., 2022). In a recent commentary, Cristea et al., (2022) argued that both placebo and wait-list controls do not address key ethical concerns and the methodological assumptions of equipoise, with their use as control arms potentially leading to misrepresentation of the benefits of a new treatment. Using active comparators can restore equipoise, reduce ethical risks of not offering intervention to those seeking support and may improve acceptability of RCTs for the target population. Furthermore, parenting interventions are offered by most local authorities in the U.K., including in the four boroughs where the research was based, and using a waitlist control would withhold treatment from a group of individuals in need of support.

Finally, a superiority trial design is used because BaP-Enjoying Family Life has been developed to target the specific need of parents with significant emotional and interpersonal difficulties. Non-inferiority (evaluating whether the new intervention is not worse than an existing intervention) and equivalence (evaluating whether the new intervention has equivalent effectiveness to an existing intervention) designs require similar design choices and eligibility criteria to the RCT that demonstrated efficacy of the reference intervention (Stefanos et al., 2020). The efficacy of the existing intervention (BaP-Standard) on child outcomes has not been examined for parents with significant emotional and interpersonal difficulties, therefore non-inferiority and equivalence designs were not appropriate. This PhD tests the feasibility of a pragmatic, superiority RCT and hypothesizes there will be an initial indication of an intervention effect on primary and secondary outcomes.

4.2.2 Key uncertainties

There are several key uncertainties identified during trial planning about the intervention and chosen trial methodologies, including the rate of recruitment and

identification of the target population and retention. RCTs of group parenting interventions and personality disorder interventions can be challenging to recruit to for both pragmatic and motivational reasons, such as timing of the group and stigma associated with parenting and mental health (Cooper et al., 2022; Day et al., 2020; Iliakis et al., 2021; McMurrin et al., 2010). In addition, recruitment of participants with significant emotional and interpersonal difficulties through only health and social care pathways can be challenging as many individuals are not engaged with services (Dale et al., 2017; Day, et al., 2020; S. Evans et al., 2017; Troup et al., 2022). Furthermore, recruitment relies on practitioner understanding, motivation to share information, confidence and time to discuss parenting support and research (Diggin, 2011; Tuck et al., 2023). Therefore, this study examines a more inclusive approach to recruitment using both community (e.g., social media and schools), mental health and social care pathways. In addition, retention of individuals in personality disorder trials can be challenging. Retention is estimated around 65-73% with reasons for drop out including dissatisfaction with treatment; expulsion from treatment; lack of motivation; and life events or change in living situations (Iliakis et al., 2021; McMurrin et al., 2010). Prior to a definitive trial, it is helpful to have estimates of rate of recruitment and retention to guide planning for sample size calculation and problem solve any barriers to access.

Furthermore, the acceptability of the novel intervention BaP-Enjoying Family Life is unknown and the acceptability of BaP-Standard, whilst well-established for the general population (Day et al., 2012a, 2022), is also unknown for parents with significant emotional and interpersonal difficulties. Evaluating the acceptability of online and in-person delivery for the target population is also important for guiding future trial and intervention implementation. Additionally, there is uncertainty around whether the interventions will be delivered as intended (fidelity) and how to measure

fidelity (Walton et al., 2020). Evaluating fidelity is important for (i) ensuring clear delineation of what was delivered in intervention and active control arm; (ii) reassuring the initial estimates of intervention effects are due to intervention delivered; (iii) identifying barriers to intervention delivery which can be addressed prior to definitive RCT; and (iv) examining the feasibility and acceptability of fidelity measurement prior to definitive evaluation.

Finally, whilst feasibility studies are typically under-powered for examining intervention effects, feasibility studies can indicate initial estimates of the plausible range of the interventions' effects which can be used for future trial planning e.g., sample size calculations. Evaluation of clinical outcomes can also help identify which clinical outcomes are most appropriate for the full-scale trial. Here, the methods and quantitative findings for evaluating the feasibility and acceptability of the trial methods and interventions for parents with significant emotional and interpersonal difficulties who are concerned about their child's (aged 2-11) behaviour are presented. Followed by the initial estimates of intervention effects of BaP-Enjoying Family Life and BaP-Standard on parent and child outcomes.

4.3 Method

4.3.1 Trial design

A single site two-arm parallel-group feasibility RCT assessed whether a full scale RCT is feasible and acceptable to participants. Ethics approval was obtained from London-Camden & King's Cross Research Ethics Committee (reference: 21/LO/04/73). The study was prospectively registered on ISCTRN registry (ID: ISRCTN10950727) and a protocol paper published (Baker et al., 2023). Trial governance was held by PhD supervisors.

4.3.2 Participants

4.3.2.1 Sample size

A sample of 72 parents with significant emotional and interpersonal difficulties was calculated as sufficient for precise feasibility parameter estimates. The primary feasibility criterion was trial retention rate of 65%, based on median completion rates for personality disorder intervention trials (McMurrin et al., 2010). Reaching a total sample of 72 enables 95% confidence that the anticipated 6-month follow up rate will be 70% or larger, within $\pm 10.7\%$ percentage point (95% CI .65-.85; Browne, 1995).

4.3.2.2 Eligibility criteria

Table 8 outlines the trial eligibility criteria. Both participant and index child had to meet eligibility criteria to participate. The focus on primary caregiver and requirement for the child to be living with the participant was theoretically guided based on the hypothesis that change in child outcome are possible by changing the parenting environment (Belsky, 1984; Bronfenbrenner, 1977). The exclusion of parents with psychosis, intellectual disabilities and brain injury was due to evidence suggesting alternate parenting concerns (Butera-Prinzi & Perlesz, 2004; Karpa et al., 2020; Minary et al., 2019; Radley, Barlow, et al., 2022; Tarleton & Ward, 2007), and recommended intervention (e.g. explaining parent's unusual experiences to children; Radley, Sivarajah, et al., 2022; home-based intervention for parents with intellectual disabilities, Wade et al., 2008).

The Standardized Assessment of Personality-Abbreviated Scale (SAPAS; Moran et al., 2003) was used to identify parents who are experiencing pervasive and persistent emotional and interpersonal difficulties. The SAPAS is an 8-item brief screen assessment of personality difficulty. Each item is rated *yes or no* based on whether the description applies *most of the time* and *in most situations*. Scores of 3 or above indicate a personality difficulty. Initial psychometric validation identified that a cut-off of 3

Table 8. Feasibility study eligibility criteria

Inclusion criteria	Exclusion criteria
<u>Participant inclusion criteria:</u>	<u>Participant exclusion criteria:</u>
(i) Primary caregiver, including non-biological caregiver, for index child.	(i) Presence of active psychosis, significant brain injury and/or learning disability
(ii) Aged between 18-65 years.	(ii) Engaged in another structured parenting intervention or recent (<12 months) attendance to BaP-Standard group.
(iii) Persistent emotional and interpersonal difficulties, assessed by a score of ≥ 3 on the Structured Assessment of Personality- Abbreviated Scale (SAPAS)	(iii) Receiving inpatient mental health treatment
(iv) Caregiver must have proficient written and spoken English.	(iv) Caregiver pregnancy
(v) Caregiver must have capacity to provide informed consent to participate.	(v) Family is subject to safeguarding proceedings to remove child from the home.
<u>Index Child inclusion criteria:</u>	<u>Index child exclusion criteria:</u>
(vi) Aged 2-11 years.	(vi) Presence of neurodevelopmental disorder and/or psychosis
(vii) Living with participant	(vii) Not residing with participant
(viii) Caregiver reported behavioural difficulties	

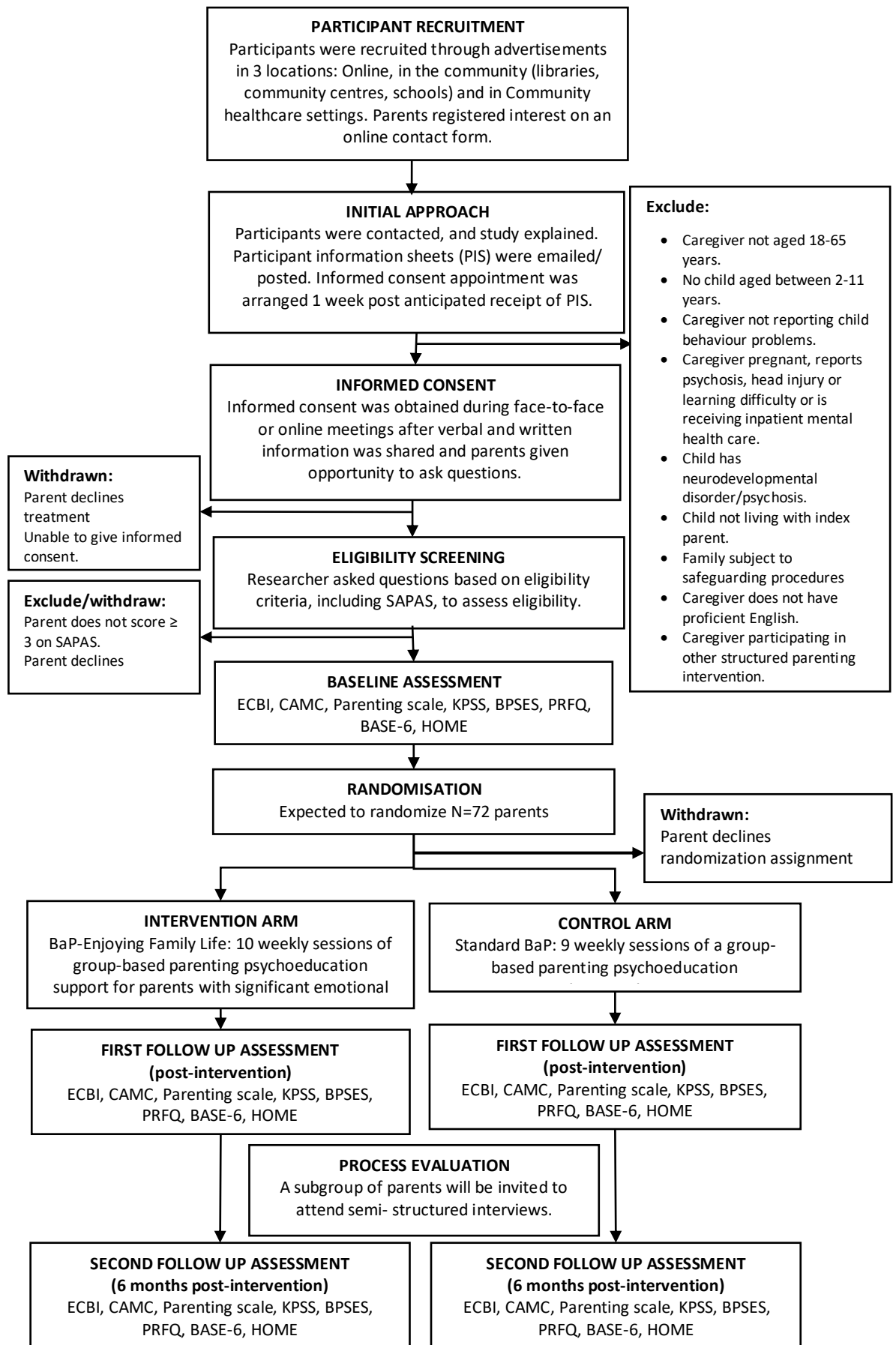
correctly identified personality difficulties 80% of the time, with high sensitivity (0.94) and specificity (0.85; Moran et al., 2003). Further validation replicated good sensitivity (0.73-0.83) and specificity (0.70-0.90) in Dutch and Spanish samples and outpatient mental health and probation settings (Bukh et al., 2010; Germans et al., 2008; Muñoz-Negro et al., 2020; Pluck et al., 2012).

4.3.3 Procedures

An outline of the trial procedures is presented in Figure 5.

4.3.3.1 Recruitment & eligibility

Prospective participants registered interest via. an online form. They were recruited through three self-referral pathways: (i) online via. social media and study

Figure 5. Feasibility trial design flow diagram

website; (ii) community recruitment via., primary schools, charities and children's centres in Southwark, Lewisham, Lambeth and Croydon, and (iii) clinical recruitment from community mental health and social care services in the same boroughs.

Recruitment activities included sharing posters and videos online in parent Facebook groups and with practitioners from community and health and social care settings, phone calls with practitioners, presentations at practitioner's team meetings and parent-focused recruitment workshops at schools. Health & Social care professionals informed parents of the research and self-referral process. The broad recruitment approach aimed to increase access and reduce stigma for parents who self-identify with significant emotional and interpersonal difficulties.

Participants who completed the interest form were contacted by the PhD researcher. The potential participant was sent an email summarizing trial aims and participation and inviting them to an informed consent meeting, with the longer participant information attached (see Appendix N). If requested, some parents were also contacted by phone to have the trial aims briefly explained and any concerns addressed prior to informed consent meeting. Informed consent meetings were held over Zoom or, less frequently, over the phone and were about 30 minutes to 1 hour long. The PhD researcher summarised key information from the participant information sheet and participants were given the opportunity to discuss their interest in the project and any concerns about participation. The participants completed an online consent form on MS forms and the PhD researcher received an email notification confirming completion. The PhD researcher then determined eligibility by asking yes or no questions based on the eligibility criteria and administering the SAPAS screen. Participants were informed of eligibility during the same informed consent appointment. Alternative local parenting

support was shared with ineligible participants. Eligible participants were invited to baseline data collection meeting.

4.3.3.2 Data collection schedule and process

Participant demographics were collected at baseline. Outcome measures (see section 4.3.5 below) were collected across three time points by the PhD researcher who was masked to group allocation. Data collection involved two components: (i) parent-report questionnaire measures (ii) structured observational interview (HOME inventory; Department of Health et al., 2000) with the participant and index child. Children above the age of 6 were given information sheets and opportunity to assent to take part (see Appendix N for child information sheets). The questionnaire measures were administered via Qualtrics either face-to-face using an iPad or online over video link with the PhD researcher completing via a shared screen or the participant completing themselves and PhD researcher contactable for questions. Total data collection time ranged from 15 minutes to 3 hours. Reminders to not disclose allocation status were given to maintain masking at time 2. Outcome data collection occurred within a 6-week window of the group start or end date and 6 months since group end date to allow sufficient time to invite participants to the groups and for data collection. A sub-group of participants were selected using purposive sampling to participate in qualitative interviews at post-intervention timepoint (outlined in chapter 5). The PhD researcher became unmasked to participants' group allocation at this stage via a sealed envelope, however all participants were interviewed after questionnaires were completed. Participants were reimbursed £25 for each assessment and £10 for the interview following INVOLVE guidance (INVOLVE, 2010).

All data was stored at King's College London in accordance with the Data Protection Act and General Data Protection Regulation. Identifiable data e.g., contact

details, was stored separately to research data in a password protected spreadsheet. Research data was fully anonymized. Group allocation was concealed until after the last data collection appointment.

4.3.3.3 Randomisation

A minimisation approach to randomisation was selected to ensure balance across groups using the minimisation factors: currently receiving mental health treatment (0-no,1-yes); and delivery preference (0-online, 1-face-to-face). Currently receiving mental health treatment was selected as a minimisation factor to balance the influence of other mental health treatment on outcomes across the two arms. Delivery preference was selected to ensure equal distribution of participants requiring online or in person delivery in both arms to reduce influence of delivery preference on intervention non-completion. Participant anonymized ID numbers were entered into the randomisation service after baseline data collection was completed. Confirmation emails were generated and sent to JT, a researcher not involved with data collection, who shared the participants' contact details with the clinical teams. Participants were informed of allocation by the group's supervisor. Other members of the research team were masked to participant allocation status.

4.3.3.4 Strategies for trial engagement and retention

Informed consent and data collection appointments were arranged over the phone or via an online booking system (Calendly). An email with the PhD researcher's availability or booking link for an informed consent meeting were sent to interested participants where they indicated a preference for email contact. For all unsuccessful contact attempts, a voicemail and email or text message was sent explaining the reason for contact, the booking links and/or suggested time and date to meet. All telephone

calls, successful and unsuccessful were documented. Opt-in messages were sent to participants after four consecutive contact attempts. A reminder text message was sent before the scheduled assessment meeting. For time 2 and time 3, a reminder was sent 3 weeks prior to intended assessment, including links to the online booking system. An email with the questionnaire link was shared with participants after two contact attempts so participants could complete in their own time. If contact was unsuccessful at time 2, renewed efforts were made at time 3 unless the participant opted out of further contact. In addition, a newsletter was emailed to all participants every two months including a summary of enrolment figures and reminders of schedule for data collection. The PhD researcher was mindful to call participants during the school day (between 10am-2:30pm) and, where possible, outside the school holidays.

4.3.4 Interventions

As outlined, participants were randomised to either BaP-Enjoying Family Life or the active control of BaP-Standard. Intervention content and delivery of BaP-Enjoying Family Life and BaP-Standard are outlined in greater detail in chapter 3, and TIDieR (Hoffmann et al., 2014) checklist was used to ensure sufficient information for replication is reported (See Appendix O). Sessions use experiential learning and interactive methods facilitated by two highly trained Parent-Group Leaders (PGLs) experienced in delivering the BaP-Standard intervention. PGLs had previously attended a BaP-Standard course and successfully completed an accredited training programme including 60 hours of workshops, a written portfolio and supervised practice (Day et al., 2012b). PGLs were selected to deliver BaP-Enjoying Family Life intervention if they were experienced at delivering the BaP-Standard course and had interest in parent mental health. BaP-Enjoying Family Life PGLs received a further one-and-a-half day training on the new content, theory and facilitation skills.

Over the course of the intervention, PGLs received fortnightly supervision from a mental health clinician with expertise in parenting. Training background of clinicians included two clinical psychologists; an occupational therapist; one social worker and family therapist; one child and adolescent psychoanalytic psychotherapist; and one EPEC programme coordinator who has extensive experience delivering the intervention and training and supervising PGLs. Two BaP-Enjoying Family Life (one online, one in person) were supported by a master's placement student and one BaP-Standard online group was supported by an undergraduate student. All students studied psychology. Students supported the set-up of interventions and offered technological support to participants and Parent Group Leaders.

Ten groups (5 in each arm) were recruited across three school terms (January 2022, May 2022 and September 2022), with eight delivered as intended and one BaP-Standard group cancelled after the coffee morning and one BaP-Enjoying Family Life group cancelled after session five due to low attendance. The interventions were delivered over 10-11 weeks for 3-8 parents during school term times, with a break for half-term. They were delivered in schools or children's centres. BaP-Standard consists of nine sessions and BaP-Enjoying Family Life consists of ten sessions with accompanying handouts (accessible from: epecproject@slam.nhs.uk). Both started with an introductory coffee morning, and refreshments were provided for in person groups. PGLs sent text reminders each week to participants and an email summary after each session, with supervisors supporting participant engagement where PGLs could not. PGLs also completed weekly review forms to assess fidelity and support planning for the next session.

4.3.4.1 Concomitant interventions & Safety

Participants continued to receive usual care including concurrent mental health, social care and educational support and prescribed medications (including psychotropic medications). Adverse events and serious adverse events were defined in the research ethics protocol. Self-harm events and referral to Social Services are expected events within the target population (Day et al., 2020) and were not reported to Research Ethics Committee, unless they had resulted in death, were life-threatening, required hospitalization or resulted in child removal or initiation of care proceeding.

4.3.4.2 Context and impact of COVID-19 pandemic

The design and development of the feasibility trial protocol occurred from October 2020 - June 2021, during the second and third UK national lockdowns. The procedures were therefore kept flexible, with online via Zoom the preferred format for data collection appointments to allow for the uncertainty of the pandemic and reduce risk of COVID-19 transmission. The clinical teams delivering BaP-Standard had already adapted and developed online delivery methods during the pandemic which BaP-Enjoying Family Life could also adopt. During data collection (November 2021- July 2023) and intervention delivery period (January 2022- December 2022), the PhD researcher and clinical teams followed the government guidance and made decisions to reduce risk of COVID-19 transmission. Groups run in cohort 1 (January-March 2022) required participants and PGLs to regularly test for COVID-19 and wear facemasks, with some participants having to self-quarantine for 14 days. Participants were supported to catch up by PGLs, with PGLs offering 30 minutes before the group or online phone calls to catch up, as is typical if participants missed a session.

4.3.5 Measures

Demographic measures. Demographic data including participant/child age, sex, ethnicity, household composition, household income and previous education, current mental health treatment (including medication) and previous attendance to a parenting intervention were collected at baseline using Qualtrics.

Feasibility measures. Structured record MS Excel sheets were completed by PGLs and PhD researcher to document key feasibility parameters, including (i) rates of participant identification (number of participants registering interest, numbers eligible after consent); (ii) rates of trial participation (number of consenting participants, number of randomised participants), and reasons for non-participation; (iii) rates of data collection at baseline and follow-up, and reasons for missing data; (iv) rates of intervention use (uptake, attendance and retention) in both trial arms, and reasons for missed sessions and dropout.

Two fidelity measures were created for BaP-Enjoying Family Life and BaP-Standard (see Appendix P) following guidance from Walton et al. (2020). The measure was added to the weekly review forms completed by PGLs after each session and asked four questions to assess whether (i) most or all of the content were delivered; (ii) the session kept to time; (iii) the session was delivered in accordance to intervention methods and skills, and (iv) the session was delivered in accordance with the intervention's theory. Guidelines were developed to support use of fidelity measure and supervisors were reminded to remind PGLs of the measure biweekly by the research team. PGLs could score each item as either: Yes- the item was completed in accordance with manual expectations, with perhaps some deviation to tailor and adjust to circumstance; Unsure- fidelity item delivered but in an imprecise way with substantial deviation from manual expectations, not appropriately tailored and adjusted; No- fidelity item undertaken in ways that are not in accordance or contradict manual expectations.

Clinical outcome measures. Validated parent-report measures (see Table 9) with well-established psychometric properties were used to assess primary and secondary clinical outcomes, using COSMIN definitions (Mokkink et al., 2010, 2016). Measures were selected to balance sensitivity to change with participant response burden, with attempts made to keep the total number of items low. Measures were also selected if they were commonly used in BaP-Standard and wider parenting intervention evaluations to support statistical comparison and synthesis of the findings with others in meta-analyses (Mokkink et al., 2016). In addition to parent-report measures, an observational assessment was administered. Multi-method designs are particularly beneficial in parent populations where high levels of stigma and fear of judgement may increase self-report bias (Morsbach & Prinz, 2006). However, multi-method designs can also be time consuming and have a high respondent burden for participants. The practicality and acceptability of using a multi-method assessment in clinical trials of parenting interventions for parents with significant emotional and interpersonal difficulties is assessed as part of the feasibility evaluation in chapter 6. The primary end point is change at time 2 (3-5 months post-randomisation).

4.3.6 Analysis

Statistical analysis was mainly descriptive at this feasibility stage, aiming to capture data related to the key uncertainties around feasibility and acceptability of the trial methods and interventions and followed the published statistical analysis plan (accessible via ISCTRN registry: <https://doi.org/10.1186/ISRCTN10950727>). This feasibility trial is underpowered to conduct inferential statistics evaluating intervention effectiveness. Instead, descriptive data are reported using frequencies and proportions for categorical variables and means and standard deviation for continuous data.

Table 9. Clinical outcomes measures and description of measures to capture clinical outcomes.

		Baseline	T 2	T 3
<u>Eyberg Child Behaviours Inventory (ECBI)</u> (Eyberg & Ross, 1978)	36-item questionnaire that assess the intensity and number of disruptive behaviour problems in 2-16-year-olds. Participants are asked to assess how often the behaviour occurs with their child and whether it's currently a problem for them. Items include <i>Dawdles in getting dressed</i> . The ECBI is a validated measure with good internal consistency and sensitive to change across short interventions (Pote et al., 2020). The ECBI is commonly used and was used previously in the BaP-Standard evaluation (Day et al., 2012).	X	X	X
<u>Kansas Parental Satisfaction Scale</u> (James et al., 1985)	A 3-item scale that provides a brief measure of participants dissatisfaction in the parenting role. Participants rate their level of satisfaction on a 7-point Likert scale. Example items include: <i>How satisfied are you with yourself as a parent?</i> The measure is valid, has an internal consistency ranging from 0.78 to 0.95 (James et al. 1985) and is commonly used in BaP-Standard routine practice (Day et al., 2022). In addition, it's low number of items is optimal for reducing response burden.	X	X	X
<u>Brief Parental self-efficacy scale</u> (National Academy of Parenting Research, King's College London, n.d.)	A 5-item scale that provides a brief measure of participant's belief in their ability to perform the parenting role. Participants rate their agreement with each statement on a 5-point Likert scale. Example items include <i>Even though I may not always manage it, I know what I need to do with my child</i> . The measure is recommended by the Child Outcome Research Consortium and shows good reliability and preliminary evidence of internal consistency (Child Outcome Research Consortium, n.d; Selwyn et al., 2016)	X	X	X
<u>Parent reflective functioning questionnaire</u> (Luyten et al., 2017a, 2017b)	An 18-item scale that measures three capacities relating to the caregiver's ability to reflect on his/her own internal mental experiences as well as those of their child, aged 0-5 years. Participants rate their agreement with each statement on a 7-point Likert scale. Example items include <i>I always know what my child wants</i> . The three reflective capacities are: Pre-mentalising, Certainty about mental states and Interest and Curiosity about mental states. The measure has been validated across different samples of parents and shows reliability, internal consistency and convergent validity when compared to interview assessments of reflective function (Anis et al., 2020; Luyten et al., 2017a; Moreira & Fonseca, 2023).	X	X	X
<u>Arnold O'Leary Parenting Scale</u> (Arnold et al., 1993)	A 30-item questionnaire that assesses dysfunctional discipline styles in parents of children aged between 2-16 years. There are three subscales: Laxness, Over-reactivity and Verbosity. The scale is sensitive to change (Pote et al., 2020), correlates with observational measures of parenting (O'Leary et al., 1993) and has good psychometric properties, including in discriminating dysfunctional discipline and good reliability (Lorber et al., 2014). The measure is commonly used, particularly in BaP-Standard evaluation (Day et al. 2012).	X	X	X

<u>Brief Adjustment Scale-6</u> (Cruz et al., 2020)	A 6-item scale that measures both symptom distress and functional impairment on a 7-point Likert scale. Items include <i>To what extent have you felt irritable, angry and/or resentful this week</i> . An additional item will be added, asking: <i>“how much has emotional distress interfered with your parenting this week”</i> The measure demonstrates high internal consistency, good re-test reliability and convergent validity across ethnicities (Ko et al., 2022; Cruz et al., 2020). The measure is relatively new therefore not commonly used, however the measure’s ability to capture both distress and impairment as well as its low participant response burden made it appropriate for this study.	X	X	X
<u>Concerns About My Child (CAMC)</u> (Day et al., 2012a; S. Scott et al., 2001)	A visual analogue scale that requires participants to state and rate three concerns about their child on a scale of 0 (not at all concerned) to 100 (the most concerned they could be). The same concerns that are nominated at baseline will be re-rated at time 2 and time 3, providing a sensitive, individualized index of change. The measure has been used in BaP-Standard evaluation (Day et al., 2012).	X	X	X
<u>Home Observation Measurement of the Environment (HOME)</u> (Department of Health et al., 2000)	An observational and structured interview measure of quality and quantity of cognitive stimulation and emotional support via parenting behaviour and home environment. Three versions: Infant/toddler HOME (ages 0-3), Early Childhood HOME (ages 3-6) and Middle Childhood HOME (ages 6-10) will be used in the current study. There are 8 subscales for each measure, capturing developmentally appropriate parenting (e.g., emotional and verbal responsiveness, discipline, parental involvement) and family environment (e.g., cognitive stimulation, academic stimulation, learning materials). The HOME takes around 1 hour-1 hour 30 minutes to complete and involves binary scoring of 45 items for the IT-HOME, 55 items for EC-HOME, and 59 items for MC-HOME based on observation, interview responses or a combination of both. The HOME is easy to administer and score and shows sound psychometrics, namely moderate to high internal consistency, good test re-test reliability (Totsika & Sylva, 2004), and cross-cultural validity, particularly with the more cognitive stimulation subscales (Bradley et al., 1996; Sugland et al., 1995).	X	X	X
<u>Treatment acceptability rating scale (TARS)</u>	a 13-item measure, with 11 quantitative items split into two subscales: knowledge and skills gained and facilitation and satisfaction with the intervention. There are three open-response questions for capturing qualitative feedback. Participants rate acceptability 4-point scale from <i>“Not at all”</i> to. The TARS is commonly used in BaP-Standard evaluation (Day et al., 2012, 2022).		X	
<u>Group Cohesiveness Scale</u> (Wongpakaran et al., 2013)	A 7-item measure of connectedness between group members, rated on a 5-point Likert scale of agreement with the statement. Preliminary evaluation indicates good internal consistency and validity as a brief tool of group cohesion (Klocek et al., 2020; Wongpakaran et al., 2013) Items include: <i>I feel accepted by the group</i> .		X	

Demographic and feasibility outcomes. Rates of participant identification, trial participation, data collection and reasons for withdrawal will be summarised.

Compliance with treatment is described in terms of number of group sessions attended in each trial arm. The baseline demographic characteristics of those in each attendance group (low attenders (<5 sessions), high attenders (5 or more) and non-attenders) and those with missing data at follow up are compared in each trial arm and statistically significant patterns reported to examine contextual influences on trial and intervention retention. Fidelity data was collected using four items scored as No= 0, Unsure=1 and Yes=2 for each session. A total score across sessions and percentage of the maximum total score (Intervention= 80; Control= 72) was calculated and used to evaluate whether the intervention was delivered as intended.

Intervention acceptability. Treatment acceptability is identified by the proportion of participants with a total rating of above 27 and knowledge and skills subscale rating above 12 and facilitation and satisfaction subscale rating of above 15, indicating participant's rated "quite a lot" (score=3) or "a great deal" (score=4) for each item. The qualitative treatment acceptability data captured in the three open-response questions (*What were one or two most helpful things of the programme? Are there any changes you would like to make to the course? Please make any other comments that you would like to offer*) was analysed using content analysis (Bengtsson, 2016).

Analysis of the acceptability data in this chapter aimed to summarise common areas of feedback on intervention content and delivery, with the reflexive thematic analysis of interview data chapter 5 generating a rich and in depth understanding of participant's experience.

Content analysis followed the four stages outlined by Bengtsson (2016). First, the PhD researcher familiarized themselves with the data by open coding written

feedback to generate a list of codes. Then the list of codes was reviewed, compared to the aim and text re-read to identify and begin summarizing feedback relevant to delivery and content. Third, sub-categories and overall categories of feedback on content and delivery were generated from the list of codes. Fourth, the coded written feedback was re-read and frequency of each subcategory and category across participants feedback counted and reported in Appendix Q. TARs qualitative analysis occurred after reflexive thematic analysis of interview data (outlined in chapter 5). Therefore, the PhD researchers in depth understanding generated from conducting interviews and analysis is likely to have shaped the categories generated from content analysis. The PhD researcher was mindful of this influence and kept analysis descriptive and objective, focusing on summarizing common categories of feedback.

Clinical outcomes. Analyses of clinical outcomes estimates the difference in mean outcomes between patients randomised to BaP-Enjoying Family Life and BaP-Standard followed an intention-to-treat principle. To indicate initial estimates of treatment effect for clinical outcomes, the mean difference from baseline to time 2 and time 3 (mean difference= baseline mean – timepoint mean) are reported for primary and secondary outcomes. Cohen's *d* was calculated to indicate the effect of intervention from baseline at time 2 and time 3 and interpreted as: 0.2-0.4 indicates a small effect; 0.5 - 0.7 indicates a moderate effect; and 0.8 or above indicates a large effect (LeCroy & Krysik, 2007). For the primary clinical outcome of child behaviour, proportions of children scoring above the clinical cut-off of ≥ 131 for the Intensity Scale and ≥ 15 for the problem scale will be reported at each time point. Whilst this trial is a superiority design, the effectiveness of both interventions has not been tested in this population. Therefore, Cohen's *d* reporting the effect of intervention at each timepoint (i.e., comparing baseline mean to time 2 mean and time 3 mean within-subjects) is also

reported. Finally, participant's three concerns collected by CAMC were coded using five categories of concerns identified by Day et al., (2022) and the frequency of concerns under each category reported (Appendix T). Mean rating out of 100 for all three concerns was calculated at each time point and used to calculate mean difference and compare interventions.

As analysis was descriptive, no imputation of missing data and adjustment for multiple comparisons was applied. Missing items in scales and subscales followed guidance by the scale developers when provided, or will be pro-rated if 20% or fewer items are missing where no scale guidance provided, as outlined in the SAP. In addition to the primary intention-to-treat analysis, the effect of completing treatment as defined in the protocol (per-protocol analysis; 5 or more sessions) will also be estimated. The number of safeguarding events, and the number of planned and unplanned unmasking of the PhD researcher are reported.

4.3.7 Pre-specified feasibility success criteria

Progression from feasibility to a future definitive RCT is based on the criteria in Table 10. A traffic light system was used with rating (a) as green and indicating progression to full trial is feasible; rating (b) is amber and indicates progress should be considered if adjustments identified through feasibility evaluation are possible, and rating (c) is red, do not progress before further testing.

Table 10. Primary and secondary feasibility progression parameters, pre-defined to identify whether the research should progress to a definitive evaluation.

Parameter		Justification	
Primary progression parameter: <i>Participant identification</i>	Trial participants who meet SAPAS criteria are identified at a sufficient rate for a definitive RCT.	<p>a) > 60% of participants who complete informed consent will meet SAPAS criteria.</p> <p>b) 33%-60% of participants who complete informed consent will meet SAPAS criteria.</p> <p>c) < 33% of participants who complete informed consent will meet SAPAS criteria.</p>	<ul style="list-style-type: none"> • Proof of concept testing (n=44) found 33% of parents attending standard BaP-Standard met SAPAS score of ≥ 3. 80% of parents (n= 10) who self-identified and choose BaP-Standard for parent's experiencing emotional and interpersonal difficulties met the SAPAS criteria. • A conservative threshold of 60% of participants who consent to the study and meet SAPAS criteria is applied to allow for the small sample in proof-of-concept testing. • The lower threshold of 33% is based on the number of participants in standard BaP-Standard groups who meet SAPAS criteria. • The process evaluation will be used to develop recruitment material should rates of identification lie between 33-60%.
Primary Progression Parameter: <i>Trial Retention</i>	Time 2 participant retention rate is sufficient for a fully powered definitive RCT.	<p>a) Time 2 retention at >65%</p> <p>b) Time 2 retention at 45-65%</p> <p>c) Time 2 retention rate at <45%</p>	<ul style="list-style-type: none"> • Previous proof of concept testing showed retention rates of 76.9% for BaP-Standard in the target population (n=10). • Rates of completion are 65% for standard personality disorder trials (35% drop out; McMurran et al., 2010). • Drop-out for participants with personality disorder has not been tested in standard BaP-Standard group, however, drop out may be higher as the group is not tailored for significant emotional and interpersonal difficulties. • Therefore, a feasibility threshold of 65% was appropriate.
Secondary progression parameter:	Trial participants are recruited at a	a) 50-72 participants are randomised as planned.	<ul style="list-style-type: none"> • The study uses an intent to treat analysis, therefore the sample size at randomisation is the most appropriate assessment of recruitment feasibility.

<i>Recruitment rate</i>	sufficient rate required for a definitive RCT.	<p>b) Between 25-50 participants are randomised.</p> <p>c) Less than 24 participants are randomised.</p>	<ul style="list-style-type: none"> • A sample of 12 per group is sufficient to obtain variance estimates (standard deviation) for outcomes that can inform sample size calculations (Julious, 2005). This informs the lower threshold of study recruitment. • A sample size of 50 is required to determine sample size for outcome analysis in a definitive trial (Sim and Lewis, 2012), which informs the lower bound of the studies upper criteria. • In order to obtain estimates of retention for a definitive clinical trial within a 95% confidence interval of $\pm 10\%$ (Browne, 1995), a sample of 72 is required.
Secondary progression parameter: <i>Intervention acceptability</i>	BaP-Enjoying Family Life intervention is acceptable to participants.	<p>a) At least 75% of participants rate BaP-Enjoying Family Life with a total TARs score of ≥ 27.</p> <p>b) 55-74% of participants rate BaP-Enjoying Family Life with a total TARS score of ≥ 27.</p> <p>c) <55% of participants rate BaP-Enjoying Family Life with a total TARs score of ≥ 27.</p>	<ul style="list-style-type: none"> • Nine Treatment Acceptability Rating Scale items are rated on a 4-point Likert scale, yielding a Total Score between range 9-36. • An intervention acceptability cut off ≥ 27 equates to rating of 3 or above (<i>Quite a lot</i>) on each item.
Secondary progression parameter: <i>Intervention fidelity</i>	BaP-Enjoying Family Life & BaP-Standard Fidelity will be reached.	<p>a) 80% or more – Good Fidelity.</p> <p>b) 60-80% - Fair fidelity, deviation from the manual that may require further training and/or supervisory support.</p> <p>c) >60% - Significant deviation from manual, poor fidelity</p>	<ul style="list-style-type: none"> • Previous measures have used 60% as a cut off for fidelity (Bond et al., 2011). • A cut-off of 80% would mean 8/10 sessions or 7/9 sessions had been delivered as planned. • With the possibility of participants missing sessions quite high, impacting the “dose” of intervention they may receive, a higher threshold of 80% was appropriate to ensure fidelity.

Note. a) indicates progression to full trial is feasible; b) indicates progress should be considered if adjustments identified through feasibility evaluation are possible, and c) indicates do not progress before further testing

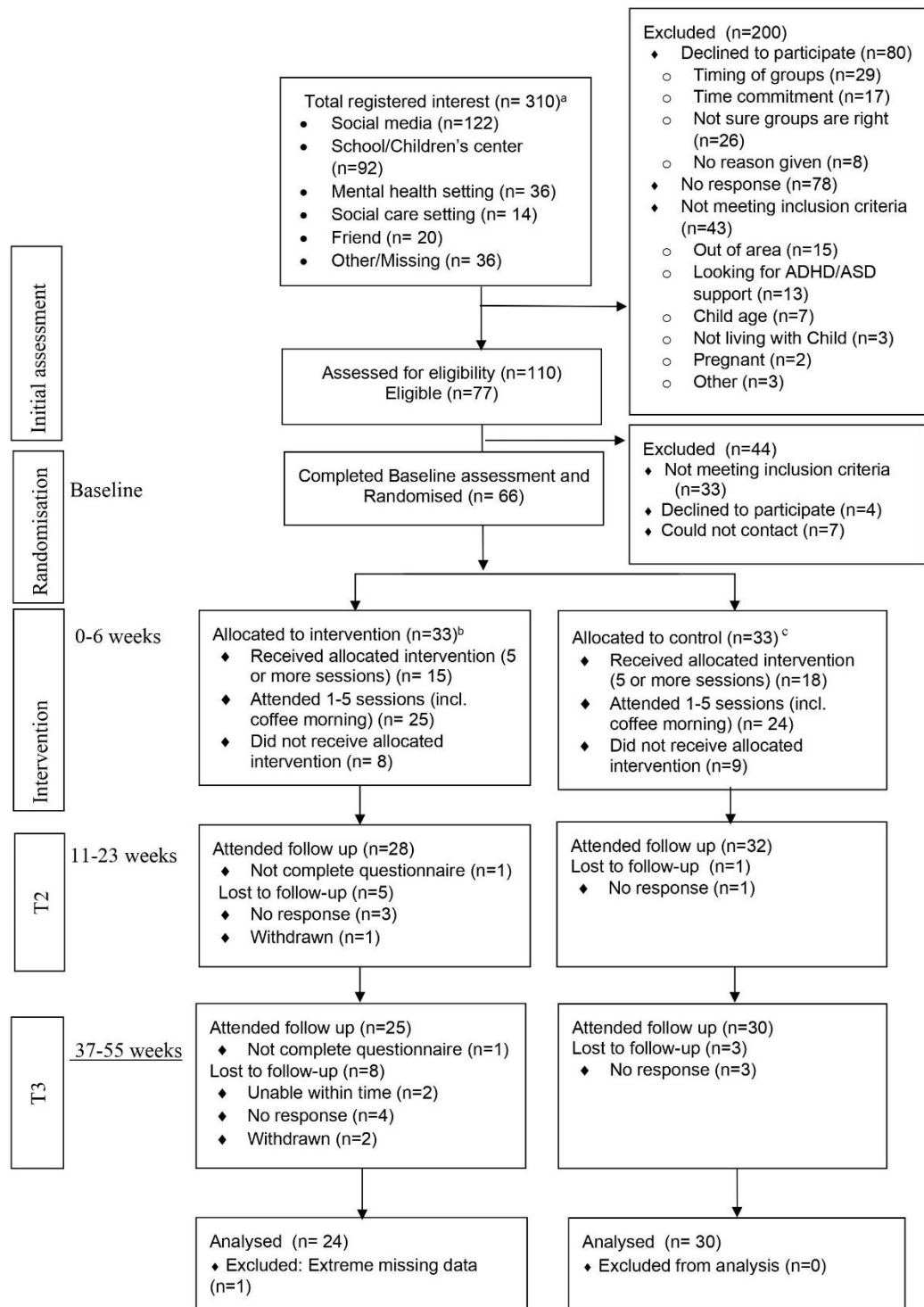
4.4 Results

4.4.1 Feasibility outcomes

4.4.1.1 Rates of participant identification

The CONSORT diagram (Figure 6) describes participant flow through the study. Of 310 parents registering interest, 77 (24.84%) were identified as eligible, and 66 (21.29%) were randomised. Most of the 310 parents registering interest found out about the project on social media (38.13%), with 28.75% through schools or children's centre, 11.25% through mental health settings, 6.25% through friends and 4.38% through social care settings. 11.25% did not report how they found out about the groups.

Of those parents who initially registered their interest, 25.81% (n=80) of parents withdrew interest after receiving more information about the study, 25.16% (n=78) were non-contactable after 4 attempts and 13.87% (n=43) the project was not suitable for. The trial was most frequently not suitable because parents were looking for support for child with ADHD or Autism (n= 13) or lived out of area (n=15). The PhD researcher kept a written record of reasons for parent's withdrawal where given, identifying that the timing of the groups (n=29), the time commitment the project involved (n=17) and the project not being right for parents or their families (n=26) as the main reasons for parent withdrawal. Eight parents did not give any reason for their withdrawal after initial interest. Of the parents who described that the project was not right, nine parents did not believe the project fit their or their child's needs, eight parents though it wasn't the right time in their lives to join, one parent wanting professional support, one parent wanting more local support, one parent wanting something sooner, one parent interested in EFL course only and one parent wanting an online course.

Figure 6. CONSORT flow diagram of participants through the trial stages

Note. a. Ten parents heard about the group from multiple sources b. Four parents in the intervention arm repeated baseline c. One parent in the control arm repeated baseline

4.4.1.2 Rates of trial participation

Of the 110 participants who completed informed consent appointments, 77 (70.00%) of parents were identified as eligible to participate in the study and scored 3 or more on SAPAS indicating significant emotional and interpersonal difficulties. Of those eligible (n=77), most parents scored 3 (n=23) with a median of 5 (range 3-8). There was no significant difference in mean SAPAS scores between randomised participants (M= 4.68, SD= 2.27) and eligible participants who dropped out prior to randomisation (M= 4.55, SD= 1.23, $p=.776$). 10.65% parents (n=33) who registered interest were identified as ineligible after providing informed consent. The main reason for post-consent ineligibility was failure to meet SAPAS cut off (n=30). Three further parents were identified as ineligible to participate: one parent was pregnant at the time of consent; one parent had a child in full time foster care and one parent had a mild learning difficulty. Of the 77 parents who were eligible and consented, 11 did not complete baseline data collection appointments and were not randomised to the trial due to timing of the group and conflicts with work or appointments (n=4) or being non-contactable (n=7). The overall number of participants randomised to the trial was 66 parents.

Figure 7 shows participant flow by recruitment location. Whilst the small sample prevents significance testing, the highest proportion of parents to drop out between consent and randomisation were recruited from social media (only 18.18% of participants recruited through social media were eligible and 13.93% randomised) and schools (only 23.91% eligible and 18.48% randomised). Whilst a smaller number of parents heard about the project through mental health services, 54.29% were eligible to take part and were randomised. 14.29% of parents who heard about the groups through social services were

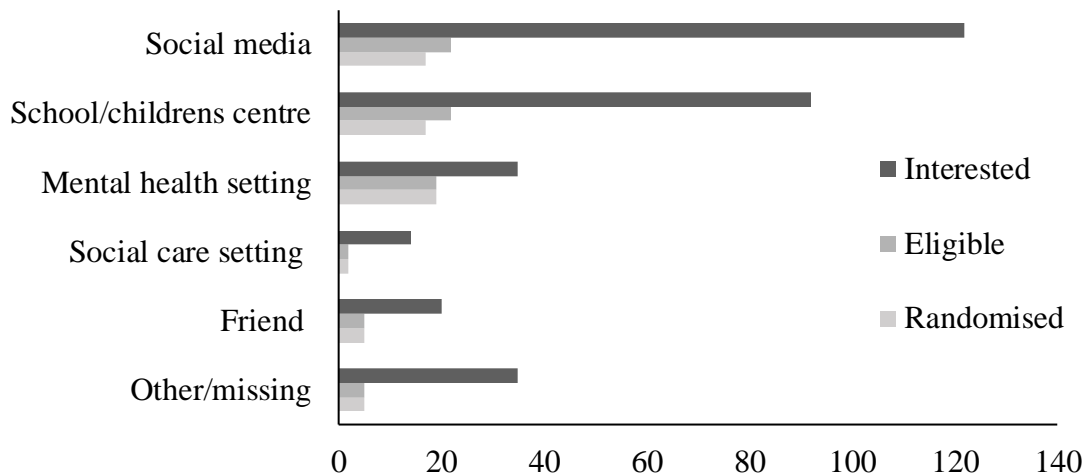


Figure 7. Numbers of parents registering interest, identified as eligible and randomised from different recruitment locations

eligible and randomised, and 25.00% of parents who heard about the project through a friend consented and were randomised. This suggests that hearing about the project from mental health practitioner or friend leads to greater trial enrolment.

4.4.1.3 Rates of data collection & retention

Retention at post-intervention timepoint was 91% for the primary clinical outcome (Eyberg Child Behaviour Inventory; see Table 12). The retention at post-intervention was higher in the control arm (97%) compared to the intervention arm (84.8%), with four of five participants lost to follow up in BaP-Enjoying Family Life arm (three non-response and one withdrawal). One participant withdrew post-intervention because they had not attended the group and did not want to complete the questionnaire. At 6 months follow up, eight BaP-Enjoying Family Life participants did not provide any data, and three BaP-Standard participants did not provide any data, with all three non-contactable. Two BaP-Enjoying Family Life participants were contacted and agreed to complete questionnaires in their own time but were unable to complete the questionnaire before the closing date, four

Table 11. Data completion for clinical outcomes across time points.

Complete data:	Baseline	Time 2	Time 3
All questionnaires	66	60/66 (91%)	53/66 (78%)
Demographics	66 ^a		
ECBI Intensity	65/66 ^b		
ECBI problems	64/66 ^b	57/60 ^b	
PSS			
BSES			
PRFQ		59/60 ^c	
Parenting Scale		59/60 ^c	
BASE-6		59/60 ^c	
CAMC	65/66	59/60 ^c	
TARS		52 ^c	
GCS		49 ^c	
HOME Inventory	32	22 (68%)	20 (63%) ^d
IT- HOME	3	3	3
EC-HOME	18	12	11
MC-HOME	11	7	6

^a 55/66 completed income and 64/66 reported number of adults living with them.

^b Missing items above threshold for pro-rating.

^c Participant declined or unable to complete questionnaires.

^d 2 participants completed HOME without questionnaire data.

did not respond and two declined. Three BaP-Enjoying Family Life participants and 1 BaP-Standard did not provide any time 2 or time 3 data. No significant differences in data completion by arm at time 2 ($p=.087$), time 3 ($p=.122$) or both time 2 and 3 ($p=.302$) were found.

Chi-square tests of independence were conducted to test whether any demographic variables were associated with missing data at time 2, time 3 or both time 2 and time 3. At time 3, the proportion of data completion was significantly different between different participant employment status at baseline (χ^2 (df=5) = 14.671, $p=.012$). There was a greater proportion of participants who were unemployed or selected “other” who had missing data at time 3 (41.67% and 50.00% respectively) compared to full time employed participants

(11.76% missing), part time employed (6.25%), looking after family (0.00%) and students (0.00%).

For the observational assessment, 32 participants completed HOME inventory interviews at baseline. Nine of the 34 missing HOME at baseline were cancelled by the PhD researcher due to COVID-19 and a risk of transmission. Twenty-two participants were recruited too close to the group start date (1 week before) to arrange a HOME inventory appointment and leave enough time to randomize and inform participant of allocation. Three participants declined HOME inventory appointments due to concerns around the impact on their child. Retention was 68% at time 2 and 63% at time 3. The reasons for not conducting HOME inventory were participant declining to participate in HOME inventory due to lack of available time (time 2 n=2; time 3 n=4), participants were non-contactable (time 2 n= 5; time 3 n=4) and one participant withdrew at time 3 as she had not completed the group and did not want to complete data collection.

4.4.1.4 Intervention attendance and completion

Thirty-three participants (50.00%) completed 5 or more sessions, 49 participants (74.24%) completed at least one session (including coffee morning) and 42 participants (63.64%) completed between 2-4 sessions. By arm, 15 participants (45.45%) completed BaP-Enjoying Family Life and 18 (54.54%) completed BaP-Standard, with 25 (75.76%) participants attending at least one session in BaP-Enjoying Family Life and 24 (72.72%) participants attended at least one BaP-Standard session. There was no significant difference in the average number of sessions attended in each arm (BaP-Enjoying Family Life 4.45 (SD=3.91); BaP-Standard 4.67 (SD=3.56), $p = .495$, $d = -0.57$, [95% CIs= -.539, .426]). Four participants in BaP-Enjoying Family Life and one participant in BaP-Standard repeated

baseline assessment as they had been unable to join (n=3) or had only joined the coffee morning (n=2) at the first attempt. Three of the five (two BaP-Enjoying Family Life and one BaP-Standard) participants who repeated baseline completed the course.

Thirty participants in BaP-Enjoying Family Life and 25 participants in BaP-Standard accepted the invitation to join the groups. For the three BaP-Enjoying Family Life participants who declined at invite, the time didn't work due to work commitments (n=2) or conflicts with mental health treatment (n=1). For the BaP-Standard participants who declined at invite, the time of the group also did not work due to work commitments (n=3), college courses (n=2) or other commitments (n=1), travel was too far and conflicted with childcare arrangements (n=2), or there was no response to invite (n=1). The remaining four BaP-Enjoying Family Life participants who accepted the invite but did not attend the course tried but were unable to attend due to work commitments (n=2), travel difficulties (n=1), childcare support (n=1).

Intervention use was similar between delivery method and intervention arm. Twenty-four (48.00%) of 50 participants who were given a choice between online and in person indicated a preference for the online group. 16 participants joined in cohort 3 were not able to indicate delivery preference as the group was only offered in person. Twenty five of 28 (89.29%; 15 BaP-Enjoying Family Life) participants accepted an invite to online group; seventeen (60.71%; 12 BaP-Enjoying Family Life participants) attended one or more session; and thirteen (46.43%; 9 BaP-Enjoying Family Life participants) completed the online course. Twenty-nine of 38 (76.31%; 15 BaP-Enjoying Family Life) participants accepted the invite to an in-person group, with 26 (68.42%; 15 BaP-Enjoying Family Life)

participants attending one or more session and 20 (52.63%; 7 BaP-Enjoying Family Life) participants completed the in-person course.

Baseline demographics of each attendance group (low attenders (one-five sessions), high attenders (five or more) and non-attenders) were compared across each trial arm. A multivariate ANOVA indicated that participant age was associated with attendance status ($F(2,65)= 3.26, p=.045, \eta^2= 0.098$). No significant interaction effect of arm was found. Examining the mean age, non-attenders had the lower mean age (34.41 (SD=6.25)), and low attenders had the highest mean age (40.52 (SD=6.15)), with the mean age of high attenders in the middle (37.05 (SD=7.06)). No other variables were significantly different between trial arm and across attendance group.

4.4.1.5 Fidelity

Fidelity scores indicated that six of the ten intervention sessions were delivered as intended (see Table 12), with three interventions in each arm scoring 80% or more of total possible fidelity score (BaP-Enjoying Family Life mean fidelity score 45.80 (SD= 41.91) out of 80; BaP-Standard mean score 56.00 (SD= 27.71) out of 72). Missing data was high (18.95% of scores were missing), particularly in BaP-Enjoying Family Life arm. Two BaP-Enjoying Family Life online groups had no fidelity data collected at all, and one of these groups was cancelled after session 5 due to low attendance. Two BaP-Standard in person groups also did not meet fidelity, with one group cancelled after the coffee morning due to low attendance and one had data from 2 sessions missing.

4.4.2 Demographics

Demographics were only collected for 66 parents who consented and completed the baseline assessment, and are presented for this total sample and separately by arm in Table

Table 12. Intervention fidelity by intervention arm.

	Intervention: BaP-Enjoying Family Life		Control: BaP-Standard	
	Score and percentage of total (80)	Missing scores	Score and percentage of total (72)	Missing scores
Cohort 1				
In person	77 (96.25%)		56 (77.78%)	8/36
Online	0	40/40	72 (100.00%) ^a	
Cohort 2				
In person	80 (100.00%) ^a		8 (11.11%) ^b	
Online	0 ^c	24/40	72 (100.00%)	
Cohort 3				
In person	72 ^d (90.00%)		72 (100.00%)	

^a Data added retrospectively (outside 6-week data collection window)

^b Group cancelled after coffee morning due to low attendance.

^c Group cancelled after 5 sessions due to low attendance.

^d One session cancelled by practitioners in advance due to low attendance.

13. Most participants recruited were female, White or White British (54.55%) and with a high level of education, with more than 50% receiving undergraduate or postgraduate qualifications. Non-British white ethnicities included European (n=9), South American (n=3), African (n=2) and Australian (n=1). 50.00% of participants were in some form of part-time or full-time employment, and those who selected “other” were self-employed (n=7), unable to work due to health reasons (n=2) or volunteering (n=1). 29 (43.93%) reported receiving some sort of mental health care (medication or talking therapies). Mean index child age was 5 (range: 2-11 years), with slightly more male than female children identified as index child. 40.91% of families were lone parent households, with 30.30% receiving no co-parent support, and most families having one or two children (15.15% respectively, range 1-5 children).

Table 13. Demographic characteristics for total feasibility sample

	Intervention (n=33)	Control arm (n=33)	Total sample (N=66)
Parent			
Age (Mean (SE))	37.90 (1.27)	36.52 (1.14)	37.2 (0.85)
Gender: Female N(%)	31 (93.93%)	31(93.9%)	62 (93.9%)
Ethnicity (N(%))			
White British	4 (12.12%)	9 (27.27%)	13 (19.69%)
Other white background	14 (42.42%)	9 (27.27%)	23 (34.84%)
Black or Black British Caribbean	6 (18.18%)	5 (15.15%)	11 (16.66%)
Black or Black British African	0 (0.00%)	4 (12.12%)	4 (6.06%)
White and Black Caribbean	2 (6.06%)	1 (3.03%)	3 (4.54%)
Chinese	0 (0.00%)	1 (3.03%)	1 (1.52%)
Other Asian background	2 (6.06%)	0 (0.00%)	2 (3.03%)
Other mixed background	1(3.03%)	2 (6.06%)	3 (4.54%)
Other ethnic group	3 (9.09%)	1 (3.03%)	4 (6.1%)
Missing	1 (3.03%)	1 (3.03%)	2 (3.03%)
Relationship status N(%)			
Married	13 (39.39%)	15 (45.45%)	28 (42.42%)
Divorced	1 (3.03%)	0 (0.00%)	1 (1.52%)
Separated	2 (6.06%)	2(6.06%)	4 (6.06%)
Single	11 (33.33%)	10 (30.30%)	21 (31.81%)
Living with partner In a relationship	4 (12.12%)	5(15.15%)	9 (13.63%)
	2 (6.06%)	1 (3.03%)	3 (4.54%)
Co-parenting	22 (66.66%)	24 (72.72%)	46 (69.69%)
Education			
Left school at 16 with qualifications	2 (6.06%)	1(3.03%)	3 (4.54%)
Attended further secondary or college education	7 (21.21%)	5 (15.15%)	12 (18.18%)
University education begun but not complete	3 (9.09%)	4 (12.12%)	7 (10.61%)
University education complete	9 (27.27%)	9 (27.27%)	18 (27.27%)
Postgraduate qualification	7 (21.21%)	11 (33.33%)	18 (27.27%)
Any other qualification	5 (15.15%)	3 (9.09%)	8 (12.12%)
Work			
Full time employed	7 (21.21%)	10 (30.30%)	17 (25.76%)
Part time employed	7 (21.21%)	9 (27.27%)	16 (24.24%)
Looking after family	5 (15.15%)	5 (15.15%)	10 (15.15%)
Unemployed	7 (21.21%)	5 (15.15%)	12 (18.18%)
Student	1(3.03%)	0 (0.00%)	1 (1.52%)
Other	6 (18.18%)	4 (12.12%)	10 (15.15%)
Mental health care			
Care coordinator	5 (15.15%)	2 (6.06%)	7 (10.61%)

Short term treatment	2 (6.06%)	3 (9.09%)	5 (7.58%)
Long term treatment	7 (21.21%)	0 (0.00%)	7 (10.61%)
Medication	12 (36.36%)	11 (33.33%)	23 (34.84%)
Physical health medication	6 (18.18%)	3 (9.09%)	9 (13.63%)
Previous parenting support			
Yes	9 (27.27%)	9 (27.27%)	18 (27.27%)
Being a Parent-Standard	0 (0.00%)	2 (6.06%)	2 (3.03%)
English as additional language	12 (36.36%)	7 (21.21%)	19(28.79%)
Index Child* (all biological children)			
Age	4.85 (0.42)	5.24 (0.39)	5.05 (0.29)
Gender: Female	14(42.42%)	14(42.42%)	28 (42.42%)
Living status			
Lives with parent 100%	29 (87.88%)	31 (93.93%)	60 (90.91%)
1-2 nights with another caregiver	3 (9.09%)	2 (6.06%)	5 (7.57%)
> 1-2 nights with another caregiver	1 (3.03%)	0 (0.00%)	1 (1.52%)
Household composition			
Couple family with children	17 (51.51%)	19 (57.57%)	36 (54.55%)
Blended/stepfamily	0 (0.00%)	2 (6.06%)	2 (3.03%)
One parent family with children	15 (45.45%)	12 (36.36%)	27 (40.91%)
Other	1(3.03%)	0 (0.00%)	1 (1.52%)
Multigenerational household	1(3.03%)	0 (0.00%)	1(1.52%)
Type of housing			
Privately rented	11 (33.33%)	8 (24.24%)	19 (28.79%)
Housing association	7 (21.21%)	5 (15.15%)	12 (18.18%)
Local authority	4 (12.12%)	2(6.06%)	6 (9.09%)
Owner	9 (27.27%)	10 (30.30%)	19 (28.79%)
Shared ownership	1(3.03%)	3 (9.09%)	4 (6.06%)
Temporary accommodation	1(3.03%)	4 (12.12%)	5 (7.58%)
Other	0 (0.00%)	1(3.03%)	1 (1.52%)
Number of children	1.58 (0.12)	1.88 (0.17)	1.73 (0.11, range= 1-5)
Number of adults	0.69 (0.11)	0.69 (0.10)	0.69 (0.07, range= 0-2)
Household Income	£55,074.07 (£9805.65)	£42,803.57 (£6203.79)	£48,827 (£5763.69)

4.4.3 Intervention acceptability

Intervention acceptability was measured at time 2. Seventeen (60.71%) of 28 participants in BaP-Enjoying Family Life arm and 20 (62.50%) of 32 participants in BaP-Standard who completed time 2 data collection gave a rating of 27 or above. Mean TARs

score was 25.00 (SD= 11.29) for BaP-Enjoying Family Life and 24.30 (SD=11.52, $d= 0.06$ [95% CIs -.45, .57]) for BaP-Standard. Seven participants (three in BaP-Enjoying Family Life and four in BaP-Standard) left the TARs blank as they had been unable to join the intervention. For items on knowledge and skills, 46.42% ($n=13$) participants scored 9 or above for BaP-Enjoying Family Life and 46.88% ($n=15$) scored 9 or above for BaP-Standard. Mean subscale score was similar in both arms (BaP-Enjoying Family Life Mean= 9.89 (SD=4.94); BaP-Standard Mean= 9.84 (SD= 4.91), $d=0.01$ [-.50, .52]). For items on the facilitation and satisfaction subscale, slightly more (78.57%) participants scored 15 or more in BaP-Enjoying Family Life arm compared to BaP-Standard (65.63%), indicating the facilitation and delivery of the course was acceptable to a greater proportion of BaP-Enjoying Family Life participants. Mean scores were similar in both arms (BaP-Enjoying Family Life Mean= 15.07 (SD=6.66); BaP-Standard Mean= 14.41 (SD=6.83), $d=0.10$ [-.41, .61]).

Content analysis of the TARs qualitative data indicated that 42 of 55 (69.23% of BaP-Enjoying Family Life and 82.76% of BaP-Standard) participants who gave qualitative TARs feedback spoke positively about the content (Category 1; see Appendix Q). Additionally, 33 of 55 (57.69% of BaP-Enjoying Family Life and 62.07% of BaP-Standard participants) gave positive feedback about the delivery (Category 2). Eleven of 55 (19.23% of BaP-Enjoying Family Life and 20.69% BaP-Standard participants) suggested changes and addition to intervention content (Category 3) and 33 of 55 (65.38% of BaP-Enjoying Family Life and 55.17% of BaP-Standard participants) suggested changes to intervention delivery (Category 4). Fifteen (26.92% of BaP-Enjoying Family Life and 27.59% of BaP-Standard) participants made no suggested changes to intervention. Strategies which

improved parent-child communication (including play, acknowledging feelings and praise, n=12) and increased self and child acceptance (including good enough instead of perfect parent and understanding behaviour as communication, n=11) were the most common helpful strategies mentioned. Supporting parent emotions and wellbeing was more frequently reported in BaP-Enjoying Family Life. The most common positive delivery feedback was about group format (feeling safe and normalizing parenting concerns, n=22), followed by facilitation by peers and supervisors (n=13).

The most common suggested content change was to improve signposting and support for Equality Diversity and Inclusion and neurodiversity in the group (n=5, all BaP-Standard participants), as well as long-term parent mental health support and strategies for older children (n=5, 2 BaP-Enjoying Family Life and 3 BaP-Standard participants). Five participants described there was no new helpful content, or they didn't feel able to suggest improvements due to non-completion. The most common suggested delivery change was to increase the flexibility of delivery method (n=15, seven BaP-Enjoying Family Life participants and eight BaP-Standard participants) with participants suggesting more available days, flexibility when choosing a time that suited and suggesting hybrid format. Three participants described preferring in person over online for facilitating connection, however three participants also described how remote and hybrid options could help more participants join. Nine participants discussed length of the group, with three suggesting a shorter group whilst six wished the group could continue.

Alongside treatment acceptability, participant's also rated group cohesion (BaP-Enjoying Family Life n=23, BaP-Standard n=26). The mean total group cohesion score was

higher for BaP-Enjoying Family Life ($M=31.9$, $SD= 3.67$) compared to BaP-Standard ($M=28.2$, $SD=6.92$) with a medium effect size ($d= 0.66$, [95% CIs 0.08, 1.23]).

4.4.4 Clinical outcomes

The analyses presented of clinical outcomes is descriptive to give an indication of the range of effect sizes when comparing BaP-Enjoying Family Life to BaP-Standard.

4.4.4.1 Primary Clinical Outcome

Change in child behaviour difficulties at post-intervention was the primary clinical outcome, measured using participant reported ECBI scores. The mean intensity of child behaviour difficulties reduced from baseline at time 2 and time 3 in both the intervention and control groups. Figure 8A. shows a larger reduction in mean child behaviour intensity from baseline to time 2 in participants in BaP-Enjoying Family Life compared to participants in BaP-Standard. At time 3, overlapping error bars suggest similar reduction in child behaviour difficulties from baseline in both groups. Cohen's d indicates no difference in effect between intervention arm (see Table 14). Similarly, the average number of

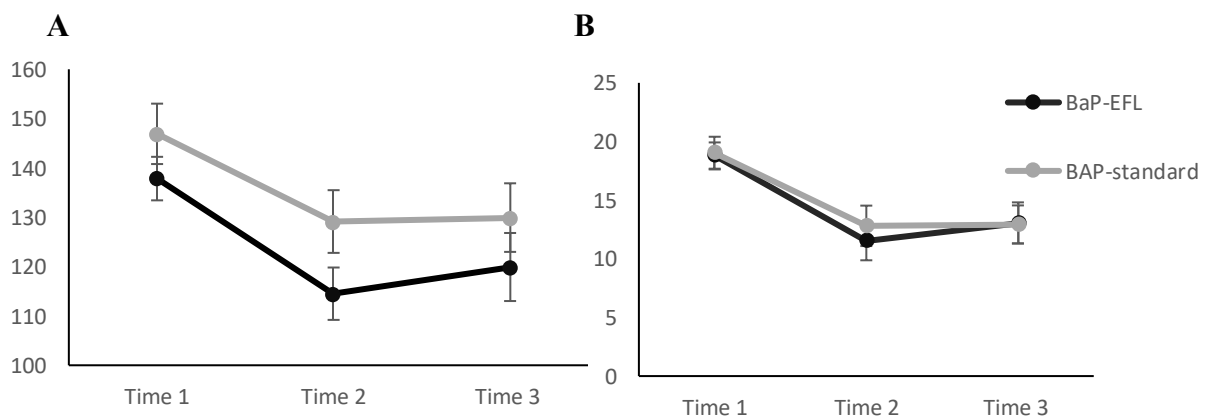


Figure 8. Means and standard error for the primary clinical outcome (child behaviour difficulties) separated by intervention arm across three time points. 8A. ECBI Child Behaviour Intensity; 8B. ECBI Child Behaviour problems

problematic child behaviours reduced from baseline to time 2 and time 3 (see Figure 8B), with Cohen's *d* indicating no difference in effects between intervention arms.

Figure 9 displays the proportions of parents scoring above the clinical cut-off of ≥ 131 for the ECBI child behaviour intensity Scale (Figure 9A) and above ≥ 15 for the ECBI child problem behaviour scale. The figures show that the proportion of participants reporting child behaviour intensity above clinical cut-offs dropped between time 1 (65.15%) and time 2 (38.33%) and was maintained at time 3 (45.28%). Figure 9A indicates that there was a larger reduction in the proportion of participant's reporting mean intensity of child behaviour difficulties above clinical cut-offs compared to baseline in the BaP-Enjoying Family Life arm (63.64% at baseline dropping to 25.00% at time 2) compared to BaP-Standard (66.67% at baseline dropping to 53.33% at time 2). At time 3, the proportion of participants reporting child behaviour intensity above clinical cut-offs was similar in both interventions (44.00% in BaP-Enjoying Family Life arm and 43.33% BaP-Standard arm). Change in the proportion of participants reporting number of problem

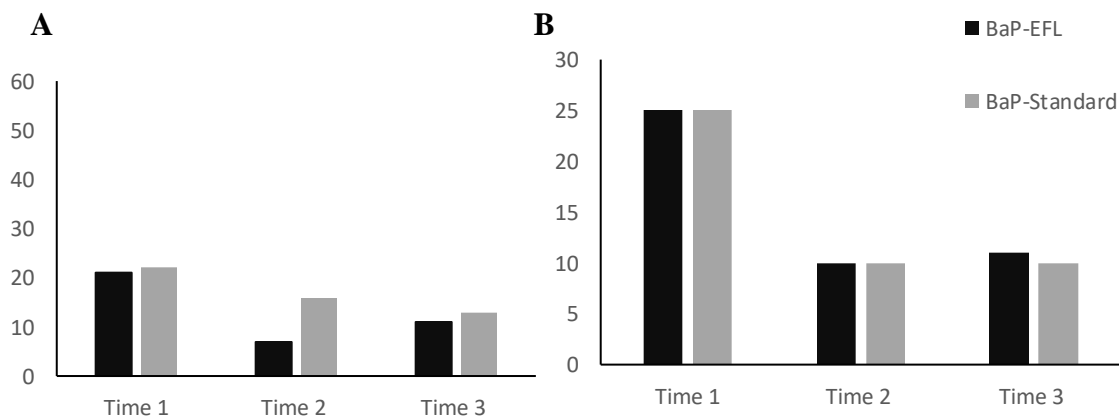


Figure 9. Proportion of participants in each trial arm with total ECBI scores above clinical cut offs for child behaviour difficulties across the three time points.

9A. ECBI child behaviour intensity. 9B. ECBI child behaviour problems

Table 14. Clinical outcomes (Intention to treat) reported as means (M) and standard deviation (SD) across time point; mean difference (MD) from baseline to time 2 and time 3, and the between-group effect size for mean difference scores (Cohen's *d* [95% Confidence intervals]).

	Baseline	M (SD) Time 2	Time 3	MD (SD), n Baseline-time 2	<i>d</i> [95% CIs]	MD (SD), n Baseline- time 3	<i>d</i> [95% CIs]
ECBI Intensity							
BaP-EFL	137.84 (24.95)	114.51 (28.08)	119.92 (33.79)	-21.03 (28.98), 27	-0.09 [-0.6, 0.42]	-18.71 (29.27), 24	0.04 [-0.5, 0.58]
BaP-Standard	146.91 (35.17)	129.13 (35.94)	129.93 (37.44)	-18.55 (25.38), 32		-19.90 (25.69), 29	
ECBI Problems							
BaP-EFL	18.80 (6.24)	11.52 (8.56)	13.06 (8.59)	-6.81 (8.98), 26	0.08 [-0.44, 0.61]	-5.71 (7.97), 24	0.17 [-0.37, 0.71]
BaP-Standard	19.01 (8.01)	12.81 (9.44)	12.93 (8.72)	-7.50 (7.58), 30		-7.01 (7.41), 29	
Parent Satisfaction							
BaP-EFL	11.70 (2.47)	14.86 (2.69)	15.38 (2.72)	2.82 (2.61), 28	-0.1 [-0.61, 0.41]	3.50 (2.40), 24	0.11 [-0.43, 0.66]
BaP-Standard	11.48 (2.60)	14.53 (3.42)	14.45 (2.76)	3.16 (3.89), 32		3.21 (2.70), 29	
Parent Self efficacy							
BaP-EFL	18.45 (3.42)	20.75 (2.37)	21.50 (3.49)	1.96 (2.86), 28	-0.31 [-0.82, 0.2]	2.92 (3.40), 24	-0.14 [- 0.68, 0.4]
BaP-Standard	16.67 (3.38)	19.47 (3.33)	19.90 (3.34)	2.91 (3.15), 32		3.34 (2.61), 29	
Parent reflective function							
Pre-mentalising							
BaP-EFL	2.58 (0.99)	2.13 (0.80)	2.16 (1.06)	-0.38 (0.65), 28	0 [-0.51, 0.51]	-0.41 (0.96), 24	0.07 [-0.47, 0.61]
BaP-Standard	2.60 (0.99)	2.26 (1.25)	2.15 (1.11)	-0.38 (1.07), 31		-0.47 (0.80), 29	
Certainty about mental states							
BaP-EFL	3.77 (0.96)	4.03 (1.09)	4.21 (0.88)	0.18 (1.08), 28	-0.35 [-0.86, 0.17]	0.59 (0.91), 24	0.12 [-0.43, 0.66]
BaP-Standard	3.32 (0.94)	3.79 (1.08)	3.80 (0.96)	0.51 (0.74), 31		0.49 (0.87), 29	
Interest and curiosity about mental states							
BaP-EFL	5.94 (0.77)	5.82 (0.95)	5.94 (0.77)	-0.10 (0.65), 28	-0.38 [-0.89, 0.14]	0.36 (0.64), 24	0.26 [-0.28, 0.81]
BaP-Standard	5.91 (0.72)	6.05 (0.83)	5.91 (0.72)	0.14 (0.64), 31		0.18 (0.70), 29	
Parenting scale							
BaP-EFL	112.64 (15.64)	90.93 (18.53)	90.17 (18.61)	-20.04 (19.17), 28	-0.09 [-0.6, 0.42]	-21.63 (19.89), 24	-0.22 [- 0.76, 0.32]
BaP-Standard	116.12 (15.67)	97.90 (16.87)	98.83 (18.00)	-18.48 (15.21), 31		-17.83 (14.76), 29	
Laxness							

BaP-EFL	3.51 (0.87)	2.75 (0.84)	2.77 (0.74)	-0.67 (0.77), 28	0.05 [-0.47, 0.56]	-0.66 (0.94), 24	0 [-0.55, 0.54]
BaP-Standard	3.63 (0.83)	2.96 (0.77)	3.02 (0.78)	-0.70 (0.73), 31		-0.65 (0.69), 29	
Over reactivity							
BaP-EFL	3.34 (0.98)	2.64 (0.88)	2.65 (0.79)	-0.63 (0.92), 28	0.15 [-0.37, 0.66]	-0.75 (0.97), 24	-0.01 [-0.55, 0.53]
BaP-Standard	3.57 (0.89)	2.80 (0.77)	2.81 (0.70)	-0.77 (0.99), 31		-0.75 (0.88), 29	
Verbosity							
BaP-EFL	4.38 (0.82)	3.68 (0.88)	3.65 (1.09)	-0.67 (0.90), 28	-0.27 [-0.788, 0.24]	-0.61 (1.15), 24	-0.26 [-0.81, 0.28]
BaP-Standard	4.31 (0.83)	3.86 (0.81)	4.02 (0.99)	-0.45 (0.72), 31		-0.35 (0.86), 29	
Brief Adjustment Scale– 6							
BaP-EFL	28.39 (9.95)	22.57 (12.45)	25.79 (11.80)	-5.21 (8.97), 28	0.02[-0.49, 0.53]	-3.50 (11.84), 24	-0.11 [-0.65, 0.43]
BaP-Standard	27.91 (11.44)	22.84 (11.07)	26.10 (10.43)	-5.45 (14.28), 31		-2.21 (11.18), 29	
Concerns about my child (mean of 3 concerns)							
BaP-EFL	72.13 (16.07)	40.81 (24.11)	38.35 (24.28)	-31.62 (18.17), 28	-0.15 [-0.37, 0.66]	-33.71 (22.40), 23	-0.07 [-0.47, 0.63]
BaP-Standard	79.55 (17.35)	45.22 (25.85)	44.28 (25.68)	-34.72 (23.47), 31		-35.60 (23.01), 29	
HOME inventory							
Infant-Toddler							
BaP-EFL	32 (7.55)	33 (10.50)	30.50 (12.50)	1 (3.06), 3	N/A	1.5 (0.50), 2	N/A
BaP-Standard				.		.	
Early Childhood							
BaP-EFL	45.22 (1.41)	47.71 (1.25)	46.5 (1.77)	3.43 (1.36), 7	-0.99 [-2.2, 0.26]	3 (1.55), 6	-2.41 [-3.98, -0.76]
BaP-Standard	36.14 (3.46)	40.2 (2.63)	43.8 (1.59)	7.8 (2.42), 5		12 (1.64), 5	
Middle Childhood							
BaP-EFL	38.4 (2.46)	35.50 (1.50)	38 (.)	-2.5 (5.50), 2	-1.28 [-3.0, 0.58]	4 (.), 1	0.54 [-1.67, 2.68]
BaP-Standard	37.6 (2.56)	40.8 (1.984)	39.6 (2.79)	3.2 (1.39), 5		2 (1.67), 5	

Note. Bold indicates small, moderate or large effect size based on (LeCroy & Krysik, 2007).

behaviours above clinical cut-offs was similar between groups at time 2 and time 3 (see figure 9B).

4.4.4.2 Secondary Clinical Outcomes

Table 15 presents effect sizes for within group change in questionnaire scores from baseline to time 2 and time 3, separately for each intervention arm. Cohen's d suggests a large effect of the interventions on within group change for parent satisfaction, self-efficacy, positive parenting, and concerns about their child, indicating increases in satisfaction, self-efficacy and reduced dysfunctional parenting and concerns at time 2 and 3 in both arms. Small-to-moderate effect sizes were identified for total BASE-6 score and parent reflective function, indicating lower parent distress and greater reflective function across the three domains.

Initial intervention differences are presented in Table 14, with Cohen's d indicating the estimated between group effect size (i.e. BaP-Enjoying Family Life compared to BaP-Standard) at time 2 and time 3. Cohen's d indicated a small effect of intervention arm on outcomes at time 2 for parent self-efficacy, with greater mean difference in self-efficacy from baseline in BaP-Standard at time 2 and time 3. For reflective function, Cohen's d indicated a small effect of intervention arm on mean difference from baseline for certainty about mental states at time 2 and interest and curiosity subscales at time 2 and 3. Specifically, participants in BaP-Enjoying Family Life showed a smaller mean difference in certainty about mental states at time 2 compared to BaP-Standard. For interest and curiosity about mental states, BaP-Enjoying Family Life participants showed a negative change at time 2, and then greater increase from baseline at time 3.

Table 15. Clinical outcome within-group effect size for mean comparison of Baseline to time 2 and time 3.

	Baseline- Time 2 <i>d</i> [95% CIs]		Baseline- Time 3 <i>d</i> [95% CIs]	
	BaP-EFL	BaP-Standard	BaP-EFL	BaP-Standard
ECBI Intensity	0.73 [0.30, 1.15]	0.73 [0.34, 1.12]	0.64 [0.19, 1.07]	0.77 [0.35, 1.19]
ECBI Problems	0.76 [0.32, 1.19]	0.99 [0.55, 1.42]	0.72 [0.26, 1.16]	0.95 [0.50, 1.38]
Parenting Satisfaction	-1.08 [-1.54, -0.61]	-0.81 [-1.21, -0.41]	-1.46 [-2.03, -0.87]	-1.19 [-1.66, -0.70]
Parent Self-efficacy	-0.69 [-1.09, -0.27]	-0.92 [-1.33, -0.50]	-0.86 [-1.32, -0.38]	-1.28 [-1.77, -0.78]
Parent Reflective Function				
Pre-mentalising	0.59 [0.18, 0.98]	0.36 [-0.01, 0.72]	0.43 [0.01, 0.84]	0.59 [0.19, 0.98]
Certainty about mental states	-0.17 [-0.54, 0.21]	-0.68 [-1.07, -0.29]	-0.65 [-1.09, -0.20]	-0.56 [-0.95, -0.16]
Interest and Curiosity about mental states	0.16 [-0.22, 0.53]	-0.22 [-0.58, 0.14]	-0.56 [-0.99, -0.13]	-0.26 [-0.63, 0.11]
Parenting Scale				
Total	1.05 [0.58, 1.50]	1.22 [0.74, 1.68]	1.09 [0.57, 1.59]	1.21 [0.72, 1.68]
Laxness	0.87 [0.42, 1.30]	0.96 [0.52, 1.38]	0.70 [0.25, 1.14]	0.94 [0.50, 1.38]
Over reactivity	0.68 [0.26, 1.09]	0.78 [0.37, 1.18]	0.78 [0.31, 1.23]	0.85 [0.42, 1.28]
Verbosity	0.75 [0.32, 1.16]	0.62 [0.23, 1.01]	0.53 [0.10, 0.96]	0.41 [0.02, 0.78]
BASE-6 Total	0.58 [0.18, 0.98]	0.38 [0.01, 0.74]	0.30 [-0.12, 0.70]	0.20 [-0.17, 0.56]
Concerns about my child				
Concern 1	1.36 [0.84, 1.87]	1.04 [0.60, 1.47]	1.47 [0.86, 2.05]	1.48 [0.94, 2.00]
Concern 2	1.33 [0.82, 1.84]	1.35 [0.85, 1.83]	1.23 [0.68, 1.77]	1.15 [0.68, 1.62]
Concern 3	1.25 [0.74, 1.74]	1.25 [0.78, 1.72]	1.12 [0.59, 1.64]	1.21 [0.72, 1.68]

Note. Bold indicates small, moderate or large effect size based on (LeCroy & Krysik, 2007).

Decreased scores on the parenting scale indicate a reduction in dysfunctional parenting, as well as in the subscales of laxness, over-reactivity, and verbosity from baseline. Cohen's *d* indicates a small effect of intervention arm on mean change in verbosity at time 2 and time 3 and total parenting scale at time 3, with participants in BaP-Enjoying Family Life showing greater changes in total parenting scale from baseline at both time 2 and time 3. Verbosity indicated greater mean difference from baseline in participants in the BaP-Enjoying Family Life arm compared to BaP-Standard arm at time 2 and time 3. For the BASE-6, Cohen's *d* indicated no effect of intervention arm on total score. Finally, concerns about my child also showed a reduction from baseline scores across time points and in each arm. Cohen's *d* indicates no effect of intervention arm for mean difference in concerns across 3 ratings. Challenging behaviour was the most frequent rated concern (44.76% of parents' concerns, n=94), see Appendix T for a summary.

4.4.4.3 Observational assessment

Three different HOME inventories were administered based on child's age: Infant-Toddler, Early Childhood and Middle Childhood. Table 15 shows the mean and mean difference from baseline to time 2 and time 3 with the effect size for intervention comparison in HOME inventory total scores. No Infant-Toddler HOME inventories were administered to participants randomised to BaP-Standard; therefore, no intervention comparison can be made. For the Early Childhood HOME, Cohen's *d* indicates a large effect of intervention arm at time 2 and time 3, with participants in BaP-Standard showing a greater change in total mean score for the HOME inventory from baseline to time 2 and baseline to time 3. For Middle Childhood HOME, Cohen's *d* indicates a large effect of intervention arm. Specifically, participants in BaP-Enjoying Family Life showed a decrease

in HOME inventory total score from baseline at time 2 whereas BaP-Standard showed an increase. At time 3, one participant in BaP-Enjoying Family Life showed greater increase from baseline in middle childhood HOME total scores compared to five participants who were in the BaP-Standard arm. The HOME inventories were conducted on very small sample sizes; therefore, caution must be taken in interpreting these results.

4.4.5 Per protocol analysis

Thirty-two of 33 participants who completed a full intervention completed time 2 data collection and 27 also completed time 3 questionnaires. Eleven and nine participants completed a HOME inventory assessment at time 2 and time 3 respectively. A per-protocol analysis was conducted on these treatment completers to indicate the effect of receiving the intervention as intended. Aside from participant age, there were no significant demographic differences between participants who completed the intervention (presented in Appendix R) and those unable to complete the allocated intervention.

4.4.5.1 Treatment acceptability

Of the 15 participants who completed BaP-Enjoying Family Life intervention and of 17 participants who completed BaP-Standard, 93.33% (n=14) and 88.24% (n=15) respectively gave a TARs rating of 27 or above. Mean TARs score was 31.4 (SD=2.83) for BaP-Enjoying Family Life and 30.5 (SD=4.74, $d= 0.23$ [95% CIs -0.46, 0.93]) for BaP-Standard. For items on knowledge and skills, 73.33% (n=11) participants scored 9 or above for BaP-Enjoying Family Life and 64.71% (n=11) scored 9 or above for BaP-Standard. For items on the facilitation and satisfaction subscale, all participants scored 15 or more in BaP-Enjoying Family Life arm compared to BaP-Standard (88.24%), indicating a facilitation and delivery of the course was acceptable to a greater proportion of BaP-Enjoying Family

Life participants. For group cohesion, mean total score was 32.87 (SD=1.85) for BaP-Enjoying Family Life and 29.35 (SD=7.13, $d= 0.66$ [95% CIs -0.62, 1.37]) for BaP-Standard. Cohen's d indicates moderate effects of intervention arm for group cohesion.

4.4.5.2 Primary Clinical Outcome

For the primary clinical outcome, Table 16 indicates a decrease in the intensity and number of child behaviour problems at time 2 and time 3. Cohen's d indicated a small effect of intervention arm for behavioural intensity at time 2 and 3 and problems at time 2, with BaP-Enjoying Family Life showing greater reduction in intensity and number of problems at time 2 and behavioural intensity at time 3. The pattern of change in the proportion of participants whose mean scores were above the clinical cut off for the ECBI behaviour intensity and problems scores were similar to the intention to treat analysis. For child behaviour intensity, there was a larger decrease in the proportion of participants with scores above the clinical cut off in BaP-Enjoying Family Life group (from 53.33% at baseline to 20.00% at time 2) compared to BaP-Standard (from 61.11% at baseline to 52.94% at time 2). However, by time 3, there were similar proportion of participants in BaP-Enjoying Family Life and BaP-Standard reporting scores above the clinical cutoff (45.45% and 50.00% respectively). There was a greater reduction in proportion of behaviour problems reaching clinical cut off in BaP-Enjoying Family Life group (from 73.3% at baseline to 26.67% at time 2) compared to BaP-Standard at time 2 (from 72.2% at baseline to 41.18% at time 2), maintained at time 3 (27.27% and 31.25% respectively).

Table 16. Clinical outcomes (Per-protocol) reported as means (M) and standard deviation (SD) across time point; mean difference (MD) from baseline to time 2 and time 3 and the between-group effect size for mean difference scores (Cohen's *d* [95% Confidence intervals]).

	Baseline	M (SD) Time 2	Time 3	MD (SD), n Baseline – time 2	<i>d</i> [95% CIs]	MD (SD), n Baseline – time 3	<i>d</i> [95% CIs]
ECBI Intensity							
BaP-EFL	133.33 (31.99)	108.08 (23.40)	114.18 (33.95)	-25.25 (27.73), 15	-0.21 [-0.90, 0.49]	-22.55 (26.81), 11	-0.23 [-1.00, 0.54]
BaP-Standard	147.78 (31.47)	129.12 (36.28)	130.00 (38.40)	-20.18 (21.83), 17		-16.25 (27.31), 16	
ECBI Problems							
BaP-EFL	17.13 (6.48)	9.33 (6.56)	9.82 (8.69)	-7.80 (7.34), 15	-0.23 [-0.92, 0.47]	-6.73 (8.76), 11	-0.06 [-0.83, 0.71]
BaP-Standard	18.80 (7.44)	13.12 (9.62)	12.38 (8.76)	-6.26 (6.26), 17		-6.21 (8.17), 16	
Parent Satisfaction							
BaP-EFL	12.67 (2.50)	15.47 (2.13)	15.82 (2.09)	2.80 (1.97), 15	-0.01 [-0.70, 0.69]	2.91 (1.30), 11	0.01 [-0.75, 0.78]
BaP-Standard	12.00 (2.54)	14.65 (3.43)	14.44 (3.03)	2.82 (3.86), 17		2.88 (2.87), 16	
Parent self-efficacy							
BaP-EFL	19.07 (3.59)	21.20 (2.14)	22.18 (2.48)	2.13 (2.23), 15	-0.30 [-1.00, 0.40]	2.82 (3.87), 11	-0.16 [-0.92, 0.61]
BaP-Standard	16.61 (2.89)	19.41 (3.52)	19.69 (2.75)	3.00 (3.35), 17		3.31 (2.60), 16	
Parent reflective function							
Pre-mentalising							
BaP-EFL	2.32 (0.82)	1.87 (0.64)	2.05 (0.91)	-0.46 (0.50), 15	0.09 [-0.60, 0.79]	-0.30 (0.72), 11	0.49 [-0.29, 1.27]
BaP-Standard	2.84 (1.17)	2.40 (1.41)	2.24 (1.26)	-0.54 (1.13), 17		-0.68 (0.79), 16	
Certainty about mental states							
BaP-EFL	4.09 (0.97)	4.26 (0.92)	4.76 (0.71)	0.17 (1.10), 15	-0.35 [-1.04, 0.36]	0.88 (0.91), 11	0.83 [0.02, 1.62]
BaP-Standard	3.51 (0.87)	3.99 (0.96)	3.75 (0.84)	0.49 (0.76), 17		0.22 (0.71), 16	
Interest and curiosity about mental states							
BaP-EFL	6.11 (0.73)	6.06 (0.72)	6.53 (0.55)	-0.06 (0.50), 15	-0.04 [-0.74, 0.65]	0.48 (0.56), 11	0.38 [-0.40, 1.15]
BaP-Standard	5.74 (0.67)	5.70 (0.88)	5.89 (1.01)	-0.03 (0.75), 17		0.20 (0.87), 16	
Parenting scale							
BaP-EFL	110.33 (16.25)	85.00 (20.80)	80.00 (19.41)	-25.33 (18.01), 15		-28.45 (20.72), 11	

BaP-Standard	111.61 (13.53)	93.29 (17.68)	92.56 (16.70)	-18.47 (16.97), 17	-0.39 [-1.09, 0.31]	-19.25 (17.37), 16	-0.49 [-1.27, 0.29]
Laxness							
BaP-EFL	3.39 (0.71)	2.59 (0.88)	2.58 (0.80)	-0.81 (0.87), 15	-0.16 [-0.85, 0.54]	-0.79 (0.84), 11	-0.14 [-0.90, 0.64]
BaP-Standard	3.43 (0.73)	2.79 (0.78)	2.78 (0.63)	-0.68 (0.66), 17		-0.69 (0.67), 16	
Over reactivity							
BaP-EFL	2.98 (1.10)	2.36 (0.83)	2.22 (0.74)	-0.62 (0.89), 15	0.12 [-0.58, 0.81]	-0.74 (1.09), 11	0.00 [-0.77, 0.77]
BaP-Standard	3.33 (0.55)	2.62 (0.73)	2.61 (0.70)	-0.72 (0.91), 17		-0.74 (0.88), 16	
Verbosity							
BaP-EFL	4.48 (0.92)	3.54 (1.08)	3.17 (1.16)	-0.93 (0.98), 15	-0.68 [-1.39, 0.04]	-1.16 (1.22), 11	-0.80 [-1.59, 0.01]
BaP-Standard	4.01 (0.86)	3.64 (0.90)	3.69 (0.95)	-0.36 (0.69), 17		-0.35 (0.84), 16	
Total BASE-6							
BaP-EFL	28.13 (8.18)	20.60 (9.51)	23.73 (12.03)	-7.53 (8.68), 15	-0.09 [-0.78, 0.61]	-6.36 (13.40)	-0.47 [-1.25, 0.31]
BaP-Standard	26.44 (12.35)	21.12 (9.27)	25.69 (10.06)	-6.47 (14.90), 17		-1.00 (9.68)	
Concerns about my child (mean across 3 concerns)							
BaP-EFL	65.78 (15.70)	34.78 (20.14)	31.67 (15.85)	-31.00 (12.11), 15	0.10 [-0.60, 0.792]	-33.97 (14.22), 11	0.00 [-0.77, 0.77]
BaP-Standard	79.15 (18.40)	46.69 (23.97)	44.67 (25.35)	-33.00 (25.38), 17		-33.96 (27.33), 16	
HOME inventory							
Infant Toddler							
BaP-EFL	39.50 (2.12)	43.50 (0.71)	43.00 (.)	4 (1.41)	-	2 (.)	-
BaP-Standard	-	-	-	-		-	
Early Childhood							
BaP-EFL	45.20 (4.76)	49.25 (3.40)	45.00 (4.36)	5 (2.16), 4	-1.06 [-2.85, 0.83]	2.33 (0.58), 3	-16.30 [-28.89, -4.2]
BaP-Standard	36.33 (10.21)	38.50 (6.36)	43.00 (2.83)	8 (4.24), 2		12.5 (0.71), 2	
Middle Childhood							
BaP-EFL	34.00 (.)	37.00 (.)	38.00 (.)	3 (.), 1	-	4 (.), 1	-
BaP-Standard	33.00 (7.07)	37.00 (1.41)	35.00 (7.07)	4 (5.66), 2		2 (0), 2	

Note. Bold indicates small, moderate or large effect size based on (LeCroy & Krysik, 2007).

4.4.5.1 Secondary Clinical Outcomes and observational assessment

Table 16 shows means, mean difference from baseline and effect size of comparing mean difference from baseline by arm for intervention completers. Mean scores for participant satisfaction and self-efficacy increased from baseline. Cohen's d indicated a small effect of intervention on parent self-efficacy at time 2, with participants in BaP-Standard showing greater increase in self-efficacy. For parent reflective function, Cohen's d indicated a small effect of intervention arm on certainty about mental states at time 2 and small and moderate effects of intervention arm for subscales at time 3. Specifically, BaP-Standard intervention completers showed greater mean difference from baseline for certainty about mental states at time 2 and pre-mentalising at time 3. Whereas intervention completers in BaP-Enjoying Family Life arm showed greater mean difference from baseline for certainty and interest and curiosity about mental states at time 3.

For the parenting scale, Cohen's d indicated a small effect of intervention arm for total parenting scale score and moderate effect of intervention arm for verbosity subscale at time 2 and time 3. Participants in the BaP-Enjoying Family Life arm showed greater change from baseline in verbosity and total parenting scale score across time 2 and 3. Similarly, Cohen's d indicates small and moderate effects of intervention arm at time 3 for BASE-6 total score and emotional intensity and impairment subscales, with participants in the BaP-Enjoying Family Life arm showing greater mean difference from baseline compared to BaP-Standard across total score and subscales. Finally, concerns about my child show overall reductions from baseline to baseline and time 2 for total mean concern ratings. Cohen's d indicated no effect of intervention in mean difference of participant's three concerns from baseline to time 2 and time 3. The number of participants completing HOME inventory assessment and the intervention

were small and effect size could only be calculated for the early childhood inventory. However, all HOME inventories showed an increase in mean scores from baseline to time 2 and time 3.

4.4.6 Trial methods

4.4.6.1 Adverse events

Eighteen events were recorded across the study period where the PhD researcher was concerned for the safety and welfare of the participant and child and spoke to the Chief Investigator or supervisor. Two events resulted in safeguarding referrals and two events required sharing of information with participants' social workers. No adverse events or serious adverse events that were unexpected and related to the trial methods occurred during the conduct of the trial.

4.4.6.2 Unmasking

Two types of unmasking occurred in the trial: planned and unplanned. Planned unmasking occurred for 22 participants who participated in the qualitative semi-structured interview at time 2. Risk of bias due to PhD researcher being unmasked was low as the participants had already completed primary outcome at the end point of time 2. Two participants who were interviewed disclosed information on intervention content related to each arm during data completion, introducing potential for bias in PhD researcher's behaviour during data collection. Unplanned unmasking occurred for three participants (two BaP-Enjoying Family Life and one BaP-Standard) when the PhD researcher was cc'd into emails with supervisor during the intervention regarding attendance. The PhD researcher disposed of the emails upon receipt and recorded the unmasking in the trial log without participant IDs. Again, risk of bias was low as two of

the three participants completed time 2 and all three completed time 3 questionnaires in their own time rather than with the PhD researcher, minimizing opportunities for bias.

4.4.7 Evaluation of trial against progression parameters

Table 17 presents the evaluation of feasibility and acceptability findings against the pre-specified feasibility criteria. Both primary progression parameters around rate of participant identification and retention in clinical outcomes were met. Secondary progression parameters on rate of trial eligibility were also met. Secondary progression parameters on intervention acceptability and fidelity were partially met. Therefore, the feasibility findings indicate that progression to a full-scale superiority RCT comparing BaP-Enjoying Family Life to BaP-Standard would be feasible and acceptable after adjustments to intervention and fidelity assessment.

4.4.7.1 Sample Size calculation

In addition, the initial estimates of effectiveness can be used to calculate future sample size for the proposed superiority RCT comparing BaP-Enjoying Family Life to BaP-Standard. Before running the calculation it is important to articulate the RCT primary outcome (child behaviour intensity at time 2); type of RCT design (superiority trial); important clinical difference (small effect of intervention; $d=0.2$); consider attrition rate (90% completed time 2); and type of statistical test (repeated measures ANCOVA) (Ebrahim Valojerdi et al., 2017). A repeated measures ANCOVA was chosen over a t-test comparing change in means from baseline to reduce the number of tests run and increase statistical power. G-power was used to calculate sample size for a sufficiently powered study to indicate a small effect of intervention (effect size $f= 0.1$) using an ANCOVA comparing between subjects' effects of intervention arm (numerator $df= 1$) and within subjects' effect of time point ($3 \times 2=6$ groups) and including the two

Table 17. Feasibility evaluation findings compared to the pre-specified progression parameters.

Parameter		Finding	
Primary progression parameter	Trial participants who meet SAPAS criteria are identified at a sufficient rate for a definitive RCT.	<ul style="list-style-type: none"> a. > 60% of participants who complete informed consent will meet SAPAS criteria b. 33%-60% of participants who complete informed consent will meet SAPAS criteria c. < 33% of participants who complete informed consent will meet SAPAS criteria. 	71% of consenting participants were eligible and met SAPAS criteria.
Primary Progression Parameter	Time 2 participant retention rate is sufficient for a fully powered definitive RCT	<ul style="list-style-type: none"> a. Time 2 retention at >65% b. Time 2 retention at 45-65% c. Time 2 retention rate at <45% 	Retention: 91% (n=60) at Time 2
Secondary progression parameter	Trial participants are recruited at a sufficient rate required for a definitive RCT	<ul style="list-style-type: none"> a. 50-72 participants are randomised as planned b. Between 25-50 participants are randomised c. Less than 24 participants are randomised 	Across 3 terms, 77 eligible participants were recruited and 66 randomised.
Secondary progression parameter	BaP-Enjoying Family Life intervention is acceptable to participants	<ul style="list-style-type: none"> a. At least 75% of participants rate BaP-Enjoying Family Life with a total TARs score of ≥ 27 b. 55-74% of participants rate BaP-Enjoying Family Life with a total TARS score of ≥ 27 c. <55% of participants rate BaP-Enjoying Family Life with a total TARs score of ≥ 27 	60.72% (n=17) of 28 participants in BaP-Enjoying Family Life arm gave a TARs rating above 27
Secondary progression parameter	BaP-Enjoying Family Life & BaP-Standard Fidelity will be reached	<ul style="list-style-type: none"> a. 80% or more – Good Fidelity b. 60-80% - Fair fidelity, deviation from the manual that may require further training and/or supervisory support c. >60% - Significant deviation from manual, fidelity not reached 	60% (n=6) of the 10 interventions were delivered as intended

minimisation factors as covariates. The alpha was .05 and power .95. The total sample size required was 1,302 completed data sets, and a total sample of 1,452 when considering an attrition of 10%.

Furthermore, it's important to consider the within-group dependency (or intraclass correlation, ICC) in group therapy on sample size calculation using the variance inflation factor Deff (Alimohamadi & Sepandi, 2019; Kivlighan III et al., 2020). Deff is calculated by subtracting the ICC and average number of subjects per cluster ($n=6.6$ parents) (Alimohamadi & Sepandi, 2019). This feasibility study was too small to estimate the influence of group on outcomes in each arm. Meta-analyses of group psychotherapy indicate an average ICC of 0.06 (Kivlighan III et al., 2020). Therefore, the Deff was calculated as 1.34, leading to a variance adjusted estimated sample size of 1,932.

4.5 Discussion

The aim of this chapter was to quantitatively examine the feasibility and acceptability of a pragmatic, superiority RCT methods and initial estimates of likely intervention effects to identify whether further evaluation of BaP-Enjoying Family Life is warranted and to inform the planning of a definitive evaluation. Using pre-specified feasibility criteria, this study finds sufficient rates of recruitment, trial participation and retention to support full-scale RCT of intervention effectiveness after adjustments to intervention implementation to increase acceptability and fidelity assessment are made. Initial estimates of intervention indicate similar change from baseline to time 2 and 3 are found between BaP-Enjoying Family Life and BaP-Standard, with few intervention differences on change in primary and secondary outcomes from baseline. These findings indicate that both interventions show promise in supporting parents with significant emotional and interpersonal difficulties with limited differential effects and lack of

clarity around the superiority of one or the other. Furthermore, sample size calculation indicates that a full-scale superiority RCT would require a large sample size to be sufficiently powered to detect small intervention effects, requiring large research resources and cost to support recruitment. Therefore, whilst a full-scale superiority RCT may be feasible it may not be cost-effective and clinically useful in distinguishing clinical effects of either intervention.

Quantitative data is limited in its ability to evaluate complex research questions and identify further areas for intervention refinement and research directions, whereas qualitative data can support in-depth understanding and problem solving around intervention and trial implementation (Hamilton & Finley, 2019). The subsequent chapters generate an understanding of participant's experiences and integrate quantitative and qualitative findings to make suggestions for a future evaluation and intervention development. Here, the discussion focuses on evaluating the feasibility and acceptability of the trial methods and intervention in the context of previous research.

4.5.1 Summary of feasibility findings and previous research

This feasibility study successfully implemented both community and clinical recruitment pathways to meet recruitment targets, indicating the feasibility of an inclusive, non-diagnostic recruitment approach for the proposed definitive RCT and other studies on parenting support for parents with emotional and interpersonal difficulties (Huang et al., 2018). In this study, there was a lower proportion of parents registering interest from clinical services compared to community pathways, although a greater proportion of those referred from mental health services were eligible and remained in the project. These results indicate that health and social care can be important avenues for recruiting parents with significant emotional and interpersonal difficulties who will remain engaged with a research project, however relying only on

referrals may not lead to sufficient rate of recruitment for a definitive trial, discussed in greater detail in chapters 5 and 6.

Furthermore, most parents who consented to participate were eligible, suggesting the recruitment information shared was able to attract the target population of parents without relying on professional identification. Participant and service user feedback and previous research has raised questions about the viability of using inclusion criteria based on diagnostic status with parents recruited through community pathways (Day et al., 2020). In particular, terms such as personality disorder can be stigmatizing, pejorative and may prevent engagement with the support available due to feeling blamed (Troup et al., 2022; Warner & Wilkins, 2004; Watts, 2019). These findings indicate that non-diagnostic recruitment methods led to sufficient recruitment of the target population and suggest future research on parenting support should consider using an approach centred on parent's experience and recruiting from both clinical and community pathways to increase access for parents with significant emotional and interpersonal difficulties.

Retention of parents in the trial methods was high (90% completing primary clinical outcome at time 2) and was similar to rates of retention found in the original RCT evaluating BaP-Standard's effectiveness (between 79.3% - 99.2% completion of clinical outcomes at time 2; Day et al., 2012) and higher than the feasibility evaluation of Helping Families programme (66.7% completion at time 2; Day et al., 2020). Compared to other parenting interventions (e.g. Triple P (Hackworth et al., 2018)), rates of data completion for BaP-Enjoying Family Life trial are higher. The reasons for high level of retention are evaluated further in chapter 5 and 6.

Despite high retention of participants in data completion of questionnaire measures, the high rates of intervention non-completion (50%) and non-completion of

the observational assessment are concerning. The rates of intervention non-completion are high compared to meta-analyses of interventions for individuals with personality disorder diagnoses (27.7% for BPD; Iliakis et al., 2021 and 37% for any personality disorder; McMurran et al., 2010). Non-completion is also high compared to the original RCT of BaP-Standard (8%; Day et al., 2012) and in the national implementation evaluation (60%; Day et al., 2022), although falls within the wide range seen in non-specialised parenting interventions (ranging from 20-80%; Ingoldsby, 2010; Van Aar et al., 2017; Wilson et al., 2012). The consequences of intervention non-completion in clinical trials are (i) uncertainty and dilution of and intervention effects; (ii) concerns around fidelity, and (iii) costs of cancelling or delivering intervention to lower numbers than intended (Iliakis et al., 2021; Ingoldsby, 2010). Even more concerning, rates of non-completion suggest that individuals who are in need receive lower doses of support. These quantitative findings of high retention and low intervention completion indicate that parents with significant emotional and interpersonal difficulties are open to and actively seeking support but that this support may be more challenging for them to access. The following chapters consider of why this may be (chapter 5) and how to address the high non-completion rates (chapter 6).

Finally, the study indicates further consideration and intervention refinement to improve treatment acceptability and fidelity may be required prior to definitive evaluation. Non-attendance likely contributed to these findings, as per-protocol analysis indicated high levels of intervention acceptability in both BaP-Enjoying Family Life and BaP-Standard for intervention completers, and two groups were cancelled due to low attendance leading to low fidelity scores that did not meet pre-specified thresholds.

The use of the fidelity and treatment acceptability measurement tools may also partially explain these findings. Rates of non-completion for the fidelity measure were

high for some groups, indicating challenges in the implementation and use of the measure. Strategies to address this are discussed further in chapter 6. The treatment acceptability rating scale used has two subscales; knowledge and skills (perceived increase in understanding, skills, confidence and intended use of positive parenting), and facilitation and satisfaction (perceptions of the group facilitators and overall intervention). Facilitation and satisfaction were rated highly for both BaP-Enjoying Family Life and BaP-Standard, indicating acceptability of intervention methods. In contrast, knowledge and skills subscale items were given lower ratings, indicating either parents did not learn any skills or did not learn any new skills. Less improvement in parent knowledge and skills may reflect wider societal rhetoric on childrearing practices (Gillies, 2008) and the permeation of positive parenting ideas and knowledge across the wider parenting advice literature and industry (Lee, 2014), rather than intervention acceptability. Indeed, this finding may reinforce findings from chapter 2 suggesting that parents with significant emotional and interpersonal difficulties do not lack positive parenting skills but struggle to consistently implement them. For these parents, it may be less important for clinical change to learn new skills and more important to improve the consistency of implementing these skills. Future evaluation should assess intervention acceptability by focusing on quality and satisfaction with intervention delivery over obtaining new knowledge.

4.5.2 Strengths and limitations

This feasibility study is the first to evaluate group-based and peer-led parenting support for parents with significant emotional and interpersonal difficulties who have concerns about their child's behaviour. The study's strengths include its use of an active control arm, with similar rates of retention, intervention completion and acceptability across arms. The study also uses a rigorous, RCT design with a high level of control to

evaluate the effect of each intervention. The study was able to balance robust internal validity of RCT design with external validity through using non-diagnostic approach and using clinical teams to deliver the intervention, allowing troubleshooting, and supporting future implementation in clinical practice of the intervention at early stages. However, integrating the requirements of a controlled research study with clinical practice proved challenging and perhaps contributed to missing fidelity data. It is possible that not enough support and training were given to encourage use of the fidelity measure. The challenges in gathering completed fidelity data prevent this study from clearly delineating the delivery of the two interventions, weakening the trial's internal validity and ability to indicate differential estimates of intervention effects. Furthermore, the small sample means the study is underpowered to distinguish differences in the effectiveness of both interventions. It is also a limitation that the study was underpowered to compared baseline differences. It is possible that baseline between group differences may account for differences between interventions and should be accounted for in further studies.

In addition, whilst this study attempted to gather multi-method assessments of intervention effect through using an observational assessment, there was a high level of missing data and as a result a heavy reliance on parent-report outcomes to indicate intervention effects. The high levels of stigma and fear of judgement mean parent-report data is particularly at risk of self-report bias (Morsbach & Prinz, 2006). Whilst there is some observational data available, the opportunistic sampling may mean that the sample is biased and assesses higher-functioning families who were quicker to complete initial approach and consent meetings. Further evaluation of the practicality and acceptability of multi-method research are examined in chapter 6. Finally, the planned unmasking of

the PhD researcher to participants invited to interview may risk bias in data collection at time 3, although this was not the primary endpoint.

4.6 Chapter summary

In summary, this chapter describes the quantitative findings examining the feasibility of a pragmatic, superiority RCT comparing two group-format, peer-led intervention, Being a Parent-Enjoying Family Life and BaP-Standard. The impacts of both interventions were evaluated for two vulnerable populations; parents with significant emotional and interpersonal difficulties and their children aged 2-11 years. The findings indicate further research should be conducted on these interventions for this population after further refinement to some trial methods and interventions are considered. However, similar patterns of effect between the two intervention and the very large sample required to adequately power a definitive trial indicate that progressing to a full-scale superiority RCT trial design may be costly, complex and less clinically useful than research to address and improve intervention completion and fidelity measurement. The following chapter 5 presents findings from a qualitative evaluation to gain an in depth understanding of participant experience of intervention and trial methods. Then quantitative and qualitative data are integrated in Chapter 6 to identify areas for further trial and intervention development.

Chapter 5 Reflexive thematic analysis of participants' experiences of trial methods and interventions

5.1 Chapter outline

This chapter presents the reflexive thematic analysis of 24 semi-structured interviews with parents who participated in the Being a Parent-Enjoying Family Life trial. The chapter aims to generate an in-depth understanding of participants' experiences of trial methods and interventions in order to develop and further refine trial methods and intervention prior to definitive evaluation. The previous chapters present the BaP-Enjoying Family Life intervention development using qualitative evidence of parenting experiences of parents with personality disorder diagnoses (Chapter 3) and highlighted that few studies specifically focus on parenting experience of parents who experience significant emotional and interpersonal difficulties and have children aged 2-12 years (Chapter 2). Furthermore, chapter 4 presents quantitative data evaluating the feasibility, recruitment, retention, and acceptability of the Being a Parent-Enjoying Family Life trial. However quantitative data does not enable exploration of the complex relationships and experiences behind these rates of recruitment, retention, and acceptability.

The MRC framework highlights the value of mixed-methods research in: (i) evaluating interventions to consider contextual influences on outcomes; (ii) supporting the ongoing development and refinement of trial methods and intervention; and (iii) enhancing clinical utility, implementation, and uptake of clinical interventions. This PhD takes a convergent segregated approach to mixed-method evaluation, where qualitative and quantitative research are conducted separately and simultaneously, before being synthesized to address the research's key uncertainties in chapter 6. This chapter presents the rationale, methods, and results of a reflexive thematic analysis of

participant experiences. The discussion begins to explore possible implications, which are developed further in the mixed-methods synthesis outlined in chapter 6.

5.2 Introduction

There are many quantitative research studies demonstrating the efficacy of parenting interventions on child outcomes in controlled research settings (Mingebach et al., 2018). However, implementing these programmes in real-world settings can be challenging due to systemic, organisational, programme, and individual characteristics (Cooper et al., 2022). The MRC framework emphasizes the importance of understanding these contextual influences on intervention development, evaluation, and implementation (Skivington et al., 2021). Qualitative research is critical in: (i) understand these contexts; (ii) answering complex research questions on trial and intervention implementation; (iii) identifying barriers and facilitators of trial participation and intervention engagement; and (iv) supporting problem-solving to further develop and refine trial methods and the intervention (Hamilton & Finley, 2019). Therefore, this PhD includes a qualitative evaluation to generate an in-depth understanding of participant experiences of trial methods and intervention to inform further development and refinement.

Previous qualitative research has been conducted on parents' experiences and perceptions of parenting interventions (Butler et al., 2020) and the barriers and facilitators to implementing parenting interventions in real-world settings (Cooper et al., 2022). A recent meta-synthesis of qualitative research identified three themes which were influential in parent experience, engagement with and the acceptability of parenting interventions for parents of children aged 0-16 year olds (Butler et al., 2020). These were (1) how well the intervention fits with their family's journey, (2) valuable facilitator characteristics, programme content and delivery and group-delivery, and (3)

contextual barriers, fear of judgement and lack of support from extended family and partners. Similarly, Cooper et al.'s, (2022) meta-synthesis of the barriers and facilitators to the implementation of interventions for parents of children aged 0-12 years identified that the provision of quality childcare and the client's characteristics and perception of the programme were particularly important for facilitating engagement. Community and peer-support, shared experiences of learning, identification with parent group leaders and non-judgemental environments have been identified as particularly important in participants' experiences of peer-led parenting interventions (e.g. Kearney et al., 2020). However, these facilitators and barriers were identified in studies of general parenting interventions. It is important to consider whether the same facilitators and barriers exist and how they impact experience for parents with significant emotional and interpersonal difficulties.

Few qualitative evaluations of parenting interventions for parents with significant emotional and interpersonal difficulties have been carried out. These evaluations identified the importance of role-plays and trying strategies out with other mothers with BPD (Renneberg & Rosenbach, 2016) and qualities of the facilitators which supported help-seeking and participation (Day et al., 2020; Wilson et al., 2018). As a result of the programmes, mothers reported being better able to cope with their feelings and stress, feeling less tension in interaction with their child and being calmer (Renneberg & Rosenbach, 2016). However, these qualitative evaluations of interventions tend to focus on mothers with BPD with children aged 3 or below. The interventions evaluated were either 1-to-1 programmes (Wilson et al., 2018; Day et al. 2020) or adapted DBT groups (Renneberg & Rosenbach, 2016), rather than peer-led group support. The qualitative evaluations were also low in their methodological quality, being mainly descriptive with none of the evaluations clearly defining their

underlying theoretical assumptions and reflexivity, increasing the risk of bias from the researcher's subjective assumptions. Finally, none of the evaluations recruited and explored views from participant's who were unable to engage with the interventions. This prevents clear identification and evaluation of the barriers to attending interventions for parents with significant emotional and interpersonal difficulties.

Previous qualitative evaluations of parenting support often include interviews with practitioners alongside parents (e.g., Wilson et al., 2018; Gray et al., 2018). Individuals with personality disorder diagnoses often describe experiencing stigma and invalidation by professionals (Wilson et al., 2018), and there is a risk that the researcher's analysis is influenced by practitioners' views. Furthermore, interviews with practitioners can be helpful for identifying organisational and programme facilitators and barriers which can impact implementation, scalability and transferability across contexts. However, BaP-Enjoying Family Life was adapted from BaP-Standard, a well-established intervention that has demonstrated scalability and transferability across a number of different settings (Day et al., 2022). At the current feasibility stage of development, there was greater uncertainty around the adapted intervention's acceptability within a new target population and how participant factors may have influenced accessibility, recruitment, retention, and engagement with the intervention. Interviews with practitioners on intervention impacts would have introduced a second layer of subjective assumptions and biases which are unlikely to have added significant clarity to identifying barriers and facilitators to trial engagement. Therefore, this study focuses on gaining an in-depth understanding of participants' experience and does not include practitioner perspectives.

5.2.1 Ontology and epistemology

This qualitative analysis was conducted as part of a wider mixed-methods evaluation of Being a Parent-Enjoying Family Life. Whilst a mixed-method approach enables PhD researchers to view a problem from multiple different lenses, at the heart of mixed-methods approaches there are fundamental ontological (theories of what is real) and epistemological (theories of meaningful knowledge and knowledge production) contradictions (Blackwood et al., 2010). Namely, RCTs and quantitative effectiveness research maintain the positivist assumption that the observed changes in outcomes are due to the researchers' manipulation. In direct contrast to positivist assumptions about validity and "truth"-seeking, qualitative research is underpinned by a scepticism of cause and effect and a focus on the relativism of human behaviour (Blackwood et al., 2010; Fletcher, 2017). The constructivist and relativist approaches, commonly used in qualitative research, view reality as entirely constructed and dependent on social, historical, and contextual factors (Fletcher, 2017). Navigating these ontological contradictions can be complicated and the philosophical approach taken should be clearly articulated as it informs methodological decisions, analysis, and interpretation.

This PhD adopts a critical realist ontology and epistemology as the philosophy can offer an ontological framework that accommodates both positivist assumptions of quantitative research and relativist assumptions of qualitative research (Blackwood et al., 2010). Critical realism assumes there is a real social world which can be objectively observed, but that this observation is shaped by personal, social, historical, and cultural frames (Mukumbang, 2023). Critical realism is appropriate for this mixed-methods research as it values both quantitative and qualitative data as empirical knowledge whilst also considering both the influence of context and the participants' and the researcher's interaction on the data collected (Mukumbang, 2023; Fletcher, 2019). The

PhD researcher considered the data at the empirical level (as reported by the participant) whilst also being critical of the influence of their own and the participants' contexts and beliefs, and the interaction between the interviewer and interviewee on the construction of experience (Fletcher, 2017).

5.2.2 *The current study*

This qualitative study aimed to develop a fine-grained understanding of participants' experience of trial methods and intervention acceptability, implementation, and impact to inform further development and modification to trial and intervention. The qualitative evaluation of BaP-Enjoying Family Life is novel in aiming to gain an in-depth and interpretive understanding of the participants' lived experience of a peer-led group parenting intervention for parents with significant emotional and interpersonal difficulties. Furthermore, the evaluation aims to capture experiences of both trial methods and intervention from not only participants who could, but also those that could not, attend the intervention to support further development and refinement of trial methodologies and intervention. The focus on parents' experiences can increase the study's clinical utility in engaging and increasing access for a population of parents whose needs are often not addressed in services; who may experience distrust of professionals; and who avoid accessing parenting support due to fears of judgement. The specific research question is:

What were participants' lived experience of the Being a Parent-Enjoying Family Life feasibility RCT trial methods and intervention?

5.3 Method

5.3.1 *Design*

Qualitative semi-structured interviews were conducted with a sub-sample of parents who consented to participate in the BaP-Enjoying Family Life trial. Semi-structured interviews enabled the PhD researcher to flexibly ask and address topics whilst remaining focused on the over-arching study purpose (Flick, 2017; Fylan, 2005).

5.3.2 Participants

A purposive sample of 24 parent participants was recruited from both intervention and control arms of the trial for semi-structured interview. Purposive sampling involves selecting participants because they may be especially knowledgeable about a phenomena of interest (i.e. information rich), as well as available and willing to participate and able to communicate their experiences (Palinkas et al., 2015). Palinkas et al., (2015) highlight several different approaches to purposive sampling, broadly categorized into (i) emphasis on similarity, (ii) emphasis on variation and (iii) non-specific emphasis. This study chose to emphasize variation by purposively sampling parents from each intervention arm of the trial and sampling was based on attendance (ineligible, low attenders (<5 sessions), high attenders (≥ 5 sessions)) to ensure representation of varied experiences of trial participation. The emphasis on variation was guided by the broader purpose of the research in informing future developments, making modifications to both trial methods and interventions, and helping answer key uncertainties of the trial. By inviting ineligible participants and participants from both BaP-Enjoying Family Life and BaP-Standard, the analysis could identify shared and varied meaning and lived experience related to the acceptability of the trial methods and both interventions. Similarly, by inviting low and high attendees, the analysis identifies common and varied barriers and facilitators of attendance which may be salient to the feasibility of trial methods and intervention implementation in clinical settings.

5.3.2.1 Sample size

In qualitative research, sample size is determined by the concept of “data saturation,” defined as the point at which no new information or themes are observed in the data (Malterud et al., 2016). However, meeting data saturation is not well reported in qualitative studies, and it can be challenging to identify when data-saturation will be reached prior to recruiting participants. It is estimated that between 10-12 participants are needed to reach saturation in homogenous groups (Boddy, 2016). As there were two treatment groups, a sample of 24 was deemed to be appropriate to allow for sufficient saturation of themes regarding trial and intervention experience and acceptability.

5.3.2.2 Participant demographics

Table 18 identifies the participant IDs, attendance, and group of the participants interviewed. Two of the 24 parents interviewed were ineligible for the trial and did not complete questionnaires capturing demographic information. Here the whole sample demographics are also presented to protect participant anonymity. Mean parent age was 38 years (SD= 7.8 years, range 26.5-58.1 years), with 20 female and two male parents interviewed. The ethnicity of the parents interviewed was predominantly white (27.27%, n= 6) or White British (31.81%, n=7), with three (13.64%) parents from Black or Black British Caribbean, one (4.55%) from White and Black Caribbean, one from Black or Black British African, one from Chinese, one from mixed and two (9.09%) from other ethnic backgrounds. 18.18% of parents interviewed were full-time employed, 31.81% were part-time employed, 13.64% looking after home, 18.18% unemployed and 18.18% other. 36.36% (n=8) were currently receiving mental health support and 22.73% of parents had previously attended a parenting support group. 59.09% of index children were male, and mean index child aged was 4.5 years (SD-2.13 years, range- 2-9 years).

Table 18. Participant IDs, group attendance and relevant demographics

Participant ID	Group & Attendance	Number of sessions	Gender	Child age	Household composition
Participant 1	Ineligible	0	Female		
Participant 2	Ineligible	0	Female		
Participant 3	BaP-EFL high	5*	Male	3	One parent with child
Participant 4	BaP-EFL high	9*	Female	2	Couple with children
Participant 5	BaP-EFL high	9*	Female	5	One parent with child
Participant 6	BaP-EFL high	7*	Male	9	One parent with children
Participant 7	BaP-EFL high	6*	Female	2	Couple with children
Participant 8	BaP-EFL low	4*	Female	5	One parent with children
Participant 9	BaP-EFL low	0	Female	3	Couple with child
Participant 10	BaP-EFL low	3*	Female	6	One parent with child
Participant 11	BaP-EFL low	0	Female	2	One parent with children
Participant 12	BaP-EFL low	2	Female	8	One parent with child
Participant 13	BaP-EFL low	0	Female	2	Couple with child
Participant 14	BaP-S high	6	Female	5	One parent with child
Participant 15	BaP-S high	8*	Female	3	Couple with child
Participant 16	BaP-S high	6*	Female	5	Couple with children
Participant 17	BaP-S high	8*	Female	2	Blended family with children
Participant 18	BaP-S high	7*	Female	6	Couple with child
Participant 19	BaP-S high	7*	Female	7	One parent with child
Participant 20	BaP-S low	2*	Female	6	Couple with child
Participant 21	BaP-S low	1*	Female	7	Couple with children
Participant 22	BaP-S low	0	Female	2	One parent with children
Participant 23	BaP-S low	0*	Female	5	One parent with child
Participant 24	BaP-S low	0	Female	6	One parent with children

*attended coffee morning

5.3.3 Procedure

Informed consent for semi-structured interviews was sought as participants entered the BaP-Enjoying Family Life trial prior to eligibility assessments.

5.3.3.1 Sampling method

The method of purposive sampling was determined by considering the most feasible, ethical, efficient, and practical approach, as outlined by Palinkas et al. (2015).

A single invite opt-in approach for ineligible parents was chosen due to ethical considerations of the potential distress caused by being informed of ineligibility. For participants who were eligible for the trial, purposive sampling used a matrix to guide selection of equal proportions of high and low attendees from each BaP-Enjoying Family Life and BaP-Standard arms. The unmasked PhD researcher (JT) generated the matrix and organised participant IDs into high and low attendees from each BaP-Enjoying Family Life and BaP-Standard arms. Participant IDs were added to this matrix and JT used a random number generator to select a proportion of IDs from each matrix box to send through to the PhD researcher.

One BaP and two BaP-Enjoying Family Life parents self-identified as interested in the interviews in email correspondence with the PhD researcher during the post-intervention data collection period. The research team had chosen not to rely on self-selecting participants as this may reduce the size and variation in the sample. However, volunteering to participate indicated to the PhD researcher these parents may be “information rich.” There were also ethical concerns about not capturing feedback from willing participants. The participant IDs (self-selecting and purposively sampled) were fed back to JT and accounted for within the purposive sampling matrix to inform sampling for the subsequent cohort.

The target number of participants interviewed for each cohort was determined based on the target sample and how close the data seemed to saturation. The proportion of participants invited from each box of the matrix was determined by dividing the *cumulative* target number of interviewees (i.e., the number of participants who were interviewed in previous cohorts plus the number of intended interviewees this cohort - January n=12, April n=20, September n=24) by the total *cumulative* sample, including participants who repeated T1 (January n= 31, April n= 55, September=71). To identify

the remaining number of parents that needed to be invited from the new cohort to meet the target proportion, the cumulative number of parents to be invited from each cell to meet this proportion was calculated, and the number of parents from previous cohorts who had already been interviewed from that cell was subtracted.

5.3.3.2 Interview methods

Ineligible parents were invited to participate in feedback interviews in the post-consent meeting email. Of 32 ineligible parents invited to opt in, two agreed to participate. Ineligible parents were offered the opportunity to give feedback to someone other than the PhD researcher who had conducted the consent appointments to reduce any distress and conflict parents may feel after being told they are ineligible for the trial. One parent said they preferred to be interviewed by the PhD researcher and the other parent preferred to be interviewed by another PhD researcher (NK) who was familiar with the broad research aims and used the same topic guide. All other interviews were conducted by the PhD researcher. A maximum of four attempts were made to contact and invite parents to interview. Twenty-two of 29 invited agreed to participate in semi-structured interviews, four did not respond to any time 2 data collection, and three did not have time to complete interview alongside the questionnaire.

Participants who were invited to interview were reminded of the study aims, re-sent the information sheet, and asked if they were still willing to participate in the interviews. Semi-structured interviews of between 6 minutes – 1 hour 12 minutes occurred in person and online in a quiet location where the participant felt comfortable (e.g., the participant's home). To support childcare and prevent children from being present during interviews, the PhD researcher had intended that the timings of the interview would be during school hours or after child bedtime. However, parents'

schedules did not always allow for this, and for three of interviews one or two children were present.

A semi-structured topic guide (Appendix U), developed with PPI input based on the trial's key uncertainties identified during planning stages, was used to guide the interviews. Three different schedules were developed for ineligible participants and participants in the intervention and control arm. For eligible participants, open questions organised under two topics: (1) Trial implementation and acceptability and (2) Intervention implementation, and seven subtopics: 1.1 Recruitment; 1.2 Randomisation; 1.3 Data collection; 2.1. Engagement and attendance; 2.2. Intervention acceptability; 2.3. Intervention content; 2.4. Impact. The differences in BaP-Standard and BaP-Enjoying Family Life topic guides were superficial (i.e., change names) and additional questions introduced on BaP-Enjoying Family Life topic guide to evaluate the acceptability of the new content and structure. For ineligible participants, one topic (trial acceptability) and three sub-topics (1.1. Recruitment, 1.2. SAPAS screen and 1.3 follow up) were used to organise open questions and probes. Two PGLs from the studies stakeholder involvement group were sent guides for feedback and determined the guides were suitable. The topic guides were not piloted with participants as the PhD researcher was confident in their interview technique, relationship with participants and the relevance of the questions after stakeholder feedback. Furthermore, the inductive, reflective, and dynamic interview approach taken, in line with the analytic approach, allowed adjustments based on PhD researcher's initial themes and piloting was not deemed necessary. At the end of the interview, participants were given the opportunity to ask questions. Participants were reimbursed £10 for their time.

Data was recorded on an encrypted device (iPad) with the Wi-Fi access turned off to prevent automatic upload to cloud software. Completed recordings were manually

uploaded onto password-protected computers and deleted from recording devices once transcribed. To preserve anonymity, participant numbers were assigned to each participant to identify the interview transcript, and pseudonyms were used in interview transcripts where participants mentioned names, places or any other identifiable information. Interviews were securely transferred in line with Data Protection Act and transcribed verbatim using an online transcription service (Clearvoice transcription). Data was analysed using NVivo-10.

5.3.4 Analysis

The study is underpinned by a critical realist philosophy and takes a phenomenological approach, emphasizing the participants' subjective experiences and sense-making whilst being critical of the influence of participant and researcher's contexts and interaction (Braun & Clarke, 2021a; Roulston & Choi, 2017). This study was interested in patterns of experience across the dataset rather than on an individual basis such as in an Interpretative Phenomenological Analysis approach. In addition, the PhD researcher was heavily involved in intervention development and data collection and their subjective influence on the participants' experience is important to consider (see section 4.3.5 on reflexivity). Coding reliability and codebook approaches to thematic analysis use structured procedures and codes to identify patterns across data to reduce bias introduced from the researcher, whereas reflexive thematic analysis embraces the researcher's subjectivity and reflexivity in the generation of themes (Braun & Clarke, 2023). The inductive and interpretative nature of Reflexive Thematic Analysis fitted the research purpose to identify areas for further trial method and intervention development and it enabled the PhD researcher to identify and reflect on their own assumptions. Therefore, reflexive thematic analysis was selected as the most appropriate methodological approach for this research.

5.3.4.1 Reflexive thematic analysis

Reflexive thematic analysis was inductive, aiming to represent patterns in participants' experiences. Analysis followed the phases laid out by Braun & Clarke (2006, see Table 19), with the PhD researcher iteratively moving between phases over time. All data was coded, and all codes were noted. Analysis was semantic (reflecting the explicit meaning of the data) as opposed to latent (going beyond the surface meaning to identifying underlying assumptions) in line with the philosophical approach, with data organized to show, and then interpret, patterns in semantic content.

Data collection occurred alongside analysis, with the PhD researcher keeping a project journal to note down ideas and reflections as they arose and using these to shape subsequent interview questions. Data transcription had not been included on the initial consent documents and the PhD researcher had to obtain consent prior to sending the recordings to a transcription service, leading to a delay between the first interview (April 2022) and initiation of coding (October 2022). Therefore, adjustments to interviews for participants from cohort 2 of the parenting groups were guided by patterns observed by the PhD researcher whilst interviewing and recorded in their reflective journal, whereas cohort 3 were informed by coding and theme generation. The PhD researcher generated initial codes as data was collected and transcribed (from October 2022 - February 2023) in groups of six interviews until all 24 transcripts were coded. The initial codes generated by the PhD researcher were numerous and closely reflected the participant's language, demonstrating the PhD researcher's closeness to the data and the valuing of each participant's individual stories. The codes reflected the PhD researcher's lack of confidence in their ability to determine broader codes across a varied dataset and the PhD researcher's desire to ensure every participant's voice was heard. Initial codes with similar meanings were condensed to 180 codes once all 24

Table 19. Thematic analysis phases (adapted from Braun & Clark, 2006)

Phase	Description
Phase 1	Familiarization with the data through re-reading and free coding the interview transcripts Transcription was checked against the tapes for accuracy and given pseudonyms at this stage.
Phase 2	Line-by-line coding of each transcript Each data item was given equal attention.
Phase 3	Generation of themes from the line-by-line coding An interactive process using maps and tables was used to think about relationship between codes and themes.
Phase 4	Reviewing of themes in comparison with the coded extracts Internal homogeneity and external heterogeneity were be checked to establish whether data within themes cohere together meaningfully and are demarcated from other themes. This will be done at 2 levels: 1) all codes and extracts will be reviewed and consider whether they form a coherent pattern and 2) each individual themes validity in relation to the data set will be considered.
Phase 5	Refining and organization of themes into an internally consistent structure. The essence of each theme and the aspects of the data captured will be identified and fitted into a broader overall story.
Phase 6	Writing of interpretation and thematic framework This phase involves going beyond the description to make an argument in relation to the research questions.

transcripts were coded.

The PhD researcher generated initial themes after completing coding for the first groups of six transcripts. Initial themes were generated by printing out codes from NVivo; cutting up codes and placing them on a large table; and then creating a map of clusters of codes with a common meaning and signalling inter-relationships between codes. Finally, the PhD researcher created a list of codes under rough themes in a Word document. This process was repeated with another group of six transcripts and then the 12 remaining transcripts until all 24 transcripts were coded and themes generated through integrating initial, new and renamed codes identified from subsequent coding.

Themes were presented and discussed with PhD supervisors (CD and PS) throughout analysis. In reflexive thematic analysis, a theme captures patterns of meaning anchored by a shared idea or core concept, whereas domain summary themes are organized around a shared topic but not shared meaning (Braun & Clarke, 2019, 2023). The PhD researcher's initial themes were very descriptive and linear, organizing participants' experiences based on the "key events" of the trial (e.g., finding out about the project, randomisation). Organising the data in this way helped the PhD researcher identify patterns in the meaning assigned to these key events (e.g., connecting with others, relating to trial methods and intervention). However, the subsequent themes were still very descriptive and focused on different experiences in relation to one phrase (e.g. choice, information sharing) which resembled a more domain-focused analysis (Braun & Clarke, 2019). Through discussions with supervisors, the PhD researcher began to focus on the meanings participants assigned to the event rather than the event itself. Returning to the quotes and coded extracts helped the PhD researcher consider the different meanings that participants assigned to the event. Writing key definitions of the themes helped the PhD researcher to refine the essence of each theme.

Once the PhD researcher believed she had had generated themes of common meanings, a participant reflections meeting was held to hear participant reflections on the themes prior to writing the thematic framework into a coherent results section. Participants' reflections supported the general themes and meanings generated by the PhD researcher and identified changes to the language and structure of the themes. For example, the term "relating" was used by most parents for the first theme presented and described how well their experiences fit the project and others in the course, rather than an appraisal of value. Appendix V further details changes to the structure of themes and subthemes identified after participant reflection meetings.

5.3.5 *Reflexivity*

Critical realism and reflexive thematic analysis highlight the role of the researcher, research team, and their implicit ideologies on the analysis process. Practicing reflexivity was important throughout data collection and analysis in acknowledging the role of the researchers' assumptions. The PhD researcher is a female White British Psychology PhD student in her mid-twenties with no children. She has previous experience clinically supporting adults with complex PTSD, psychosis, and children with social communication difficulties. From her clinical work, she has interests in trauma adversity and how this impacts development, and she strongly believes in the importance of understanding an individual's behaviours, thoughts and affect in the context of their past and current experiences. These experiences and empathic approach facilitated relationships with the participants and identification with their individual stories which made identifying patterns across the dataset challenging for the PhD researcher. She has limited experience of qualitative methods, so, to support her understanding of qualitative research and reflexive thematic analysis, she attended a training session at King's College London and an additional online training session provided by [Braun & Clarke \(2021\)](#).

The PhD researcher was heavily involved in study design and selection of measures in collaboration with the chief and co-investigators, and she independently conducted recruitment and data collection. She also edited and developed the Being a Parent-Enjoying Family Life manual. Participants were unaware of the PhD researcher's role in intervention development and attempts were made to distinguish the PhD researcher from the clinical teams who deliver the intervention. The sense of responsibility felt towards participants (see subtheme 2.1), motivation to develop and improve support for parents and their children (in line with the research aims) and

awareness of their learning process enabled the PhD researcher to be open to both positive and negative feedback and participant experiences. The PhD researcher kept reflective records throughout interviewing and data analysis to record thoughts, assumptions, and concerns which came up during the process. Supervision helped to identify and discuss the researcher's assumptions.

The PhD researcher was supervised by Prof. Crispin Day and Prof. Patrick Smith. Prof. Day is head of the clinical teams delivering the EPEC interventions and has been heavily involved in developing and evaluating peer-led and specialist parenting interventions. He has previous experience of research involving parents with significant emotional and interpersonal difficulties and qualitative research methods. Prof. Smith is the research director for the IoPPN Clinical Psychology doctorate and his research interests are in the aetiology and treatment of trauma reactions in children and young people. Both Prof. Day and Prof. Smith are White Male Clinical Psychologists, and Prof. Day is a parent. NK and JT supported the sampling and interviewing with an ineligible parent. Both are White British Females who work as PhD researchers within a research unit that supports service evaluation and research for the clinical teams delivering BAP-Standard and Helping Families Programme. NK is also a parent.

5.4 Results

Using Reflexive Thematic analysis, the PhD researcher generated four themes and nine subthemes (See Figure 10 for themes, subthemes, and emerging concepts summarising clusters of codes, and Appendix W. for themes, subthemes, emerging concepts and codes). Theme 1, relating to the trial and intervention, consists of four subthemes and encapsulates parents' sense-making about the ways in which they connected, or did not connect, their individual experience to the trial's methods,

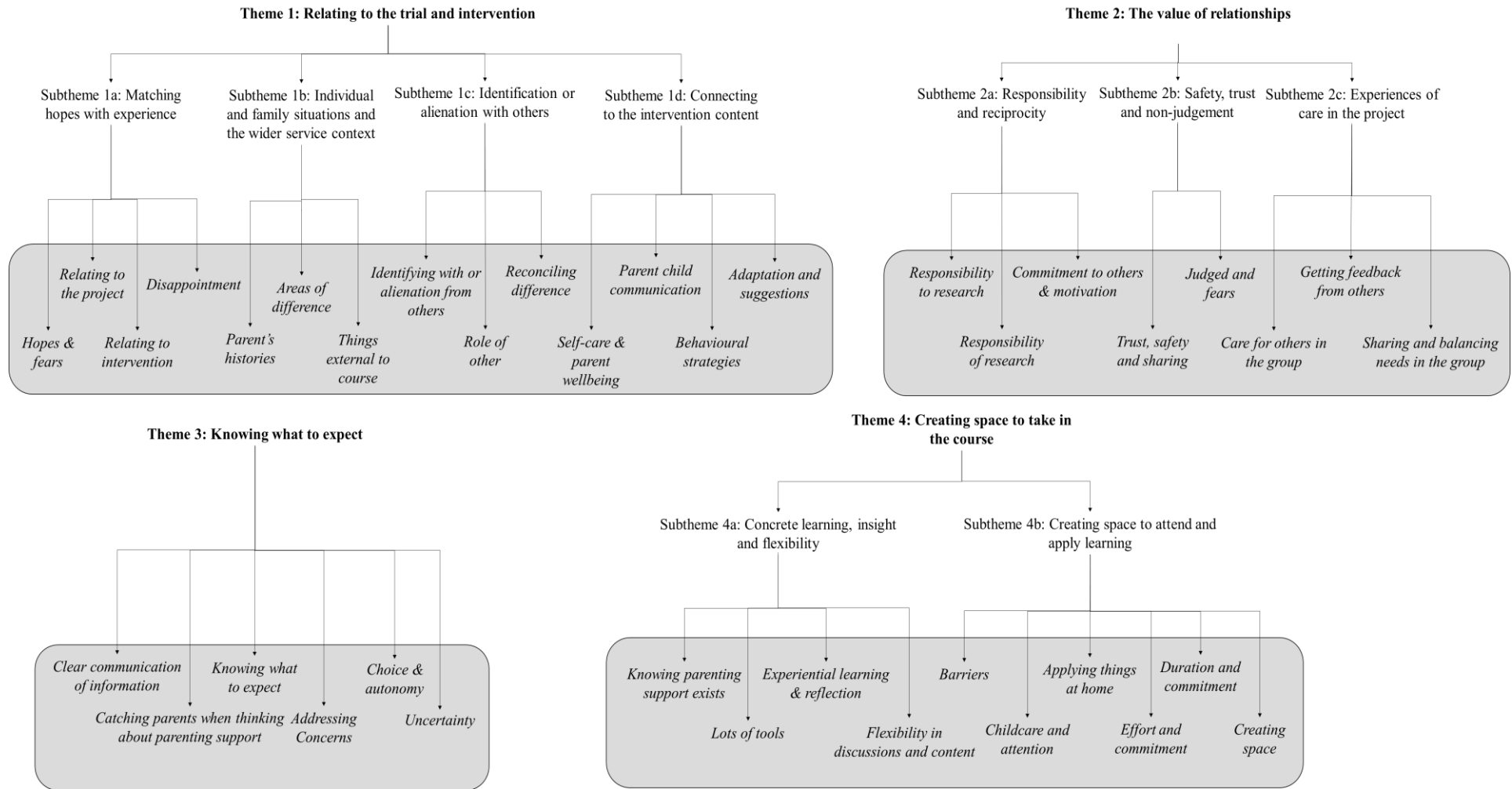


Figure 10. Themes, subthemes, and emerging concepts in grey boxes generated through reflexive thematic analysis. The emerging concepts are interpretive titles given to clusters of codes identified during analysis.

interventions, and other intervention participants. Theme 2, the value of relationships, emphasises the role and qualities of the relationships that were central to parents' experiences of the intervention and trial methods. Theme 2 consists of three subthemes. Theme 3: Knowing what to expect reflects parents' descriptions of communication, autonomy and choice around trial and intervention participation. Finally, Theme 4, creating space to take in the course, refers to parent's engagement with the trial, including their experience of learning, and effort and commitment required to attend and apply learning from the course. Theme 4 includes two subthemes. All names included in quotes are pseudonyms.

Theme 1: Relating to the trial and intervention

Parents made sense of their experience of the research methods, intervention and interaction with others within the context of their individual hopes and needs, their individual and family situations, and their experiences in the wider environment. Parents' descriptions included both active experiences of relating to others and the intervention content (i.e., I related to it/them) and passive descriptions of how the course aims and content related to their situations (i.e., it related to me). The experience of relating was based on perceived similarities or not in their hopes and concerns, individual and family situations, and previous experiences. Subtheme 1A, matching hope with experience, reflects parents' experience of relating their personal and family hopes to their ongoing experience of the trial's methods and interventions. Subtheme 1B explores how the situational features of parent, child and family context impacted the experience of connecting with the trial methods and intervention. Subtheme 1C identifies parents' experiences of relating to or alienation from other parents in the group. Subtheme 1D describes parent's experience of connecting the intervention content back to their situations.

Subtheme 1a: Matching hopes with experiences

Parents' hopes and fears shaped their experience of how they related to the trial aims and how relevant the research felt to them across all trial stages. This subtheme emerged from the analysis to suggest that many parents engaged in an ongoing appraisal of the extent to which the trial methods and intervention matched their personal hopes and fears, including concerns about their parenting, the challenges they experienced with their children and their motivations for the course.

*So particularly the fact that it was erm aimed at parents that have, I can't remember what the phrasing was, difficult, strong emotions, that have strong emotions. Yeah, that felt like it was [background noise] sort of encapsulates what I was experiencing at the time, which was just feeling very distressed by spending time with my own child, essentially. **Participant 4, BaP-EFL high***

*I wanted to do it because at the time it was really difficult dealing with my daughter [laughing]. She was having a lot of like intense emotions, and I didn't really know what to do and it kind of felt like I tried everything. **Participant 14, BaP-S high***

*[It] was really interesting to me, because it was, like, parenthood support where we can be completely honest and say, 'Look, this is the thing that we're finding really, really hard and, you know, let's all figure this out together'. So, I was up for it, particularly for that reason.' **Participant 23, BaP-S low***

Some parents described immediately identifying with the course aims, and many described the relevance of, and relating to, the research questionnaires.

*I didn't understand exactly what it was, but that it was for us was absolutely clear **Participant 7, BaP-EFL high***

*[The questionnaire] is very relevant because we were living all the questions, we actually lived them **Participant 6, BaP-EFL high***

Parents' hopes and fears also shaped their preferences, or lack of preference, for allocated intervention and format of delivery (online or in person). For many, the appealing characteristics of both groups (e.g., peer-led, with other parents and focused on the child) meant the outcome of randomisation was less relevant to them. For others, hopes for targeted support led to experiences of either disappointment or happiness with their allocated intervention.

I was kind of just excited because you said it had been, it was led by people who were parents, who are parents, and everybody was there for the same reason. Participant 14, BaP-S high

It was all about kids in some way or another, wasn't it? Participant 6, BaP-EFL high

I wanted the group that dealt with both parent and child. Yeah, so I was just kind of happy that I got the group that I did to be honest. Participant 8, BaP-EFL low

In-person delivery format was preferred by many parents because of their hope for connection. For some, commitments such as work narrowed their choice. The help-seeking underlying their hopes and fears meant that the delivery format became less relevant.

Um, they give us the option of kind of face to face or zoom, and I think you know, I do believe it worked out I would have loved to have done the face-to-face groups, but just kind of logistically working around workwise and stuff like that. Participant 15, BaP-S high.

There was variation in parents' descriptions as to how well the research and course met their hopes and needs. For some, the research and allocated intervention only partially met their needs. For others the project had little impact on them or their family.

I think I appreciate the opportunity, like I said, even some of my specific comments on the course, say a little bit, were a little bit mixed for me personally, overall, I enjoyed it Participant 3, BaP-EFL high

Failure of the research and parenting course to match parents' hopes could lead to disappointment, uncertainty, or mixed feelings. For example, one parent described the disappointment of finding out that they were ineligible.

So even though I know you said that you would sign post me at the beginning to different places, I think I had my heart set on being on it. So not being on it made me feel really disappointed because it felt like I wasn't able to tell you how much difficult times I had with her, or sort of still have with her, really. Participant 2, Ineligible.

For one parent who declined the intervention, the course not matching their hopes helped her identify the areas in her family life which needed to change.

Well, that's a big thing, I need to change that. I need to enjoy spending time with my child. Okay, like, how do I do that? I don't think I do that by going to

this course. So, erm, yeah, that was, no, that was a real, that was life changing. **Participant 21, BaP-S low**

Subtheme 1b: Individual and family situations and the wider service context

In addition to their hopes and fears, analysis identified different situational characteristics and wider service contexts which influenced their experience. Personal and family situations included both current and historical experiences, such as addiction and mental health difficulties and past relationships with their own parents and partners.

I didn't even know me after 33 years of addiction and suddenly, I've got a child and I'm trying to teach them skills that nobody ever gave me, **Participant 6, BaP-EFL high.**

Oh, my God. Like, I feel like I've missed so much of who you are. While I was in this relationship with this person, **Participant 5, BaP-EFL high**

Anxiety and depression, I think it clouds my judgement in the fact that I know what I'm talking about, or I know what I'm doing. **Participant 17, BaP-S high**

Current characteristics included parent gender; age; co-parenting arrangements; parent neurodiversity; child age; child diagnosed or suspected neurodiversity; and number of children. Although the specific impact of these historical and current characteristics was unique to each individual, analysis identified two common ways in which these individual and family situations affected their experience of the trial: how parents related to others, detailed in subtheme 1.3, and how the intervention content related to the parent's and their family situation, detailed in subtheme 1.4.

And, even with the strategies, it just doesn't work. But I think because the other women had children that were younger, and also, they probably don't have an idea about ADD **Participant 17, BaP-S high**

Parents' previous experiences of parenting support and services outside of the project could also shape parents' experiences of the trial, recruitment, and perceived value of the project. There was variation in parents' knowledge and awareness of parenting support, how to access it, and who it was for. For those who had tried to access parenting support before, they described “*services are under extreme pressure*” (Participant 13, BaP-EFL low), with “*waiting lists everywhere*” (Participant 7, BaP-EFL

high). There was often a lack of continuity and consistency between services offering mental health and parenting support.

*It was only because when I was diagnosed with borderline personality disorder, and I wanted some sort of therapy to help. It was the lady at [mental health service] who said that she thinks I could do with Early Help. But Early Help didn't think I really needed that. But she helped me with my housing and stuff, and all, so it wasn't useful to my situation. **Participant 10, BaP-EFL low***

Schools were identified by many as important for understanding the family's situation and recommending appropriate support. However, sometimes schools offered support which did not feel relevant to their situation or meet their needs.

*They're [school] very well placed to notice what's going on. Erm and kind of take that as their role as part of the community rather than just an education provider **Participant 16, BaP-S high***

*my school is a very predominantly middle-class school, and I feel like there's other parents in the midst of that that get a bit lost. **Participant 5, BaP-EFL high***

The lack of perceived relevant support meant that it was upsetting if the course did not meet their needs.

*I found it quite upsetting because I think, in my mind, I knew I was -- I would probably really benefit from that because of the lack of what's available. **Participant 2, Ineligible.***

Some parents were able to get their needs met by experiences outside of the course, for example through paediatric assessment, receiving diagnosis, or changing schools. These experiences either enhanced the impact of the course or made up for the course not meeting parent's needs in some way.

*it's got better since he went to this new school. It helped for the simple reason because Danny was getting sort of therapy all day at school,[...]. I'm not saying it was all the group, because it was the school helped as well as what I was learning from the group, **Participant 6, BaP-EFL high***

*Also, you don't want to label your kids having ASD, if it's not that, and it's a trauma response, or it's something else you know. But it's very hard to own it, because you have to wait so long. [...] But having that pre-assessment and even being on the waiting list, and getting access to some thing's kind of just, just enabled me, it just has really changed everything in our house, a lot. **Participant 23, BaP-S low***

Subtheme 1c: Identification or alienation with others

The analysis revealed that identification with the PGLs, the PhD researcher and other parents in the intervention shaped participants' trial engagement and experience. Identification was based on perceived similarities in goals, experiences and concerns. The shared characteristics that facilitated identification varied based on the role of the other in the relationship. For example, it was not important that the PhD researcher shared parent's parenting concerns for identification to occur and for parents to feel able to share.

No, good, it's. If we would not be on the same wavelength. I would not talk to you like that. Participant 7, BaP-EFL high

During the intervention sessions, identification with other parents was based on similarities in perceived hopes, experiences and concerns. This helped to normalise and validate parents' concerns, reduce isolation, and enabled vulnerability and sharing. Sometimes identification meant that parents did not feel the need to share as the other person already understood them.

It's just so refreshing to to, you know, have the dad after me go. Yeah, everything that Sophie said, you know, I need to shout less. I need to regulate my emotions better. And I was just like, Oh my God, I'm not the only one. I'm not the only one that's a horrible person to their daughter, you know, or their child, um, and that that instantly just felt, you know, like a huge burden lifted off me. Participant 15, BaP-S high

One of them, she has been in the same shoes. Like I'm now in the same situation. Just that her kids are 10 years older than mine. So, it was immediately that connection. Oh, you have PND too Okay, Good. I don't have to explain how it feels because yeah. Participant 7, BaP-EFL high

Identifying with PGLs lived experience of having previously attended the parenting group, their parenting concerns, and perceived similarities to the PGLs parenting situations helped some parents to feel understood. It also provided hope and facilitated group bonding.

They had a really good understanding of what it was we were going through and what our frustrations were, even with the sort of things that they were telling us and they knew I suppose like, the reality of putting in the effort of the things that they're advising us to do, and they know that it's not always gonna work, and there are different things to try, and it can get hard. Participant 14, BaP-S high

and it was nice also having a leader who has experienced kind of parenting erm. ADHD children as well. So, it just made everything feel more relevant erm, and made you feel more positive, really that these things can still have an impact on children who are neurodiverse. Participant 16, BaP-S high

For others, identification with PGLs did not occur as their problems were seen as resolved or hard to relate to, with some parents feeling PGLs couldn't empathise with their situation.

spoke about their own struggles, but ... because they were resolved. I don't think they ever spoke about this strength of feelings that we were all feeling.

Participant 20, BaP-S low

Not really, to be honest. I felt like they really have their things figured out, they showed their perfect solutions. They -- it just seemed difficult to relate to that. I feel --felt like all their methods worked for them if that makes sense.

Participant 18, BaP-S high

Not identifying with other group members and PGLs led to some parents feeling misunderstood and alienated. This prevented sharing and generated a sense of demotivation and reduced confidence in the usefulness of the strategies.

I just I couldn't relate to these things. So, I just kind of backed out of it.

Participant 12, BaP-EFL low.

And then I kind of didn't really want to talk about it, because it's hard for them to understand. Like, I didn't want sympathy. I just wanted someone to be like, "actually, have you tried this with him?" Because, I mean, reward charts have never worked, ever. Participant 17, BaP-S high

Perceived differences in situations could be reconciled by focusing on the similarities in parenting concerns.

They was all having similar problems in one way or another. Some it was -- I made the mistake of saying, Oh my God, you've got it easy. I wish I had that. You know that they're still struggling and it's just being a parent.

Participant 6, BaP-EFL high

The importance of similarities led the researcher to consider in the interviews and analysis whether the groups should be separated based on shared characteristics. Parents had differing perspectives. For example, with parent gender, some parents argued for same-sex groups as they would feel more comfortable to open up with parents of the same gender. Whereas others enjoyed mixed gender groups where they learnt from different perspectives.

In my case, I married a man, so encourage groups only for men as well, because that's something that my partner kind of says a lot to me. Like, I love talking about parenting, but I don't feel encouraged to talk with women because, of course, your mental load's really different than mine. So, I would like to have a safe space that I can complain without feeling that overstepping.

Participant 9, BaP-EFL low

From both perspectives, the level of parenting done and associated similarities in concerns was cited as justification for wanting to mix or split group by gender.

I prefer if it is integrated, because also, I think, I think I'm a bit unique in terms of the level of parenting that I do. [...] I actually get along more with the mothers than the dads because I'm dealing more with those issues **Participant 3, BaP-EFL high**

Subtheme 1d: Connecting to the intervention content

Three main types of intervention content emerged from analysis as salient to parents in both interventions; parent self-care and wellbeing; parent child communication; and behavioural parenting strategies. Parents' descriptions of which intervention content was important to them varied based on their family and individual situation, addressed later in this subtheme. There were limited differences parent's description of content in either arm. Repetitions of the messaging around self-care and separation of parents and child emotions were described as important for parents in the BaP-Enjoying Family Life arm. This content related to self-care motivated participants and galvanised coping.

I really appreciated the emphasis that was on self-care, and the sort of the privacy of that within within the course was something we kept coming back to, [...] was just really kind of the push that I need to actually say, do you know what, it's going to help everyone if I have washed my hair. **Participant 4, BaP-EFL high**

Because they [parent and child emotions] were very, they were two subjects that were approached on different occasions. So, you'd have one day, in one of the sessions looking at about how you feel, how you cope with stuff, and time to yourself. And another one was about, you know, looking at your child and how they learn and how they develop, how they feel. So, they were both looked at separately, and then together. **Participant 10, BaP-EFL low**

For some parents, the course valuing self-care could be challenging to relate to and did not feel possible to achieve alongside other competing demands such as work.

Repetition of messages about the importance of self-care was important to overcome any guilt and to give parents' permission to look after themselves.

You're feeling a level of wrongness in the way that you are, and subsequent guilt. [...] and solving it by paying attention to ourselves or rewarding ourselves in a sense, it feels weird. And so, I suppose this is something that should be yeah, should be introduced more **Participant 20, BaP-S low**

But it's it's juggling the balance of work, when you're working full time, obviously, you're at work while they're at school. You both come home at the same time. If you don't have that support of a child minder or another parent, or family, then you haven't got anyone to leave your child, so you can't go and get your nails done. You can't go to the gym. **Participant 12, BaP-EFL low**

In addition to self-care, analysis identified that the course gave parents new ways of communicating with their child and a respect for their child's needs and independence. For example, acknowledging feelings was important for parent and child emotion regulation and compromise to reduce conflict.

And just now, helping her to instead of asking, why are you doing this? Why are you doing that? And just getting frustrated, actually going okay? You're feeling really sad right now. Um, and so, yeah. Acknowledging what their feelings are, I think that was That was a hugely, um Yeah, useful kind of tool to to kind of helped a few situations. **Participant 15, BaP-S high**

Giving children dedicated time and attention, learning not to lead, and allowing children to come up with their own solutions were also described as important for some families.

so now I've been trying to encourage her just by, I think it was active listening, just by having a conversation with her. I'm sort of just repeating what she says back to me and then these days, especially now she just kind of comes up with their own solutions and she's like, well, I'll try and do this, and I will just sort of validate that, like Oh, that's a really great idea [laughing]. And try to help make that happen without just jumping in. So, I think that's also helped to regulate her emotions, because she's actually a bit more in charge I suppose **Participant 14, BaP-S high**

Behavioural parenting strategies such as establishing boundaries were described as helpful for some parents. Behavioural strategies and discipline could be challenging for some parents depending on their past experiences in their own upbringing.

And I thought, boundaries? I've never had a boundary in my life. My mum never give me boundaries. And that's where you have to learn **Participant 6, BaP-EFL high**

I think it was a bit hard for me to kind of, you know, to to kind of talk about, you know, the discipline that I went through when I was a child. Um, and you

know what my parents saw as acceptable forms of discipline. Participant 15, BaP-S high

The relevance of certain intervention content varied based on their individual and family situations and their expectations of the intervention. For example, parents of older children described some of the intervention strategies were not so helpful for their child, whereas parents of younger children saw the intervention strategies as preparing them for the next few years.

Okay, but she's eight, it's not the same age group. Maybe her behaviour, she's portraying is a bit like their behaviour, but it's not -- I can't treat her how you'd treat a four-year-old, or a five-year-old Participant 12, BaP-EFL low

So, I'm seeing a lot of stuff through the lens of a three-year-old, and I always wonder. Oh, but you know, by six they'll grow out of that or it's just a phase. But actually, if I don't teach her what these emotions mean now, she'll still get to that point when she's six and still not understand it. Participant 15, BaP-S high

Child suspected neurodiversity was a particularly salient influence on how well parents could relate to course content, with several parents stating that the behavioural parenting strategies offered do not work for their children.

And erm timeouts do not work, they're quite negative for us. Like we've done a one, two, three kind of system previously, which was, [second child] would work with that. But I think due to [first child]'s autism, he wouldn't and he would find it very, he would get very, very upset. Participant 16, BaP-S high

Parents identified further content and changes to research methods which may better suit their situation. For example: adapting questionnaires to better support parents with neurodiversity; greater consideration of parent and child mental health needs both in the questionnaires and intervention content; including trigger warnings; including children in the group; and more techniques on how not to let situations escalate other than breathing techniques. In addition, parents who were co-parenting described the importance of including their partner in their learning in some way, and the lack of inclusion of partners in the course could create unbalance and inconsistency between parents.

*I suddenly had tools in my house that I desperately wanted to communicate to him. But it was not my place to do so, [...] and therefore we found ourselves sometimes at odds as to not even an argument, but with two very different styles of sudden parenting that was creating a lot more - It was a harder situation to accomplish at home where I felt that I was. I had to push lots of things, not push, but kind of pull him towards my direction. And he was willing to come. But, you know, like he had to check things out with me. It's like it wasn't balanced. **Participant 20, BaP-S low***

Some parents also described how they adapted course content to match their family's needs.

*So, in terms of kind of stepping back and having his diagnoses and then understanding who he is, and then how we need to work with him very differently, erm, and then taking the parts of the course that are still relevant and can help us on that journey, really. **Participant 16, BaP-S high***

*All the strategies are working with all ages of children. You just have to approach the child in a different way. [...] one of the mums and child is, I think, 14 or something. So, she learned the same strategies, but she just has to approach her child in a different way. **Participant 7, BaP-EFL high***

Theme 2: The value of relationships

Analysis identified the value of relationships and qualities of reciprocity, responsibility, safety, non-judgement and care were core to parent's experience of the research project and interventions. Subtheme 2a reflects the sense of responsibility and reciprocity parents experienced in their intervention group and towards research more generally. Subtheme 2b describes the key characteristics of the relationships that facilitated sharing, safety, trust and non-judgement. Subtheme 2c describes the care felt in the group and how care impacted the individual's experience of intervention and trial methods.

Subtheme 2a: Responsibility and reciprocity

A sense of responsibility to others underpinned parent's participation in the research methods and intervention. The sense of responsibility was important across all stages of the trial and was felt towards themselves, their children, others in the intervention and future parents who may access the interventions. During the research

meetings, parents felt responsible to give a fair assessment of their situation, which at times could be challenging.

*If you're participating in a research, you got to take it seriously. You can't just brush it off as yes. No. Yes. No. I think it has to be useful for you and for everybody else who comes after me in the courses. And so, like, I felt that there was a responsibility there that I had to take it seriously. **Participant 20, BaP-S low.***

When attending the intervention, parents described a responsibility to others to share, feedback on how things are going, and continue attending the parenting groups. Parents also felt a sense of responsibility to their children which motivated their participation.

*Just because, one, I made a commitment to join these groups and I didn't want to let the other parent down [...] And also, I joined it for a reason, I needed help in dealing with my child when my emotions are high, and when his emotions are high so. You're not really gonna get that anywhere else. **Participant 10, BaP-EFL low***

This sense of responsibility to the research, interventions and others was reciprocal and parents placed responsibility on others to listen to their experiences. Opportunities to feedback and parents getting value from the time they put in were important for encouraging participation, engagement, commitment, and attendance.

*You want to feedback what's was working and what's not working. And so, it's actually a -- that continuation thing, you look forward to it. **Participant 6, BaP-EFL high***

*Having these research studies, I think whether you get in them or not, I think it's still a positive experience because you get to be seen and heard. **Participant 2, Ineligible***

The belief in the genuineness of the research project and the opportunity to be seen and heard supported parents' engagement with, and the acceptability of, research procedures. For example, one parent described the length of the questionnaires as:

*About right, yeah, slightly long. But I think you needed that probably going in. But again, I think if had been much more brief, you wouldn't have felt like it was, it was a genuine research question. **Participant 16, BaP-S high***

Subtheme 2b: Safety, trust and non-judgement in building relationships

Feeling safe, trust, and non-judgement were also important in supporting trial participation and the reciprocal processes of sharing, responsibility, and commitment. Many participants felt that sharing could only occur when there was trust, where they could be honest and accepted.

Trust, you know that as well as I do. It felt like that you could just share anything, you wasn't judged for it, [...] You needed to feel that, not feeling that, you know, social services was going to come as soon as you say you'd beaten your child, you weren't but it's -- you could share that you were struggling with him and that you'd slapped him before and things like that.

Participant 6, BaP-EFL high

Hearing about the project from a trusted source was also important for participation.

I went through my doctor. So, because you just feel a bit more secure that they're going to point you in the right direction, because you don't actually know where to go, or what to ask for

Participant 12, BaP-EFL low

I think it's easy if you've got a mentor with you or a counsellor. But with my sister, she doesn't have anyone, so she's clueless. So yeah, you need to have someone to know.

Participant 22, BaP-S low

Experiences of safety in the group was unique to each individual. Trust and safety could be experienced with the entire group or one individual within the intervention group.

I was a bit more within myself in in the wider group. I thought that if you're going to have, like, a 1 to 1 with people, then like, mix it up because me and Sarah you were just like, "oh, you again",

Participant 5, BaP-EFL high.

Change in the group could break the continuity in a way that felt unsettling for some parents. For example, the supervisor joining the group made one parent feel uneasy.

I don't think it disrupted the group itself. It made me feel like I I think that it was just all internal with me, but it was like, "oh, my gosh, like, what do I have to do?" But I suppose it's just the effect of as soon as somebody else and just this kind of bubble of security. Then you kind of feel slight unease.

Participant 20, BaP-S low

Feeling pressure, judgement, or simply not building a relationship with others could impact safety and lead to parents feeling less able to share. Two parents described feeling judged by PGLs on the course which led to alienation or a decision not to attend.

she called, she called me up and she kind of said, very nicely, but it was still very uncomfortable, she wanted to check up on some of the things that I'd

said in the meeting, because the people who'd facilitated wanted to flag [inaudible]. It really made me feel like, unsafe it really made me feel like wait a minute, I was open, I was honest, and now they're [inaudible] you know safeguarding concern, my child is not at risk. Participant 23, BaP-S low

So, I felt better when we weren't in the breakout rooms near the end. [...] because I felt like there was less pressure. There was less eyes on me to have an opinion. Um, some days I just didn't have any thoughts. I just I've just been I'm just so sad inside about thinking about the stuff that I could do better that I don't want to share. Yeah, yeah, I'm even holding back tears. So that's kind of how I felt. And I, I realised I-I-I don't think that they were trying to be judgmental. Participant 5, BaP-EFL high

Many parents stated there were times when they would have preferred to sit back and listen, particularly for parents who described experiencing anxiety around others and a fear of judgement. However, some parents who described anxiety were able to overcome their discomfort by focusing on the commitment they made to themselves and their child.

Because of the anxiety, just being there around people and no one was judging me, I know no one was judging me, but when the anxiety kicks in, you've got so many things flying around in your head. It's just, you know, but I still went and I still done it. It was out of my comfort zone, but I've done it for my child, and I would do it again. Participant 12, BaP-EFL low

Subtheme 2c: Experiences of care in the project

Care for others and experiencing care towards themselves was an important interpersonal experience for parents in facilitating trial participation, learning from others, and engaging with the intervention content. Care was experienced from others in the intervention group, PGLs, supervisor and the PhD researcher. This appeared to help parents to feel welcomed and motivated for the course. Being able to talk through and being kept in mind for future groups by the supervisor was valued by parents who were unable to attend.

and it just didn't kind of work out, but that's really helpful to know, actually, that it was a helpful conversation anyway. And, that, you know, it's nice to kind of be kept in mind as well for the other groups. Participant 24, BaP-S low

Care for others in the group impacted intervention participation and sharing.

Wanting the best for others and moments of humour could be very motivating, whereas concern about what happened to parents who dropped out could be demotivating.

We're also chatting with each other because even though we don't really know anything else about our lives outside of the kids and that we that we all want better parents, there is that sense of we want each other to do the best.

Participant 15, BaP-S high

It's just like the group got smaller, so you're kind of with the same group and then the people that we did connect with in the beginning groups, it's like, Oh, where are they kind of thing?

Participant 5, BaP-EFL high

Some parents described finding the balance between others getting value from the course and getting value for yourself challenging. Consequently, they would share less so that others could get value from the course.

But, I think for me the combination of a couple of people sharing a lot, plus the fact that I felt like my challenges were not as challenging, erm there were times when I would speak less because I'm like, "oh, I want those people to get the value". And so sometimes that's neglecting, you know, what I want.

Participant 3, BaP-EFL high

The PGLs helped to facilitate balance in sharing between different group members.

Yeah. I mean, there was some really outgoing, some like myself who suffers from anxiety. So, you know, there was some kind of, like, the ladies [PGLs] made us feel like a balance, you know, they didn't, you know, they let the ones that was more outspoken talk and, you know, it's just kind of, it flowed. It's kind of hard to explain, but it just flowed.

Participant 8, BaP-EFL low.

In addition to care impacting participation and sharing, care for others also enabled learning. Discussing and getting advice from others in the intervention and PGLs supported parents to identify and make changes. Experiencing care from others in the group helped parents to take a new perspective, encouraged self-compassion and reinforced messages from the course.

And then one of the people in the group said, "you just called yourself disgusting twice, and that that's really, you need to be, you need to talk to yourself in a really kind way". Whereas I was, my mind was kind of more wrong, you know, saving other people from having to hear about my hygiene issues. Erm. But it was another person in the group who was kind of able to point out one of the sort of key things that was going on in the group, which was trying to encourage self-care and positive self-talk, like being compassionate, self-compassion. [Background noise]. So that was, that was actually really helpful, and a real kind of moment of vulnerability, for me.

Participant 4, BaP-EFL high

Getting guidance from the PGLs and others could be challenging for some parents. One parent describing feeling triggered by what the PGL said, but they also recognized the care behind the challenge from the PGL and that the experience helped her to grow.

*She's like, I think she said, "um, there's lots of blame in that when you're when you are speaking to [child] and you, um, may be sure you should change your the way you speak in terms of that". And then I remember my partner used to say that to me and in regards to our relationship and in regards to her. [...] It's helped me to grow in the way I do speak. **Participant 5, BaP-EFL high.***

Experiences of unavailability of PGLs and supervisor were negative as parent's didn't feel heard or cared for.

*I found that when I emailed them to say to them that I wasn't coming back, I didn't get any response back, which I felt, I found a bit, you know, not very professional, **Participant 12, BaP-EFL low***

Theme 3: Knowing what to expect

This theme describes the information received about the project and how it shaped parents' understanding of what participation in the project involved.

Communication about the research was important in shaping expectations throughout the trial, and having parent's concerns addressed was important for facilitating engagement and choice in trial participation. Uncertainty about allocated intervention was reconciled by the newness of the group, the understanding of research designs, and the active control arm meaning that parents were certain that they would receive some help.

Clear communication of information was valued at all stages of trial method and group and was important in parents knowing what to expect. Analysis identified that being clear on what's being offered in the advertisement material, focusing on parent's experiences and sharing advertisements in the places where parents and children go was key to enrolment and parents knowing support was an option.

In summary, I wish that there were more things right in my face, I guess, like the invitation to participate in the study because I'm more likely to er, join if it's easy, or if you're communicating to me that this is an option for you, as opposed to saying, "well, I'm going to spend this Saturday and look through all the things

in Lambeth to see if there's any that would be helpful for me. Participant 3, BaP-EFL high

Specific to the BaP-Enjoying Family Life project, questionnaires and the initial coffee morning helped frame the course and what to expect for most parents. Having their concerns about research and the intervention addressed facilitated choice in participation.

The initial questionnaire was positive just in terms of framing I suppose what the parenting group might address, Participant 21, BaP-S low

The first session was actually just an introduction. So, they told us exactly what we are here for. And what we are going to learn. So, they gave us the chance to say, "yeah, well, thank you, but no, thank you". So, yeah, it was 100% my decision. If I want to stay, there Participant 7, BaP-EFL high

Whilst written communication was important, parents valued the opportunity to discuss information with a trusted other, both during recruitment and throughout trial participation. The opportunity to discuss encouraged participant choice and autonomy. For example, parents felt happy with their decision to participate and any unmet needs from the course when PGLs were honest about what the course could and couldn't help with.

They were very honest about it, so they sent me a couple of links of things that could help me. But you know, they were saying was that regardless of us not being able to help on this subject, we can help around it. Which was true, which was true. So, in relation to grief because of loss. No, there was not much discussion, but the group was very helpful, Participant 20, BaP-S low

Whereas a lack of addressing unmet needs left parent's feeling misunderstood.

Well, they tried, obviously, to be sympathetic and said, well, I can imagine this is difficult, but then was left there. I felt like they was probably -- they didn't really have an answer, so. I appreciate it, I mean, you can't always have an answer, but it felt like they -- that was it then. Participant 18, BaP-S high

More widely, when accessing parenting support, parents both highlighted the importance of being directly asked by professionals and the importance of autonomy when being signposted for support. However, parents also described the possibility of

professionals not having all the information, leading individuals to be carried over from service to service.

*What really would help is if you go to these appointments with your children and you have them to ask, "how are you, mum? [...] Are you okay? Are you coping? Do you feel that you need help or anything like that?" That will make a huge difference. Because sometimes sometimes you go into your in your shell that you would say "no, thank you". But sometimes that's exactly what someone needs. **Participant 7, BaP-EFL high***

*[Going through the GP was] Too complicated, and it felt too exposed as well, because you go to service to service until you find the right thing. erm It's just, it's weird when you're talking about such sensitive things. **Participant 9, BaP-EFL low***

Miscommunication did occur in the BaP-Enjoying Family Life project, and this led to confusion for some parents. For the two parents who were ineligible, both felt they would have benefited from greater clarity around emphasis on parent wellbeing and a clear explanation of exclusion criteria.

*I kind of felt like that should've been in the email or at the start of the, at the start. Because I thought, okay, you know, we've emailed, we've had a phone call, we've gone through this whole Zoom, and I've signed these documents and then it's like three questions in and it's like oh you're not eligible. And I thought we could've done that half an hour ago. **Participant 1, Ineligible***

Two parents also described confusion about their choice in attending the course.

Repetition of information, such as expectations of parents' attendance, would have been helpful.

*Yes, I think some things weren't made clear to me. And even if it was made clear in the beginning, I just felt I could probably maybe a repetitive thing do anything at all. Next week is our next course. Um, if you have any trouble, if you have, if you have any trouble that anything that comes up, just let us know. **Participant 5, BaP-EFL high.***

Whilst information about participation and the opportunity to discuss the groups was important for parent's knowing what to expect, there still remained a degree of uncertainty around the course until parents joined the group. The newness of the group and not knowing what to expect from each group meant randomisation was acceptable to many parents.

*I didn't really know much about both groups, so I didn't really have any strong feelings either way, to be honest. So, I thought I'd just give it a try. **Participant 18, BaP-S high***

Many parents stated that something was better than nothing. Their understanding of randomisation in research studies also meant they were resigned to how studies worked.

*Um, yeah. I can see why some people may want to be in one arm versus the other, but, you know, I I was fine with that. You I was coming from a baseline of nothing, right? [...]. But I was coming from nowhere, so even a control group would have been better than nothing for **Participant 15, BaP-S high***

*but then it is, it's fair to do it like that because maybe more people wanna go to the other group, so there will be less in the other group. So, I think it's actually okay that it's been done like that. **Participant 22, BaP-S low***

A couple of parents weren't aware of the differences in the two groups.

*That was okay. I didn't realise they were different topics, though. I just thought they were different timings. I didn't realise they were different. Sorry. But yeah, no, it was fine. I was just upset that I couldn't join. **Participant 9, BaP-EFL low***

Theme 4: Creating space to take in the course

Analysis identified different ways that parents interacted with the intervention, including how they acquired, understood and practiced parenting skills and how they made space for the course in their lives. The learning interactions that parents described included a concrete transfer of knowledge, or reflective and experiential learning which generated insight. Flexibility in the intervention facilitation and the parents' hopes and expectations for participation were important determinants of reflection. Both reflection and concrete learning also depended on the parent's ability to attend both physically and mentally and then apply learning from the interventions. Attendance required flexibility from the course to overcome practical barriers, and time and effort from parents to create space for the course and new ideas in their busy lives. Subtheme 4a. describes parents' experiences of learning on the course via concrete knowledge and through reflection. Subtheme 4b. describes the effort parents made to create space to attend and apply learning from the course.

Subtheme 4a: Concrete learning, insight and flexibility

Analysis identified two different learning experiences described in parents' narratives. The first was a concrete learning experience where knowledge was transferred from one person to another. The second experience was a reflective, experiential and social learning process where knowledge was generated through identifying and exploring problems and solutions through discussions and role play in the research meeting and the intervention. The transfer of knowledge ranged from being completely new to things that parents were already familiar with. For example, the fact that parenting support existed was completely new to some parents, whereas others were aware of parenting support. With regards to parenting strategies, parents described being familiar with some or all tools through previous reading and research, through work, or what's being used at nursery/school. Some felt the course identified things parents were already doing but of which they were unaware. Familiarity was reassuring for some parents.

*There was a lot of stuff, or there is a lot of stuff I've already did, but it was never really aware of it. So just being aware of "hey, I'm using these tools already", but I just never realised it. That was, that was very cool. **Participant 7, BaP-EFL high***

Familiarity led other parents to feeling the intervention content was superficial and not worth their time. This difference in experience was perhaps linked to parent's hopes for the course.

*I just felt like it was a bit of a waste of my time because it's a long day as well, it's from ten to 12. So just like, I've really just wasted, I've lost, like morning's work, pay, of work, to sit here and hear things that I'm already doing. So, it was a bit frustrating. **Participant 12, BaP-EFL low***

In addition to teaching tools and strategies, the research methods and interventions encouraged reflection, offering parents an opportunity to become aware of their situation and identify changes they might want to make. In addition, the research

helped parents to track changes, regardless of whether they were able to attend the groups.

*having the opportunities that kind of know that there's things out there that can help you, so that's been really positive, and it makes you think a little bit more and take the time to really think about what is going on in terms of how you're going to deal with the situation. **Participant 1, Ineligible***

*Kind of makes you reflect on areas. I think it kind of brings up areas that you may like to do better and erm maybe flags areas to focus on a bit more during the course as well. **Participant 16, BaP-S high***

Role plays, demonstrations and discussion allowed some parents to experience the skills in a way that they felt were different from 'knowledge from a book'. This helped parents to understand the impact, remember the strategies, and feel motivated to try them out at home.

*You know, just, and also reading about it is not enough, because, I mean, we'll get into details afterwards. But we did all these exercises that really make you feel certain things rather than theorise them. **Participant 20, BaP-S low***

*And they did the demonstration of something that would kind of help things to stick in your brain a lot better. **Participant 4, BaP-EFL high***

Some parents described the course shifting their thinking towards a greater acceptance of their child, their own parenting, and challenges faced. This enabled them to apply strategies more effectively and identify changes in the way they and their children handle situations.

*A different way of thinking about things, a different way of dealing with things and if that doesn't work, then try this way and then, you know, be thinking it's it's, "you know, like, let me just try that and it works". And I'd be like, "wow I was stressing myself out this whole time". **Participant 8, BaP-EFL low***

*It's this firefighting strategies to notice when it when it starts to rise up. Yeah, and then just put a stop on it. Yeah, and just giving, giving myself a stop and realise, "why is that situation so triggering from me?" Actually, right now. And why is that situation so hard for my children right now? **Participant 7, BaP-EFL high***

PGL and course flexibility was important for encouraging reflection, with parents describing the importance of being able to discuss and go off on tangent.

*Erm. We would just kind of go off on a tangent I think, and we were give them the time to do that. And they'll be allowed to go off for a bit. Maybe have those discussions and then come back onto topic again. So yeah. **Participant 16, BaP-S high***

Whereas when there was no flexibility and discussion parents found the course superficial

*Urm. They seemed -- there was this other lady who took part, urm, and she asked some quite, or raised some quite interesting issues, and they really seemed to engage with it. Whereas the other facilitators who conducted the online group were more, very focused on their script and it didn't feel like they were actually engaging with anything else or anything that kind of wasn't part of that script, that wasn't really fitting, it seemed. **Participant 18, BaP-S high***

Subtheme 4b: Creating space to attend and apply learning

Whilst the research methods and content could help facilitate learning, analysis identified the equal importance of parents creating space to physically attend the course, pay attention to the material, and then apply the strategies and new ways of thinking at home. Creating space could be challenging, and parents highlighted many practical and personal barriers to participating in the research, attending the group and applying learning outside of the course.

*So, it's sort of trying to find something that's ideal for me and everything that's sort of going on at the moment with different appointments on different days and times and everything like that. So, yeah. **Participant 24, BaP-S low***

*The challenge is to just continue to apply those tools, though, So I feel like, you know, coming out of the entire session we've been given, you know, a whole set of new tools to kind of help communicate, help, help, you know, diffusing situation, strategy, coping strategies and stuff. But it's like you have to constantly keep it in practise, though, um, and and so So, yeah. So, it's just kind of constantly remembering to go back and do those things and not slip back into old ways and old routines and stuff **Participant 15, BaP-S high***

Practical barriers included: time commitment and timing, location, travel, work and childcare commitments, group size and session length. The influence of these practical barriers was all different and depended on the parent's situation. Parents also stated that barriers unrelated to the intervention such as appointments, moving house, and work could also get in the way.

To overcome these practical and personal barriers, parents described the emotional investment, effort and courage it took to access parenting support, participate and make the changes at home. Attending and applying the course strategies was very

intentional for most parents. It involved active problem-solving, and it was underpinned by motivations for change.

I had to be very intentional. And it had to be almost like a pressure cooker situation in my life, but brought me to be like, oh, no, I'm gonna make time for this. Participant 5, BaP-EFL high.

I managed to call in all thingy, favours of babysitting. You know even the lady at the new school saying, "there's so many people coming to pick up Sonny, why?" Because I'm going a parenting group Participant 6, BaP-EFL high

Some parents felt it was their responsibility to prioritise the course whereas others described practical changes to the intervention which could be made to support attendance and engagement.

I think at the end of the day, it's kind of down to the individual to kind of make it a priority, right? I mean, I could have definitely, you know, said "sorry, my work is more important. Need to kind of use this time slot for meetings and stuff that actually". I was like, no, I want to do this. And this is more important to me. I will pick up work stuff in the evenings, Participant 15, BaP-S high

Practical things the course did to support parents to create space to attend and apply strategies included encouraging home practice activities, providing a creche, offering opportunities to catch up with PGLs, sharing handouts and videos, offering online and in person options. Not all parents were aware of home practice activities.

They didn't really give any homework, didn't -- or at least I didn't understand it like that. I mean, sometimes they said, "well try it out over the week". Participant 18, BaP-S high.

Childcare was important in giving parents mental space to engage with research meetings and attend to the course. Providing childcare during the course wasn't always straight forward, with children being too young or not settling into the crèche, or temporary creche workers not providing quality care. Concerns about childcare and children being in the session meant parents had to split their attention and couldn't engage as effectively.

So, I would have expected, even if they were, you know, temps working with children they would have known just to sit down and give him something to eat. But they didn't and I think I ended up panicking thinking, if that doesn't work, then the course doesn't really matter. Because if Ben's not comfortable, I'm not going to be thinking about the course every week. I'm just going to constantly be thinking about like, is Ben okay? Participant 17, BaP-S high.

especially obviously with baby as well. Like the thought of being there and having to try to listen and do the course so that it was actually effective for me, with, obviously, baby as well. It was just sort of a little bit daunting.

Participant 24, BaP-S low

Messages and activities from the course could be important for supporting parents to creating space for the course and applying strategies at home. For example, having allocated time to shift attention and regulate their emotions before and after the meeting could help parents to concentrate in the group and then re-enter their busy lives.

For them to teach you something, you have to be in a good place, don't you? So really, by sharing how you're feeling in that moment, you're just getting rid of that rubbish, to tell the truth, so you can concentrate on what you've got to give me here. And I got rid of yesterday's rubbish sort of thing.

Participant 6, BaP-EFL high.

I think it's the same as going to a therapy session. You need a bit of buffer. You need a bit of buffer before and a bit of buffer afterwards. Even for me, if you go from one thing to another, it just is a little bit er, unsettling. But also, it's really difficult to let things really sediment into yourself.

Participant 20, BaP-S low

Joining online gave parents flexibility to join the course and fit in with other aspects of their day. However, joining whilst doing other things could be tricky and distracting.

The session it was erm. A bit tricky because it's on the time when I normally get ready for work. And yeah, so sometimes I wasn't able to be like on camera. I'll have the camera off and just having the phone, going around, getting ready, having breakfast and heading out, you know, trying to catch the bus for work. Sometimes I'll lose connection on the outside and stuff so.

Participant 19, BaP-S high

Handouts and videos were helpful for supporting parents to catch up and also for reminding parents of strategies after the group has finished. However, handouts and videos did not quite have the same impact as being able to discuss with the group. PGLs and parents creating space to catch up in the group was important for the social learning processes too.

It was sent to me, sent to me in email, all the thingy, and then when I went there, obviously, because I missed the last week, I'd read about it, but I didn't live it sort of thing. So, the people that lived that group all explained to me and they question them and then they give back the feedback of what happened that week. And then that way you got it from the horse's mouth, so to speak.

Finally, the length of the course was described as impacting the parents'

capacity and motivation to continue to attend and apply learning from the course. Some

parents also described finding the course emotionally tiring and losing momentum at the end, and they suggested perhaps a shorter course. Whereas others were concerned about continuing to apply strategies after the course ended. They felt that a longer course or offering follow up sessions would help remind them of strategies.

*Meetings are back-to-back on a Tuesday for me. So, it was such a full-on day for me. That in the beginning I was just like, no I dedicate this time, but then after a while it just became a little bit more, I think, because of how full on it was in terms of my life and my schedule, it became a bit more harder to focus. Um, yeah, focus on the course. Maybe by, by the time we got to week 5, 5, I felt I got a bit like, muddled in terms of my engagement, Um I still attended. I still took stuff from it. **Participant 5, BaP-EFL high***

*Also, a trail out afterwards so that you can basically you keep you touch base with the group and with the supervisors over the teachers, like on a regular basis so that you have a chance to bring forth things that might, you might still struggle with, you might need reminders on. **Participant 20, BaP-S low***

*We were all very keen of, you know, how do we make sure that we continue doing this in our everyday lives and, you know, have that become the new norm? Um, so at home, I've got, like, a blackboard in our kitchen Big, massive blackboard where we just, you know, write our grocery list and stuff. But I started putting all the useful things that I needed there **Participant 15, BaP-S high***

For some, the group ending and “life stuff” meant they struggled to find the space to use some of the helpful tools outside of the group.

*No, to be honest, no I haven't. I've just been. I don't know what I've been doing, floating through again. **Participant 10, BaP-EFL low***

5.5 Discussion

This qualitative study aimed to develop a fine-grained understanding of the participant’s experience of BaP-Enjoying Family Life feasibility trial methods and interventions to inform further development and modification to the trial methods and intervention. The PhD researchers’ findings provide insight into the experience of participating in interventional research for parents with significant emotional and interpersonal difficulties which can inform further intervention development and research. Four themes were generated from interviews with 24 participants. Theme 1 captures participants sense-making, where they related to trial aims and method, other’s

experiences and intervention content based on perceived similarity in their individual and family situations, hopes and concerns, and past experience. The second theme identified the value of relationships between participants and the PhD researcher, PGLs, and other participants in facilitating trial participation. Experiencing responsibility, care, trust, and non-judgement were important from both sides of the relationship for encouraging participation and sharing. The third theme identified that clear communication of information was important for participants knowing what to expect, managing any concerns around participation and feeling autonomy in their participation. Finally, theme four depicts the varied ways of learning described by participants, i.e., through transfer of knowledge or experiential and reflective learning. Parents emphasized the need to create space to attend and apply knowledge and insight gained from the groups and research procedures.

The findings from this qualitative analysis are synthesized alongside the quantitative findings and implications for further research and intervention refinement are discussed in the following chapter. Here we will discuss the findings in relation to previous research, consider broader implications for further research, and highlight the strengths and limitations of the research presented.

5.5.1 Interpretation of findings in context of past research

Reflexive thematic analysis highlights an appraisal process where parents assigned value to the trial through actively and passively identifying connections between trial methods and intervention and aspects of their individual and family hopes and situations. The strong sense of identification with the trial aims and experiences of others in the group reinforces the benefits of parenting support that holds the parent's identity at its centre (Butler et al., 2020). The focus on the importance of parent's past and current family situations in influencing motivations and engagement with

intervention and trial methods mirrors previous meta-syntheses conducted on the experiences of parenting interventions (e.g. Butler et al., 2020; Olofsson et al., 2016). This study adds to previous research by observing that individual and family contexts may shape engagement and motivation through influencing identification with others in the group and the applicability of the parenting strategies to their situation and hopes. Preliminary quantitative evidence identifies that group cohesion is related to parent self-esteem outcomes for psychoeducational groups for single mothers (Lipman et al., 2007, 2010). Further research investigating the role of group identification processes on intervention engagement and trial participation as well as intervention outcomes may be warranted to understand the interventions' mechanism of effect.

In addition to group identification, parents described how the interventions content related, or did not relate, to them based on their individual and family characteristics. Child suspected neurodiversity was described as influencing the utility of strategies and relevance of questionnaires for some parents, whereas others described taking the strategies and tailoring them to the needs of their children. Interestingly, quantitative literature identifies behavioural parenting strategies that are effective at reducing disruptive behaviour in children with autism (Iadarola et al., 2018), whereas participants with children with suspected neurodiversity in this study described traditional parenting strategies such as "time out" and "consequences" do not work for their children, motivating their participation. There are currently long waiting times for neurodevelopmental assessment in the UK (Male et al., 2023) and parents of children with neurodevelopmental diagnoses report lower parenting self-efficacy and greater parenting stress compared to parents of children without neurodevelopmental diagnoses (Tarver et al., 2019). The findings of this qualitative analysis reinforce concerns of a gap in support for parents and children on the waiting list for neurodevelopmental

assessment (Edbrooke-Childs & Deighton, 2020). The findings therefore suggest that further research is required to understand the treatment needs and parenting strategies which can support parents and families whilst waiting for diagnosis.

In addition, the findings point to variation in participants' experiences of learning which are shaped by the flexibility of delivery and may reflect different learning styles (Kolb et al., 2001; Morris, 2020). Some parents focused on transfer of knowledge and concrete skills and strategies, whereas others described reflective, social, and experiential learning process. Analysis reinforced the idea that a key mechanism of learning in parenting interventions is through collaborative processes beyond intervention content (Butler et al., 2020; Kolb et al., 2001; Morris, 2020). Parents described the benefit of attending to course content, remembering, applying and evaluating the effectiveness of strategies within the group, mimicking Bandura's Social learning theory (Bandura, 1969). The salience of demonstrations and discussions with others emphasize the importance of social connection in this learning process. In addition, parents' descriptions of the intentional nature of engagement and emotional intensity of the group reflect key theories of experiential learning which argue that self-awareness is gained through emotionally intense experiences (Kolb et al., 2001; Morris, 2020). These findings have clinical utility in emphasising the value of group delivery, encouraging flexibility and focusing on group cohesion and relationships (Day & Harris, 2013). The implications for further intervention refinement are discussed further in chapter 6.

Finally, limited studies have conducted qualitative evaluation of participation in trial methods, with many process and qualitative evaluations of parenting interventions focusing only on intervention acceptability (e.g. Renneberg & Rosenbach, 2016) or evaluating trial methods and intervention separately (e.g. Day et al., 2020). This

reflexive thematic analysis identified the importance of providing opportunities to discuss participation with PGLs and researchers. Opportunities to discuss concerns and knowing what to expect facilitated trial and intervention participation, as discussed in greater detail in chapter 6. Furthermore, this study highlighted reciprocal, interpersonal, and identification processes, and opportunities for reflection that occur when participants engage in research procedures. Research has been conducted to examine how professional identify participants for clinical trials (e.g. Patterson et al., 2010). However, limited investigations of participant self-identification for research participation have been conducted. Future research would benefit from considering how parents, particularly parents who experience significant emotional and interpersonal difficulties, self-identify and continue to participate in research, even when they do not receive allocated intervention, as was the case for a number of parents in this trial. Furthermore, the impact of research participation on clinical outcomes should be considered. This is because it is possible that self-reflection required for self-report questionnaires may lead to some clinical change.

5.5.2 Strengths and limitations

This is the first qualitative study to evaluate participant experiences of a peer-led parenting intervention for parents with significant emotional and interpersonal difficulties. A strength of this study was that the sample was information rich, with many participants providing thoughtful, intentional, and reflective insights. By considering attendance and intervention arm in the sampling approach, this study was able to analyse a diverse range of experiences to provide key insights on the experience of trial methods, regardless of intervention completion. Nevertheless, there is no unified definition of what constitutes an information rich case (Malterud et al., 2016) and randomly selecting participants from a matrix did not guarantee a strong dialogue

existed between PhD researcher and participant. There were two interviews in which participant responses were short and the PhD researcher was unable to encourage elaboration. The matrix sampling approach to purposive sampling prevented the PhD researcher from targeting parents with whom they had built rapport during quantitative data collection appointments and it potentially prevented information rich parents from being invited to interview. Further research may benefit from using a sampling strategy that appraises the content of input across recruitment and data collection (e.g. Malterud et al., 2016).

Furthermore, there are several voices who interacted with the trial methods and who's experiences aren't represented in the analysis presented here, despite attempts to emphasize variation. Namely: parents who saw information about the project but didn't sign up; parents who withdrew from the project prior to consent; the children of parents who participated; and practitioners who delivered and supervised the groups. Harries et al., (2023) highlight that parents with significant mental illness often feel unsafe in sharing their parenting concerns and avoid parenting networks where they may experience stigma and alienation. It is important to consider whether fear of judgement and avoidance prevented some parents from signing up even though a non-diagnostic approach was used to help understand and further increase engagement with parenting support for parents struggling with their own wellbeing. Considering the child's perspective may have helped to understand the impact and acceptability of trial methods such as the observational assessment and intervention on the wider family. For example, interviews with children could consider: What is the perceived value, impact, and unintended consequences of the intervention for the child? Similarly, practitioners' perspectives could have helped indicate further facilitation challenges and barriers that parents were either unaware of or chose not to disclose. However, parents with

significant emotional and interpersonal difficulties report that often their very real challenges are dismissed as a function of their interpersonal difficulties by professionals (Wilson et al., 2018). Therefore, it was important to centre this qualitative evaluation on the parent's experiences, before conducting further evaluation with practitioners.

In addition to potential sampling strengths and limitations, the PhD researcher led the research study design and intervention development. They therefore had a high level of personal and professional investment in trial methods and intervention. It is possible that this investment could bias the PhD researcher's data collection and analysis to focus only on positive participant experiences. However, reflexive thematic analysis embraces the PhD researcher's subjectivity and assumptions in the analysis (Braun & Clarke, 2021). The PhD researcher was aware of their potential biases and took proactive steps to reduce the influence of their own subjective and personal connection to the research through discussing with supervisors and conducting a participant reflections workshop. Finally, the PhD researcher's relationship with participants encouraged sharing, and the knowledge of intervention and trial methods enabled the PhD researcher to ask relevant follow up questions. The responsibility placed on the PhD researcher by participants, as highlighted in subtheme 2a, matched the PhD researchers desire to improve the intervention and the aims of the research. Therefore, the researcher's subjectivity was incorporated into the methods and analysis and then examined by participants and supervisors to increase the credibility of the analysis and thus can be seen as a strength of this research.

Finally, these interviews were conducted post-intervention, and there may have been temporal influences on the participants' narratives and recollection of experience. Responses about the impact of the interventions may have been different at 6-month follow up. However, the participant's construction of their experience at 6-month follow

up would likely be influenced by events and experiences which occurred during the follow-up period. Longitudinal and ethnographic research may lead to a more in depth understanding of experience. However they come with their own practical and analytical constraints (Thomson & Holland, 2003) and their use may not lead to helpful insights to address the research purpose of identifying further intervention and trial refinements.

5.6 Chapter summary

Through reflexive thematic analysis, the PhD researcher generated four themes capturing parents' experiences of BaP-Enjoying Family Life trial and intervention methods. The qualitative findings add to a growing body of literature examining experiences of parenting interventions for parents with significant emotional and interpersonal difficulties. The findings also highlight areas for future quantitative and qualitative research such as the influence of group cohesion on intervention outcomes and the treatment needs of families waiting for neurodevelopmental assessment. The following chapter considers further intervention and trial method refinements based on these findings.

Chapter 6 Mixed-methods integration and appraisal of Being a Parent-Enjoying Family Life feasibility RCT findings.

6.1 Chapter summary

The following chapter presents the mixed methods integration of quantitative (Chapter 4) and qualitative (Chapter 5) findings to answer questions on the feasibility and acceptability of the trial methods and intervention design. The implications for future trial and intervention development are also highlighted. First, the rationale for mixed-methods integration and methodological justifications are presented. Then, integration of findings and implications for future trial and intervention development are presented under three subheadings: Trial implementation and acceptability, Intervention Acceptability, and Intervention Implementation (including fidelity, dose, reach, mechanism of impact, and context). Finally, proposals for intervention development and further research on the two interventions for parents with significant emotional and interpersonal difficulties are made.

6.2 Introduction

Quantitative and qualitative data can offer two different perspectives to address key uncertainties about trial method and indicate refinements prior to full-scale evaluation. For example, qualitative data can assess the validity of quantitative findings, inform development and refinement of quantitative methods, and generate hypotheses for future quantitative examination. Quantitative data, on the other hand, can capture broad patterns across larger samples which may require in-depth understanding using qualitative methods and assess the causality and generalizability of qualitative findings (Fetters et al., 2013). Integration of these two methods enables investigation of complex, multilevel processes and problems. It can also identify areas for future research and development.

In addition to understanding key uncertainties around trial method and intervention acceptability, the MRC framework recommends interventional research should seek to evaluate the intervention's processes (Skivington et al., 2021). Three intervention processes have been identified as important to investigate and can be used to guide the research questions asked across the phases of intervention evaluation. These processes are: (i) the intervention's implementation (What was delivered and how?); (ii) the intervention's mechanisms of impact (What are the core components and mechanisms which lead to intervention's effects?), and; (iii) the intervention's contexts (how does context influence intervention implementation and outcomes?; [Moore et al., 2015](#)). Questions focused on the intervention's processes are often referred to as a process evaluation. Process evaluations are becoming increasingly popular in interventional research, with a recent systematic review identifying that 80% of interventional studies include a process evaluation (Minary et al., 2019).

However, a process evaluation following recently guidance published by Moore et al., (2015) based on the MRC framework was not possible at this feasibility stage. Moore et al.'s (2015) guidance does not provide explicit suggestions for how to conduct a process evaluation for feasibility studies. For this study, limited conclusions can be made concerning the mechanisms of intervention effect and contextual influences on intervention outcomes. This is because the sample was underpowered for mediation and sub-group analyses and the research questions were broader (e.g. understanding participants experience) than those typically asked in process evaluations. Instead, mixed-methods integration can generate initial insights and hypotheses about intervention implementation, mechanisms and contexts which can be used to direct further research, process evaluation and intervention refinement. Moore et al.'s (2015) guidance was used to inform and structure the research questions asked at this stage.

Successful integration of quantitative and qualitative research can be challenging as quantitative and qualitative research methods answer different research questions (Fetter et al., 2013) and are underpinned by different epistemological assumptions (Blackwood et al., 2013). Therefore, integration of quantitative and qualitative data requires an intentional approach that is mindful of the methodological and epistemological differences which generated the two findings (Bazeley, 2016; Plano Clark, 2019). For integration of quantitative and qualitative approaches to be meaningful, it is important that researchers consider why, what, when and how (Plano Clark, 2019). That is to say: the research questions asked should contain both quantitative and qualitative components; data sources should be aligned; clear points of integration should be identified; and methods of integration should be outlined.

During the trial planning stages, the trial's key uncertainties were organized under 3 topic titles: trial implementation and acceptability; intervention acceptability and intervention implementation and impact; and the relevant methods used to answer these questions were identified (see Table 20). For the third topic, the trial's key uncertainties were organized under the subheadings: fidelity (whether the intervention was delivered as intended); dose (impact of attendance on outcomes); reach (who accessed the intervention?); impact (potential use and value); and contexts (how intervention context influence its effects?). Both interventions showed promising intervention effects and neither intervention was indicated as superior. Therefore, this chapter evaluates both interventions.

Quantitative and qualitative data were sampled from the same participants, integrating the findings at the methods level and enabling a dialogue between the two data sources (Fettters et al., 2013; Plano Clark, 2019). A convergent approach to mixed-methods research was conducted (Fettters et al., 2013), where integration occurred after

Table 20. Areas of uncertainty and planned methods to address

Uncertainty	Method
1.0 TRIAL IMPLEMENTATION AND ACCEPTABILITY:	
<ul style="list-style-type: none"> How feasible and acceptable are the non-diagnostic and community recruitment methods for participant identification and participation? 	Mixed methods
<ul style="list-style-type: none"> How acceptable are the trial methods, randomisation, informed consent procedures, data collection, and child involvement? 	Mixed methods
<ul style="list-style-type: none"> How acceptable and useful are the clinical outcome measures, including multi-method assessment and child behaviour difficulties as primary outcome? 	Mixed methods
<ul style="list-style-type: none"> What are the participants' recommendations to increase data completion? 	Qualitative
<ul style="list-style-type: none"> Are there any practical issues for the PhD researchers and clinicians e.g., data management, training needs, support (structured record sheets and reflective diaries) 	Researcher records
2.0 INTERVENTION ACCEPTABILITY:	
<ul style="list-style-type: none"> Are peer-support and group-format acceptable and safe for this population? 	Mixed methods
<ul style="list-style-type: none"> Are there any unintended benefits and harms? 	Intervention records and Qualitative
<ul style="list-style-type: none"> Are there any unintended negatives and positives to other stakeholders (e.g., children, employers)? 	Qualitative
3.0 INTERVENTION IMPLEMENTATION	
3.1. FIDELITY:	
<ul style="list-style-type: none"> What components of the intervention are being delivered and what adaptations are made? 	Mixed methods
<ul style="list-style-type: none"> What is the difference between BaP- Enjoying Family Life and BaP- Standard? 	Mixed methods
3.2. DOSE:	
<ul style="list-style-type: none"> What are the patterns of intervention attendance and non-attendance and how does this impact intervention outcomes? 	Mixed methods
<ul style="list-style-type: none"> What strategies support attendance? How can attendance be improved? 	Qualitative
<ul style="list-style-type: none"> What are the differences between online and in person delivery? 	Mixed methods
3.3. REACH :	
<ul style="list-style-type: none"> How diverse is the sample? 	Quantitative
<ul style="list-style-type: none"> What is the impact of diversity and how can the diversity of the sample be increased? 	Qualitative
3.4. IMPACT	
<ul style="list-style-type: none"> What is the perceived value, impact, and unintended consequences of the intervention? 	Mixed methods
<ul style="list-style-type: none"> What components are indicated as core to impacting outcomes and what components are flexible? 	Mixed methods
3.5. CONTEXT	
<ul style="list-style-type: none"> Which contexts may influence clinical outcomes? 	Mixed methods

separate quantitative and qualitative analysis. A convergent approach was appropriate due to separate epistemological positioning and methodologies; to ensure research quality; and to answer questions that address different aspects of the same phenomena (e.g., trial feasibility from a research perspective and a participant perspective). Finally, the method of integration occurs through triangulation using a joint display. Findings were presented together and evaluated for “fit” as either confirmatory, expanding (findings diverge and expand insights through different and complementary perspectives), or discordant (Fetters et al., 2013).

The following chapter integrates the key findings from chapter 4 and 5 to address remaining uncertainties first around the trial methods and second on intervention implementation. More specifically, the chapter aims principally to integrate quantitative and qualitative findings to inform future research on peer-led parenting interventions for parents with significant emotional and interpersonal difficulties and their children aged 2-11 years. It also sets out to:

- a. examine the acceptability of proposed trial methods, including randomisation
- b. evaluate intervention implementation, possible mechanisms and the influence of participant and service factors on intervention implementation
- c. propose refinements to intervention and its implementation
- d. propose future research directions

6.3 Overall summary of mixed-method integration findings

Quantitative and qualitative integration confirmed the feasibility and acceptability of trial methods (see Table 21). In particular, randomisation was acceptable to participants however the findings also indicated intervention preference

Table 21. Integration of quantitative and qualitative findings

Quantitative findings:	Qualitative finding:	Integration outcome	Recommendations
Trial methodologies			
Feasibility and acceptability of trial methods (including key uncertainties about trial implementation)	<ul style="list-style-type: none"> • Non-diagnostic and community recruitment approach supported sufficient participant identification and retention for future evaluation • Participant flow and retention across trial stages indicates acceptability of trial methods, including randomisation and multi-method design • Multi-method design – lower completion of observational assessment due to COVID-19 and lack of time between consent and intervention start date. • Unmasking of PhD researcher & risk to trial’s internal validity • No SAEs or AEs, although there were safeguarding referrals 	<ul style="list-style-type: none"> • Evaluation of participant experience indicated the feasibility of participating in trial methods due to clear communication of expectations (theme 3) and reciprocal benefits of participating and possibility of future change as a result of participation (subtheme 2a) • Flexibility of the PhD researcher and reminders also helped participants to create space for the research tasks (subtheme 4b) • Participants experiences of trial methods, including randomisation, indicated acceptability based on the <ul style="list-style-type: none"> ○ Relatability of the trial aims to their family situation and hopes (theme 1), ○ Characteristics of the relationship between participant and research such as responsibility, non-judgement and trust (theme 2), ○ Materials which communicate intervention is for them, and these materials facilitate informed choice (theme 3), and ○ The opportunities for reflection that enabled growth (theme 4). 	= + <ul style="list-style-type: none"> • Future research can feasibly use non-diagnostic, community recruitment and retention strategies • Strengthen recruitment through schools, clinical and social care • Child behaviour is an appropriate primary outcome • Further development to increase the completion of the observational assessment. This could include: increasing trial resource, strengthening recruitment pathways and incorporating assessment in intervention • Further evaluation of role of preference on intervention outcomes is warranted • Researcher training and supervision focused on sensitivity of research topic and emotional impact
Intervention Acceptability			
Intervention acceptability (including key uncertainties around benefits and harms)	<ul style="list-style-type: none"> • Interventions not acceptable for all-likely due to non-attendance • Facilitation and delivery subscale of TARs scores highly for both groups 	<ul style="list-style-type: none"> • Acceptability of intervention associated with how well delivered intervention matched participants situations, hopes (Theme 1) and expectations (theme 3) • Possible harms of finding out ineligible and alienation from others (Theme 1) 	+ <ul style="list-style-type: none"> • Examine association between group cohesion and acceptability • Further evaluation of intervention acceptability for other stakeholders • Evaluate the longer-term impacts of participation and non-participation

Intervention implementation and impact				
Fidelity, dose & reach	<ul style="list-style-type: none"> • Incomplete fidelity data and low attendance indicate challenges with intervention implementation within a research trial • Dose: Variation between per-protocol and intention to treat indicate that attendance influences outcomes. • Reach- proportion data indicates diverse recruitment, with low number of Asian participants recruited compared to census data and greater numbers of lone parents, higher education and employment 	<ul style="list-style-type: none"> • Participant’s experiences indicate variation in delivery AND participants use of intervention between groups (e.g., role play)– perhaps due to low group attendance (theme 4) <ul style="list-style-type: none"> ○ Participant’s situations and hopes shaped interactions with others and intervention strategies (theme 1) • Non-attendance due to barriers and busy lives impacted both individual (theme 4) and the group (subtheme 3c) • Qualitative data (incl. TARs) suggests improvements to support intervention delivery • <i>Qual evaluation of weekly review forms indicate intervention delivery changes from practitioners</i> 	+	<ul style="list-style-type: none"> • Further evaluation of the characteristics which define peer-support for this population • Further evaluation of group processes, cohesion and identification on the intervention’s outcomes • Further evaluation of impact of online and in person delivery on group processes • Further identification of other intervention characteristics e.g., community delivery on intervention outcomes
Intervention impact and potential mechanisms	<ul style="list-style-type: none"> • Changes across time points for both interventions indicate both interventions may be effective - however unable to say whether one is superior to the other and patterns of intervention effect size indicate slight differences in effect of each intervention. • Largest effect size across time points indicating reduced dysfunctional parenting, satisfaction and self-efficacy, and reduced child behaviour and parent’s concerns. • Group cohesion greater in BaP-Enjoying Family Life 	<ul style="list-style-type: none"> • Group processes vital for learning, participation and engagement with intervention (Themes 1, 2 & 4; TARs) • Peer support could foster hope, facilitate group processes, increase motivation to try strategies and was acceptable to most, but some found peer support that did not relate to their situation disappointing (Theme 1 & Theme 2) • Evaluation of parent’s concerns indicate child behaviour was the prevailing concern • Unexpected benefit of research methods in facilitated learning e.g., reflection – part of intervention (Theme 4, TARS) • Indicates areas of content which participants felt were not addressed 	+	<ul style="list-style-type: none"> • Develop and test strategies to increase fidelity measure completion. The strategies may include improved training in fidelity for routine deliverers and evaluation of psychometrics of measure.. • Development with stakeholders and evaluation of strategies to increase intervention completion. • Develop additional resources and signposting to support tailoring of intervention to parents’ contexts
Context	<ul style="list-style-type: none"> • Participant age influences attendance • Recruitment location & engagement in trial 	<ul style="list-style-type: none"> • Diverse situation of parents and families (theme 1, TARs) and overcoming barriers (theme 4) 	>< +	<ul style="list-style-type: none"> • Strengthen facilitation support for fostering group cohesion and PGL flexibility whilst maintaining fidelity

Notes. = Confirmation + Expansion >< Discordant

which may influence engagement with the intervention and outcomes, discussed in detail in section 6.4. Findings also identified aspects practical issues around trial procedures such as unmasking which may influence the trials validity. Furthermore, initial estimates of effect and qualitative evaluation demonstrate further evaluation of both interventions is warranted. This is because both interventions offer potentially effective support for parents with significant emotional and interpersonal difficulties who are also concerned about their child's (aged 2-11 years) behaviour. Mixed-methods integration demonstrates parents with significant emotional and interpersonal difficulties are open to and actively seeking support. Recruitment which focuses on parent's parenting experience and concerns, is shared by a trusted source and shared in places where parents are thinking about parenting helps increase access. Further development and support of recruitment pathways in schools, mental health and social care settings may help improve access both to research trials and for clinical practice.

Whilst they are actively seeking support and are motivated to receive peer-led support, parents with significant emotional and interpersonal difficulties struggle to consistently attend and complete group interventions in the current format. Challenges in intervention completion impact intervention fidelity, ratings of acceptability, and potentially clinical outcomes. Furthermore, intervention non-completion prevents clear conclusions about intervention implementation and possible mechanisms of impact. Minimal differences in intervention effect were identified in this underpowered feasibility study, indicating similar possible mechanisms of impact through group processes and learning processes. However, high intervention non-completion, small samples and slight intervention differences in intervention effects on parent self-efficacy, verbosity and reflective function prevent certainty in this conclusion. Quantitative and qualitative data on both interventions emphasise the importance of

group relationships, cohesion and identification with the course and other participants, although the impact of group processes on intervention engagement, acceptability and outcomes is unclear. Both concrete learning and experiential, social and reflective learning processes provided in both interventions may be important for generating change for families. Individual, family and wider service contexts influenced hopes and experiences of identification with the intervention aims, content and members of the group (PGLs and other participants), perhaps shaping a preference for BaP-Enjoying Family Life. The impact of these contexts on intervention engagement and outcomes is also unclear. Flexibility in delivery and finding opportunities to tailor the intervention content to parent's situations whilst also maintaining fidelity is a vital avenue for further intervention development. Strategies to increase engagement and completion should also be considered. Table 21 and Sections 6.7 and 6.8 lay out proposals for future intervention refinement and research.

6.4 Trial implementation and acceptability

Integration of quantitative and qualitative findings (see Table 21) confirmed the feasibility and acceptability of the trial methods, including randomisation, and expanded insights on trial implementation through identifying aspects of trial methods which supported retention and recruitment. The sufficient rate of participant identification and high level of data completion at time 2 indicate the feasibility of trial methods to support a definitive evaluation. Parents described the acceptability of recruitment materials which they could relate to. Parents mostly experienced clarity about what participation would involve, recommending clearer reporting of exclusion criteria earlier on. Data-collection appointments and randomisation were acceptable to parents. This was because of the genuineness and relatability of the research questions asked, and the reciprocal benefits to participants, PhD researcher, and future parents who

would complete the assessments. Questionnaires could offer participants an opportunity to reflect and notice changes even if they were unable to participate in the intervention, demonstrating acceptability of trial methods. Additionally, child behaviour difficulties are an acceptable and appropriate primary outcome for this research. Quantitatively, moderate-to-large effect sizes suggested that there was a reduction in child behaviour difficulties at the post-intervention time point and challenging behaviour was the most frequent reported parent concern in the concerns about my child measure (Appendix T). Parents also described improvements in parent-child communication, particularly around emotions, which may warrant consideration as a secondary outcome.

Mixed-method integration offered expansion in understanding the recruitment pathways and high retention rates and can indicate ways to strengthen recruitment. The quantitative evaluation found that, despite considerable proportions of mental health and social service users being parents ([Diggin, 2011](#); [Ruud et al., 2019](#)), there was a very low number of parents finding out about the group through these pathways. It is unclear whether the lack of interested parents from health and social care pathways was due to: low engagement of parents in services ([Dale et al., 2017](#); [Day et al., 2020](#); [Evans et al., 2017](#); [Troup et al., 2022](#)); low confidence; lack of knowledge of the project in professional bodies working with parents ([Day et al., 2012](#); [Diggin, 2011](#); [Tuck et al., 2023](#)); or parents choosing not to pursue parenting support due to stigma and fears of child removal ([Diggin, 2011](#); [Harries et al., 2023](#)). Parents described the benefit of hearing about the project from a trusted source such as a doctor or friend. This finding resonates with previous work indicating that participant perception of the provider can influence engagement ([Ingoldsby, 2010](#)). It also indicated the potentially important role of schools for recruitment. Furthermore, a greater proportion of parents recruited

through mental health services continued to consent and were randomised within the trial, reinforcing a link between trust in the provider and trial engagement.

Mixed-methods integration therefore highlights the value, acceptability, and importance of recruitment through both community and clinical pathways for engagement and trial participation for different pathways. Strengthening recruitment pathways from mental health, social services and schools, and supporting professionals to feel more confident to ask about parenting and mental health would add significant value for future research to increase trial engagement and participation. These findings contribute to the call for action to boost the awareness and the confidence of both health and social care staff when discussing the mental health impact on parenting and better interagency collaboration around supporting parent's to access appropriate support (Gregg et al., 2021; Tuck, Wittkowski, Allott, et al., 2023; Tuck, Wittkowski, & Gregg, 2023).

In addition, mixed-methods integration also highlighted three further uncertainties and challenges concerning trial methods which need to be addressed, notably: the use of both questionnaire and observational assessment; the influence of participant preference on engagement and outcomes; and the unmasking of participants & researcher. There was a lower proportion of completion of the observational assessment. Participant interviews identified the acceptability of these observational assessments. However, parents described how intentional participation in research and intervention had to be, thus requiring planning to fit in alongside other commitments (e.g., school pick up, work). Completing an observational assessment with enough time to be randomised and invited to the intervention increased participant burden and was often unfeasible. Nevertheless, not completing observational assessment with individuals recruited closer to the group start date may increase the risk of bias in

sampling parents who may experience fewer barriers to access the group. Parent-reported outcomes are vulnerable to self-report bias (Morsbach & Prinz, 2006) and reliance on these questionnaires can increase uncertainty around intervention effects. Other methods of triangulation such as capturing child-report or teacher-reported outcomes were considered. However suitable measures for children under the age of 8 have not been developed and practical (e.g., variety of primary schools) and ethical challenges (e.g., stigma and anonymity) arise with teacher-report measures. Therefore, improving completion of observational assessments can improve the internal validity of future research.

Further consideration of the contextual influences on data completion may help develop strategies to improve the completion of observational assessment. One important research step may be to compare the demographic differences between the observational assessment completers and non-completers at baseline to indicate whether non-completion was related to a participant variable. There was a higher proportion of parents who were unemployed or self-employed at baseline and who had missing data at time 3. This indicates that employment status may affect data completion, although it's unclear why this relationship exists and whether these findings would relate to specific challenges with completing the observational assessment. Practical solutions may also help improve completion of observational assessments. These could include increasing the number of individuals trained to collect observational data; increasing the data collection window; and strengthening recruitment pathways to encourage earlier participant identification. Finally, integration of observational assessments with routine clinical delivery may be another way to increase data completion (Clarke et al., 2019), considered in section 6.6.

A second area of expansion from integration regards the acceptability and influence of intervention preference on randomisation. Both quantitative and qualitative data indicated the acceptability of randomisation, with rates of intervention completion and drop-out similar in each arm and parents describing acceptability due to the use of active control arm and understanding of research designs. However, most parents did indicate a preference based on their individual hopes, the timing of the group, delivery format, and how well they felt they would fit in with others in the group. Receiving the preferred intervention has been repeatedly associated with lower intervention drop-out, with most meta-analyses also demonstrating a small effect of preference on primary outcomes for psychosocial interventions (Delevry & Le, 2019; Lindhiem et al., 2014; Swift et al., 2018; Swift & Callahan, 2009). Furthermore, preference can decrease the validity of the RCT as participants may not adhere to treatment protocol if allocated their non-preferred intervention (Wasmann et al., 2019). Finally, randomised allocation does not translate to clinical practice where interventions are agreed based on negotiation and participant choice. It is important that future research considers how preference may have interacted with participant engagement and use of the intervention strategies, particularly in the control group. This is necessary to ensure that any difference in effectiveness is not related to disappointment with being allocated the control condition. This may involve either blinding participants, or implementing strategies to measure the effect of preference on intervention adherence, or using a partially randomised patient preference trial design (Wasmann et al., 2019).

Finally, trial records and qualitative analysis indicated a researcher training need and ongoing support, particularly around safeguarding and managing distress. The sensitivity of topic discussed, concerns for participant and family safety and the importance of the relationship built between the PhD researcher and the participants

support this conclusion (see [Silverio et al., 2022](#) for practical recommendations).

Furthermore, the PhD researcher was unmasked for a high proportion of participants, increasing the risk of bias on outcomes. This was partly due to semi-structured interviews and partly due to participants contacting the PhD researcher. Whilst separating qualitative and quantitative researchers in future evaluation may be an option to reduce the risk of bias due to unmasking, it is a strength that the PhD researcher had a relationship with participants which could facilitate openness in qualitative interviews. Instead, the acceptability of randomisation using an active control arm suggests that masking both participants and researcher to allocation status is preferable to increasing the trial's internal validity with limited impacts on participant's safety and wellbeing.

6.5 Intervention acceptability

Integration of acceptability ratings, intervention record and participant's interviews do not indicate problematic acceptability or harms from either intervention. Per-protocol analysis indicated a possible effect of intervention on acceptability ratings for intervention completers, with the mean acceptability for BaP-Enjoying Family Life slightly higher than BaP-Standard. Qualitative analysis indicates that acceptability may be associated with how well participants felt they could relate to others in the intervention (including both PGLs and participants) and the intervention content (theme 1). Indeed, group cohesion was greater in the BaP-Enjoying Family Life intervention. Furthermore, it is unclear how relating or not relating to others in the intervention affected parent and child outcomes and future help-seeking. Further investigation of the impact of group cohesion on intervention acceptability, outcomes and help-seeking is therefore recommended. Finally, the integration of these acceptability findings indicates that supporting group cohesion and tailoring the intervention content to individual's situations hopes and expectations may be important for further intervention refinement.

6.6 Intervention implementation

Integration of quantitative and qualitative findings offered complementary and diverging perspectives on the implementation and fidelity of both peer-led interventions. Walton et al., (2020) defined fidelity as the extent to which interventions are delivered as planned, and engagement referring to whether the participant understands and can perform the required skill (receipt) and whether they can put this into practice in daily life (enactment). Incomplete quantitative fidelity data and cancellation of groups due to low attendance prevent clear evaluation of fidelity and engagement, although completed data do indicate interventions were delivered as planned. Participant experiences indicate minor variation in what was delivered (e.g., use of role plays and emphasis on home practice activities), perhaps due to small group sizes. Furthermore, qualitative analysis found variation in the participant's use of, and interaction with, the intervention, with some participants describing concrete learning, whereas others described more social, reflective and experiential learning processes. Further mixed-method research is required to understand the participant and intervention factors which influence these two different ways of interacting with the intervention and what impact this has on intervention outcomes to investigate and further refine the interventions' logic models. Furthermore, intervention development should incorporate strategies to improve and increase the recording of fidelity and increase consistency in facilitation whilst enabling flexibility to respond to small group sizes.

Non-attendance was higher than expected and problematic for intervention implementation (with two groups cancelled due to low attendance). Furthermore, there was variation in patterns of intervention effect identified in the per-protocol analysis compared to intention to treat, suggesting attendance also impacts outcomes. Prior to

evaluating strategies to address non-attendance (considered in section 6.7), themes generated from the reflexive thematic analysis and the experiences, particularly of low attenders, can help address key uncertainties around barriers and facilitators of intervention attendance. Themes generated from the thematic analysis indicate that there were no differences in the experience of initial identification with the trial and intervention between high and low attenders. However, focusing on the experience of low-attenders, the experience of relating to the intervention appears to have fluctuated as the intervention progressed, with some describing the content not being relevant to their child, parenting or family situations or their hopes for the group (e.g. to get new parenting tools), and others describing struggling to relate to others in the group. In addition, some parents in both attendance groups described demotivation and concern for others dropping out of the intervention, suggesting a bi-directional relationship where non-attendance also impacts group cohesion. Untangling this relationship is important for future intervention development. For example, screening for group-cohesion and relatability of the course content after the first few sessions may help identify parents “at-risk” of not attending who could be targeted for greater support to help them attend.

In addition to experiences of relating to the intervention and trial methods, low-attenders also described a greater number of individual and external barriers to attending the course. Low-attenders described not being mentally in a good place to take on information and commit to the course, with most low attenders reporting that they experienced anxiety which got in the way of attendance. Addressing anxiety may be important in increasing attendance. Low attenders also described multiple external barriers to attending the intervention, such as conflicting and multiple appointments, long journeys and school pick-ups as getting in the way. For low-attenders, overcoming

practical barriers was challenging, whereas parents in the high attendance group described being able to overcome practical barriers through engaging their social support networks, suggesting it is not just practical barriers but also a lack of social support networks which may impact attendance.

Low-attenders also appreciated the open and honest conversations with the intervention team (e.g. supervisors and PGLs), the support given to making decisions around attendance and when the intervention team kept them in mind for future groups. This qualitative data suggests that intervention and trial acceptability are not necessarily linked to attendance, rather that poor reliability and personal and practical barriers such as anxiety and long journeys plus limited support from social networks may explain low-attendance. Measuring reliability to identify those at risk of drop out and intervening, addressing these personal and practical barriers and facilitating activation of the families social network are important to explore for future intervention development.

Mixed-methods integration also helps address key uncertainty about the implementation of online and in person delivery. Whilst the sample size was too small to quantitatively examine difference in outcomes between online and in person delivery, preference for attendance was similar for both delivery methods and across arms. Parents described the benefit of in person delivery as facilitating greater connection, a hypothesis requiring further quantitative evaluation, whereas online could be more helpful for supporting attendance where parents worked. Parent anxiety may also have influenced the acceptability of online format as in person could mean parents with anxiety had to step out of their comfort zone, and online breakout rooms were challenging for parents who described experiencing anxiety as they generated a pressure to speak. In the content analysis, several parents suggested that a hybrid format may

help support attendance. Overall, integration suggests that interventions should continue to offer choice in delivery format, and an evaluation of format on group cohesion is an important next research step.

Finally, with regards to reach, integration of quantitative and qualitative data both indicate diverse recruitment, with demographic characteristics showing large variation (e.g., number of children ranged from 1-5, household income ranged from £0 to £200,000) and participants reporting differences within the group. Similar proportions of White British, White Other and Black British or Black African or Caribbean participants were found compared to the Government's 2021 census data for the four South London boroughs (Office for National Statistics, 2022). However, there was a smaller proportion of Asian participants compared to the population of South London boroughs, indicating that the project may need to better target Asian communities in South London. Interestingly, prevalence data suggests Asian communities may report lower levels of child behavioural difficulties (Polanczyk et al., 2015), perhaps contributing to the low numbers of Asian families recruited.

Compared to BaP-Standard national scaling project (Day et al., 2022), a greater proportion of parents were lone parents in this project, more likely to have achieved undergraduate or higher level of education and they were more likely to be in employment. Diversity in the sample was valued, with parents describing the benefit of having different perspectives and finding similarities within difference. However, differences in parent and family situations could also alienate parents when they felt others in the group didn't understand their experiences. In the TARs qualitative feedback, one parent identified a need for Equality Diversity and Inclusion training and ongoing support for group facilitators and a few parents described digital inclusion needs, including posting handouts for online group and providing equipment for parents

who could not use their videos in the online group. Section 6.6.2 will consider how demographic characteristics may have influenced participant experiences and outcomes and implications for intervention development.

6.6.1 Intervention impact and hypotheses about the mechanism of impact

Integration of qualitative and quantitative data was helpful in evaluating the key uncertainties concerning the impact of the interventions, identify possible hypotheses around the mechanism of impact and evaluating the programme theory articulated in chapter 3. Together, quantitative intention to treat and qualitative data suggest that both interventions have similar impacts and potential mechanisms of impact despite adaptations and differences in content and delivery structure. Large effect sizes comparing means across time point indicate that both interventions may be effective at reducing child challenging behaviour and the parent's concerns and reducing dysfunctional parenting, parent satisfaction and self-efficacy. However, effect sizes indicated no intervention effects across primary and most secondary clinical outcomes except parent self-efficacy, verbosity, and two components of reflective function. Indeed, parents in both arms described experiencing improvements in self-care, consistently applying boundaries and positive discipline. Improved parent-child communication and increased understanding and acceptance for their child and their own parenting were the most frequent positive intervention impact mentioned.

An intervention effect on the parenting verbosity subscale is interesting and indicates parents in the BaP-Enjoying Family Life intervention showed greater reduction in their wordiness of responses to their children, an unintended consequence of BaP-Enjoying Family Life intervention. Parents described improved parent-child communication, particularly around emotions, and respect for the child's independence in both arms, suggesting intervention differences may only be small and dependent on

parents' interaction with the interventions rather than differences in strategies.

Similarly, the intervention effect on parent self-efficacy at time 2 indicated that parents in BaP-Standard showed greater change in self-efficacy compared to BAP-Enjoying Family Life, further suggesting slight variation in intervention mechanisms. Further exploration in larger samples would be better powered to evaluate different patterns of effect for the two interventions for parents with significant emotional and interpersonal difficulties.

Parent emotion regulation and reflective function were key targets of the BaP-Enjoying Family Life intervention, and integration of findings suggests there may be slight differences in how each intervention impacts these two targets. The BASE-6 was used as a measure of parent emotional intensity and impairment to assess change in parent emotion regulation. This showed a small-to-moderate effects across time point and a small effect of intervention in per-protocol analyses at time 3. Content analysis and reflexive thematic analysis indicated more parents in BaP-Enjoying Family Life described having greater strategies to cope with their emotions and increased understanding of the importance of their own self-care, rather than a reduction in the experience of strong feelings, perhaps explaining why intervention effects were only small. Other self-report measures which are more specific to emotion regulation exist, for example the difficulties in emotion regulation scale (DERS; Bjureberg et al., 2016; Gratz & Roemer, 2004). The DERS targets perceived capacity to regulate emotions and may be better at capturing improved parent emotion regulation. Indeed, the DERS has been highlighted as a core outcome for personality disorder research (Prevolnik Rupel et al., 2021). Therefore, further evaluation of BaP-Enjoying Family Life intervention mechanism of impact should consider using DERS.

The Parent Reflective Function Questionnaire captured change in parent reflective function, with effect sizes reported in chapter 4 indicating that BaP-Standard and BaP-Enjoying Family Life both influence parent reflective function. However, both interventions have slightly different patterns of effect. Parents described experiencing increased acceptance for their child's behaviour and their own parenting as a result of both interventions, with parents in BaP-Enjoying Family Life describing the separation of their child's emotions and their own emotions as important. It may be that BaP-Enjoying Family Life supports greater mentalising of the parent's own emotions, which overtime improves parent reflection about their child's mental states. Conversely, BaP-Standard directly improves parent reflective function about the child's mental states without increasing parent awareness of their own mental states. Further research evaluating the parent's change in self and child reflective function may help identify whether different mechanisms of impact exist between the two interventions.

In addition to evaluating intervention effects, integration of quantitative and qualitative methods confirmed the importance of group-delivery and peer-facilitation in the mechanism of impact for both interventions. The similarities in group format and peer delivery of both interventions may explain why there were limited effects of intervention on clinical outcomes. Parents from both groups reported the centrality of the group in motivating and facilitating engagement with parenting strategies and the group being an avenue for learning from others and problem solving together. Mean group cohesion was higher in BaP-Enjoying Family Life arm compared to BaP-Standard, with effect size indicating a moderate effect of intervention. This suggests that the content and delivery adaptations supported greater group cohesion in the BaP-Enjoying Family Life group. Parents described the benefit of relating to others for normalizing, validating, and increasing self-acceptance. Perhaps the addition of an

offload, settle in and quick win allowed parents to relate to each other's personal and parenting challenges. It may also have fostered motivation for change, increasing group cohesion. Evaluating the impact of increased group cohesion on outcomes would help identify if group cohesion is core to intervention effects, or not.

Similarly, peer-facilitation was rated and described as acceptable by the majority of parents in both groups. Parents described core facilitation skills which mimicked those articulated in BaP-Enjoying Family Life programme theory. These were: care and enthusiasm; balancing sharing and the needs of the group; and using lived experience to normalise and validated parent's concerns, generate hope and facilitate group bonding. Not identifying with the PGLs was experienced when parents felt the PGLs did not share their concerns or that the PGL's concerns were resolved. These findings emphasize the importance of acknowledging challenges in peer support and the use of supervision to support self-disclosure of challenges in a way that feels safe for PGLs. Further the evaluation of PGLs' experience of disclosing personal challenges and the perception of relating, or not relating, to parents in the intervention would add an important perspective when understanding the influence of relatability in peer support.

6.6.2 Context

Finally, the integration of quantitative and qualitative findings can help examine the wider contextual impacts on intervention implementation and outcomes. Quantitative and qualitative data indicated complementary and discordant findings regarding the impact of participant characteristics on trial participation and intervention engagement. Quantitative findings indicated that participant age was associated with attendance, with non-attenders demonstrating the lowest mean age and low attenders (1-5 sessions) having the highest mean age. Participants described how their past and current contexts and hopes influenced how well they related to the intervention content

and others in the intervention. They also identified parent variables such as parent age, co-parenting status, and child variables such as child age and neurodiversity shaping experience of the group, although these demographic factors weren't identified as affecting attendance in quantitative analyses. In the wider parenting intervention literature, there is limited evidence to indicate which situational variables are influential in predicting intervention acceptability, engagement, and outcomes (McPherson, 2014; Olofsson et al., 2016). Future research should be conducted to investigate the influence of the different parent contexts highlighted here (i.e., parent age, gender, co-parenting, child age, and child potential neurodiversity) on group cohesion, intervention engagement and acceptability and parent and child outcomes to identify whether separating groups based on these characteristics is warranted. Furthermore, intervention refinements which emphasize similarities in concerns may help reduce the impact of individual and family contexts on intervention implementation.

6.7 Proposed intervention implementation refinements

Integration of quantitative and qualitative findings around intervention implementation, mechanisms, and contexts indicate three areas for intervention development and refinement before any further evaluation. These areas are non-completion of fidelity measure; intervention non-completion; and variation in facilitation and support. The following section outlines the recommended changes.

Non-completion of fidelity measures: Further work is required to: incorporate fidelity into PGL and supervisor training; increase adoption of the measure in routine practice; and validate the instrument. Non-completion of fidelity measure may have been due to failure to implement the fidelity measure by PGLs; failure of the supervisors to remind and support fidelity measure completion and collection; and failure of the research team to support clinical teams to implement fidelity measure or

fundamental problems with the fidelity measure. Adopting a different approach to measuring fidelity is not recommended as it would likely influence intervention acceptability and it may also be impractical (e.g., video-recordings may not be acceptable and they may reduce group safety, supervisors aren't in every session to report on measures, and parent reported fidelity increases participant burden). Instead, further stakeholder consultation, refinement and training on the fidelity measure for PGLs and clinicians may increase uptake and use in clinical practice without affecting the trial's internal and external validity. Furthermore, the fidelity measure has not been tested for its psychometric properties and it is unclear whether the PGLs are able to assess their fidelity to the manual reliably and without bias. Prior to full-scale evaluation, quantitative evaluation of the reliability and validity of the fidelity measure is also recommended.

Strategies to address intervention non-attendance: The high rates of intervention non-attendance and non-completion threatens the internal validity of the trial. Non-attendance compromises the delivery of the group intervention; the estimation of intervention effects and means many parents who desire support are not receiving it. Strategies to increase intervention attendance are therefore a priority for further intervention development prior to further evaluation. Qualitative analysis in this study indicated multiple practical barriers related to the intervention (e.g., time conflicts with work, long travel time) and unrelated to the intervention (e.g., appointments, house moves) were most reported as barriers to attendance. A small group of parents also reported that the intervention content and delivery was not the right fit for their needs and that this led to non-attendance. Content analysis indicated that most parents suggested that increasing flexibility and options for parents (e.g., offering online and in person, morning and evening delivery, and hybrid options) may address non-attendance

and increase intervention reach. Therefore, providing multiple delivery and time options and pre-planning intervention delivery across the trial may help improve engagement. Providing options also relies on sufficient rates of recruitment, therefore strengthening recruitment pathways may support intervention completion. Finally, qualitative data comparing low-attenders to high-attenders indicates that facilitation of the individuals support networks may also help overcome barriers such as conflicts with social pick up. Supporting those with anxiety and identifying then supporting those who are struggling to relate to the intervention content and others in early sessions may also help improve attendance.

Further strategies to improve attendance are also considered. Research indicating strategies to increase intervention attendance and completion in parenting interventions and personality disorder interventions is early in its development (Gonzalez et al., 2018; Ingoldsby, 2010; Morawska & Sanders, 2006). A systematic review by Gonzalez et al., (2018) identified 8 studies low in methodological quality evaluating strategies to improve initial engagement in parenting interventions, arguing for more rigorous experimental studies evaluating engagement strategies. Furthermore, there is huge variation in definitions and ways of measuring “engagement”, e.g., enrolment in study, attendance or completion (Hernandez Rodriguez et al., 2020) and parents may be at different levels of intervention readiness (Clarke et al., 2014). With these criticisms in mind, three additional engagement strategies were considered: monetary incentives; a brief engagement intervention; and decreasing the duration of intervention.

Based on wider interventional research and integration of quantitative and qualitative findings, this project recommends that further intervention refinement should test whether adding a brief engagement intervention could improve attendance. Brief, intensive engagement interventions involving one or two sessions in which providers

address the families practical (e.g., daily schedule, transportation) and psychological (e.g., anxiety, resistance, beliefs about the treatment) needs have been found to be effective in improving engagement during early sessions (Ingoldsby et al., 2010). In contrast, although monetary incentives show some effect on enrolment, incentives undermine parent autonomy and responsibility and also increase intervention costs (Gonzalez et al., 2018; Ingoldsby, 2010). Limited evidence has been gathered to investigate whether reducing intervention duration would improve intervention attendance and completion, although Matthey et al., (2006) suggests that programme duration does not have a significant impact on enrolment. Findings from this project do not suggest a significant problem with enrolment. Rather initial and continued attendance appear to be where the challenge lies, with 83.33% parents accepting initial invite but 25.75% of parents unable to attend any sessions. Reducing the length of the intervention would not increase access and may disrupt core intervention mechanisms of impact such as group cohesion and cycles of practice, feedback, and group problem solving.

BaP-Standard already offers a coffee morning which aims to support engagement by addressing psychological barriers and encouraging participant autonomy in deciding whether to continue with the group (Day et al. 2012). However, parents are still required to attend the coffee morning and practical barriers such as transportation and personal barriers such as anxiety in groups are not addressed in the coffee morning. High numbers of parents in this trial were not able to attend the coffee mornings for practical and personal reasons, therefore never received any engagement support. Therefore, for parents with significant emotional and interpersonal difficulties, a brief engagement session may be best implemented one-to-one by PGLs and group supervisors using a home-based format.

The content of this brief engagement session should be structured by PGLs or supervisors. Consequently, it would be easily implementable. Moreover, it would facilitate the building of working partnerships with parents prior to, or early in, group intervention. Parents described the importance of knowing what to expect and intentional planning, with Chapter 2 indicating the importance of extended assessment for this population. The engagement session could encourage parents to discuss concerns, identify motivations and obstacles to engagement, and develop action plans should disengagement occur (Chapter 2, [Clarke et al., 2014](#); [McMurrin et al., 2010](#); [Wilson et al., 2018](#)). Furthermore, qualitative findings demonstrate the acceptability of using structured questions in research meetings for encouraging participant reflection, identifying family challenges and shaping participant's expectations of the course. Therefore, future intervention refinement could incorporate an observational assessment alongside discussing practical barriers to support engagement and collecting routine data which can be used to evaluate intervention impact.

Variety in facilitation: Each group session was delivered by a different PGL and it is an established strength that each peer support worker can draw on their experience of what worked, and what did not work for them, in delivery (Watson, 2019). However, this can mean that each peer support worker has a distinct approach to delivery, with too much flexibility leading to problems with fidelity and the intervention no longer being delivered as intended (Walton et al., 2020; Butler et al., 2020). Balancing flexibility with fidelity to the intervention methods and aims was identified in this study as important for intervention engagement and acceptability, similarly to other meta-synthesis of parenting interventions (Butler et al., 2020). Parents stated that flexibility and being able to go off topic in discussions encouraged reflection and insight. A lack of flexibility in delivery left parent's feeling misunderstood. This is

perhaps a result of the inflexibility of a manualized approach, the newness of the intervention, and a lack of PGL confidence in delivering intervention to the target population. However, evaluation of TARs facilitation and satisfaction indicated higher proportions of parents scoring “quite a lot” or “a great deal” for items on facilitation and satisfaction, suggesting drastic change in facilitation methods is not needed.

Instead, this PhD makes two recommendations. First, a recommendation for greater clarity, training and supervision around the core intervention components may be sufficient to support PGL fidelity whilst enabling flexibility for PGLs to tailor facilitation to the parents who attend. Based on these findings, group cohesion and relatability are core components which support engagement. Developing clear facilitation guidance to support PGLs to foster group cohesion may be beneficial. A second recommendation is to increase opportunities within the course for support to tailor content to the individual’s context through discussion and to develop a library of additional resources and handouts which parents can be supported to use. Additional content which was suggested by some but not all parents included: co-parenting and sharing resources with partners, unpacking family dynamics, parenting a child with neurodiversity, being a parent with neurodiversity, managing mental health over time; supporting older children; encouraging children to talk; supporting children with loss; and supporting parents when they know others in the group. These handouts should be co-produced with parents and support, where appropriate, should be given to PGLs to help them facilitate discussion around handouts if parents introduce the topic, either in the group or individually in engagement sessions.

6.8 Proposed future research

The findings from chapter 4 and 5 and integration here demonstrate the feasibility and acceptability of conducting a pragmatic superiority RCT to compare

BaP-Enjoying Family Life to BaP-Standard. However, proceeding with a superiority RCT using this design is not recommended. Initial estimates of intervention effects and sample size calculations indicate that a superiority trial would require large samples, significant resources and high costs which even then may only demonstrate small effects. Furthermore, intervention non-completion and challenges with capturing fidelity may undermine the trial's internal validity, risking research waste and preventing a clear evaluation of effectiveness and clinical utility of either intervention. Instead, this project suggests further intervention refinement and testing should be conducted, particularly focusing on (i) increasing intervention attendance and engagement, and (ii) evaluation and implementation of fidelity measurement. Table 22 identifies further uncertainties generated from integration of qualitative and quantitative findings which should be considered in future evaluation. The following chapter discusses the broader clinical and research implications, strengths and limitations of project and offers overall conclusions.

6.9 Chapter summary

This chapter integrates quantitative and qualitative findings from the feasibility evaluation of BaP-Enjoying Family Life trial to examine (i) the acceptability and feasibility of trial methods; (ii) intervention acceptability; (iii) intervention implementation and impact; and (iv) identify areas for further intervention refinement and research. Quantitative and qualitative integration offers differing perspectives, generates novel insights around key uncertainties and it is particularly useful for identifying areas for future research and development. This chapter highlights that rather than progressing with full-scale feasibility evaluation, it is preferable to address

Table 22. Areas of uncertainty for future research and planned methods to address.

Uncertainty	Method
1.0 TRIAL IMPLEMENTATION AND ACCEPTABILITY:	
<ul style="list-style-type: none"> • What methods can be implemented to improve and strengthen recruitment from mental health, social care and schools? 	Stakeholder involvement, evidence synthesis and development
<ul style="list-style-type: none"> • How acceptable and useful is including a measure of parent-child relationship as an intervention outcome? 	Stakeholder consultation, Mixed methods
<ul style="list-style-type: none"> • What methods can be implemented and how feasible are they to improve completion of observational assessment? 	Stakeholder involvement, Mixed methods
<ul style="list-style-type: none"> • How does treatment preference impact intervention acceptability and outcomes? 	Mixed method
<ul style="list-style-type: none"> • How acceptable is participant masking for future evaluation? 	Stakeholder consultation
2.0 INTERVENTION ACCEPTABILITY:	
<ul style="list-style-type: none"> • Are there any unintended negatives and positives to other stakeholders e.g., PGLs, children, employers? 	Qualitative evaluation with other stakeholders
<ul style="list-style-type: none"> • What is the relationship between group cohesion and intervention acceptability? 	Quantitative evaluation
3.0 INTERVENTION IMPACT AND IMPLEMENTATION	
3.1. FIDELITY:	
<ul style="list-style-type: none"> • What are the psychometric properties of PGL-rated fidelity assessment? 	Mixed method
<ul style="list-style-type: none"> • What methods can be implemented improve completion of fidelity assessment? How successfully are they implemented? 	Mixed method
<ul style="list-style-type: none"> • What components of the intervention are being delivered and what adaptations are made? 	Mixed method
<ul style="list-style-type: none"> • What components are core to impacting outcomes and what components are flexible? 	Mixed method
3.2. DOSE:	
<ul style="list-style-type: none"> • How effective are the suggested engagement strategies at supporting intervention completion for parents with significant emotional and interpersonal difficulties? 	Mixed method
3.3. REACH :	
<ul style="list-style-type: none"> • What intervention and recruitment methods are effective at increasing diversity of sample? 	Qualitative evaluation, stakeholder involvement
3.4. MECHANISM OF IMPACT	
<ul style="list-style-type: none"> • What is the relationship between group cohesion and intervention outcomes? 	Quantitative evaluation
<ul style="list-style-type: none"> • What constitutes a “peer” in a peer-led parenting intervention? 	Qualitative evaluation
<ul style="list-style-type: none"> • How do both interventions influence emotion regulation abilities and mentalising about self and child? 	Mixed method
3.5. CONTEXT	
<ul style="list-style-type: none"> • What contexts influence intervention outcomes for parents with significant emotional and interpersonal difficulties? 	Quantitative evaluation
<ul style="list-style-type: none"> • Is it feasible and acceptable to incorporate strategies which enable tailoring of group intervention to parents’ individual needs? 	Mixed method

key uncertainties and challenges in completion of the observational assessment, intervention completion, fidelity measurement, and the tailoring of intervention to the parent's needs whilst maintaining fidelity. Further process evaluation should seek to evaluate the influence of group processes; identification with intervention aims, content and other participants; and the role of concrete and experiential, social and reflective learning processes as potential mechanisms of impact for both interventions.

Chapter 7 General discussion and conclusions.

This PhD developed and conducted an initial evaluation of a novel, peer-led, group intervention, Being a Parent-Enjoying Family Life, for parents with significant emotional and interpersonal difficulties who are concerned about their child's (aged 2-11 years) behaviour. The introduction laid out (i) the theoretical conceptualisation of parenting and child development and their determinant; (ii) the effects of significant emotional and interpersonal difficulties on parenting; (iii) the strengths and limitations of existing non-specialised and specialised parenting interventions; and (iv) the methodological framework which informed this project: the MRC framework for complex intervention development. Then, this PhD presented activities undertaken during intervention development (Phase 1), including a systematic review (Chapter 2) and stakeholder consultations and evidence synthesis to develop the intervention's programme theory and guide manual adaptations (Chapter 3). This PhD then presented the mixed-methods feasibility testing of trial methods and intervention (Phase 2), involving convergent quantitative evaluation using pre-specified feasibility criteria (Chapter 4) and qualitative reflexive thematic analysis of participant's lived experience (Chapter 5) and integration of quantitative and qualitative findings to address key uncertainties and indicate further directions for research and intervention development (Chapter 6). Here we summarise the overall findings of the PhD project, evaluate the strengths and limitations of the approaches taken and summarise the implications, contribution and future directions identified by this PhD project.

7.1 Summary of findings

Significant emotional and interpersonal difficulties, including diagnoses of personality disorders, in parents are a substantial risk factor for emotional and

behavioural difficulties such as disruptive behaviour in childhood (Petfield et al., 2015; Steele et al., 2020). Previous systematic reviews indicate maternal BPD diagnoses and traits are associated with lower sensitivity, emotional warmth and poorer emotion recognition; greater parenting stress, overprotection, intrusiveness, rejecting and laxness; and inconsistent discipline and frightened or disoriented parenting (Eyden et al., 2016; Petfield et al., 2015; Steele et al., 2019). This PhD addresses gaps in previous reviews by evaluating the relationship between all personality disorder characteristics and parenting practices of both mothers and fathers of children aged 2-12 years.

The systematic review found that mixed quality and heterogeneous studies have evaluated the relationship between personality disorder diagnoses and parenting across a range of parenting constructs, with no clear delineation between different personality categories or genders. Narrative synthesis identified relationships between personality disorder characteristics and increased parenting stress, hostility and negative affect, reduced parental involvement and negative parenting practices for parents of children aged 2-12 years. Heterogeneous, limited and low-quality research was unable to replicate findings of an association between personality disorder diagnoses and less positive affective or behavioural parenting constructs such as warmth and sensitivity in parents of this age group. These findings contributed to the intervention development outlined in this PhD project, and have wider implications for intervention development, identifying gaps and hypotheses for future research and addressing stigmatising and potentially misogynistic assumptions about parents with personality disorders.

Intervention development followed O’Cathain et al. (2019)’s guidance, as recommended by the MRC framework (Skivington et al., 2021), to generate the intervention’s programme theory and adapt an existing intervention manual. BaP-Standard was identified as an appropriate intervention for adaptation for the target

population due to its peer-led and group format, clinical effectiveness identified in both an RCT (Day et al., 2012a) and community scaling project (Day et al., 2022) and previous demonstrations of successful adaptations for other populations (Bradley et al., 2020; Harwood et al., 2022; Kearney et al., 2020; Michelson et al., 2014). Furthermore, the existing clinical teams and national network of hubs delivering the intervention ensured clinical utility and findings could be easily disseminated to clinical practice. Findings from the phase 2 evaluation demonstrate the impact of stakeholder involvement (Bagley et al., 2016; Popay & Collins, 2014; *PPI (Patient and Public Involvement) Resources for Applicants to NIHR Research Programmes*, n.d.) with participants agreeing with stakeholder on the importance of focusing on parent's emotions early on, emphasis on emotion-focused communication, group containment and managing distress and facilitation by two peer facilitators over one peer and one clinician. Furthermore, the identification of key uncertainties at the intervention development stage enabled the selection of research methods which could address these key uncertainties, improving trial design and utility of findings for intervention development and refinement.

Findings from the feasibility evaluation (chapters 4, 5 & 6) reinforced and can further develop the intervention's programme theory. Evidence synthesis and stakeholder consultation identified content and delivery adaptations which improve emotion regulation (to reduce negative affective parenting), parent reflective function, positive parenting strategies, consistency with discipline and parent warmth & sensitivity. Group-delivery and peer facilitation skills were also identified as important, with the programme theory specifying important facilitation skills for group processes and peer delivery. Findings from the mixed-methods integration reinforced the importance of peer facilitation involving self-disclosure to normalise and validate

parent's concerns and situations, facilitation of self-reflection and to support group processes such as balancing needs, creating safety and managing distress. Furthermore, mixed-methods integration also reinforced the importance of group processes around safety, care, problem solving and practice, and further identified the key role of providing opportunities for feedback and supporting identification with others in the group. Finally, reflexive thematic analysis identified the importance of session buffers (offload and settle ins), home practice and consistent reminders of self-care (quick wins) for participant's engagement both in session and after the group ended.

Mixed-methods integration also enabled identification of further key uncertainties and areas for future intervention development and refinement. Overall, the feasibility evaluation (phase 2) indicated the feasibility and acceptability of the trial design (pragmatic, superiority RCT with BaP-Standard as active control arm) and methods (non-diagnostic recruitment, strategies to improve retention). Initial estimates of intervention effects demonstrated improvements from baseline in primary and secondary clinical outcomes with moderate-to-large effect sizes, indicating both interventions may be effective at improving parent and child outcomes for parents with significant emotional and interpersonal difficulties. Limited differences in intervention effects suggest that further refinements and evaluations of both interventions for parents with significant emotional and interpersonal difficulties could be conducted. A full-scale superiority trial using the current methods requires a large sample size, involving high resource and costs and may be undermined by intervention non-attendance and poor fidelity measurement. Therefore, the PhD concludes that further intervention development and refinement to improve intervention completion and fidelity monitoring is required before progression to a wider effectiveness evaluation (phase 3).

Qualitative and mixed-methods integration supported problem-solving, identified further research questions and suggested intervention refinements which should be conducted prior to a phase 3 evaluation. Reflexive thematic analysis generated four themes related to parent's experience of trial methods and intervention. Parents described a sense-making process where they related trial aims, methods and intervention content to their individual and family situations, hopes and concerns and past experiences. The influence of context fits the dynamic and complex model of parenting and child development presented in chapter 1 (Belsky 1984; Taraban & Shaw, 2018) and highlight the importance of identification on intervention engagement and group processes. The importance of relationships in shaping participant's experience was also identified. Reciprocal responsibility, trust, safety and non-judgement and experiencing care were core characteristics in parent's experiences of relationships in the trial and potentially facilitated intervention engagement. Furthermore, knowing what to expect was important for facilitating participant autonomy and the acceptability of trial procedures. Finally, participants interacted with the intervention in varied ways, sometimes as a didactic learning experience and sometimes through social and experiential learning. Flexibility, participant motivation and intentionality were important in participants engaging with the intervention, with practical barriers related and unrelated to the intervention often getting in the way of attendance and implementation of the strategies at home. These qualitative findings both reinforced theory and evidence from intervention development phases and generated hypotheses for future research and intervention development.

Integration of both quantitative and qualitative components enable evaluation of key uncertainties related to trial methods and intervention acceptability, implementation and impact. The non-diagnostic community and clinical recruitment approaches were

feasible and acceptable, with further strengthening of clinical recruitment pathways and schools required perhaps through supporting family-focused practice in mental health services (Gregg et al., 2021; Tuck, Wittkowski, & Gregg, 2023). Child behaviour is the most appropriate clinical outcome for both interventions, with the impact of both interventions on parent-child relationship identified as a further possible outcome for evaluation. Furthermore, integration indicated peer-delivered group-support is acceptable and safe for this population, with no harms identified. Strategies to improve data completion of fidelity and observational measures were recommended.

Furthermore, participant feedback and limited differences in attendance between online and in person delivery indicate that flexibility of delivery methods should be prioritised to support parents to overcome barriers and attend the intervention. Other strategies to increase attendance are also considered. Finally, integration highlighted further hypothesis for evaluating intervention mechanisms of impact and contextual influences on intervention outcomes to develop the intervention's programme theory.

7.2 Strengths and limitations

The strengths of the project include the high external validity as the research methods, intervention development and evaluation were conducted with the clinical services who provide BaP-Standard and Helping Families programme. The close links with clinical teams enabled rich and impactful insights from stakeholders to shape trial and intervention decisions. Furthermore, collaboration with clinical teams enable the findings to be rapidly disseminated into clinical practice, reducing research waste and improving the trial's clinical utility. However, stakeholder involvement was determined by the PhD researcher. Stakeholder contribution was therefore likely biased by the researchers' assumptions, and things outside of the PhD researcher's awareness may not have been consulted upon. Future intervention development should establish a PPI

network consisting of parents with lived experience and involving regular consultation meetings to monitor research and intervention development and ensure clinical utility. Furthermore, the delivery by clinical teams who routinely deliver these interventions may have impacted the rigor with which research was conducted. Attempts were made to incorporate research requirements and data collection into routine practice using stakeholder consultation. However, there was a high non-completion of fidelity measures, indicating challenges of implementing aspects of research design within clinical service.

Nevertheless, this PhD project has several methodological strengths, including the use of the MRC framework to guide each stage of the project. The MRC framework enabled iterative and rigorous cycles of development, evaluation and consideration of the wider contexts, stakeholders, implementation and established evidence and theory. The PhD project engaged with methodological challenges such as conflicting epistemologies of quantitative and qualitative work and used critical evaluation and research synthesis alongside stakeholder consultation to drive decision making. However, the ambitious nature of the project, complex and heterogeneous constructs assessed and desire to consider research questions using mixed methods generated study limitations, particularly for the systematic review. Initially, the systematic review had intended to review parenting experiences of parents of children aged 0-18 years. However, the review's question and eligibility criteria was refined after initial screening and registration due to the broad number of parenting constructs measured across different developmental ages and purpose of review in informing intervention development for parents of children aged 2-11 years. Changes made to the protocol after registration may risk introduction of bias from screening. Discussions with the PhD

researcher's supervisors who had not been involved in screening and the reasons for changing the protocol were clearly articulated to reduce risk of bias from screening.

Finally, this project used well-established and evidence-based theories to guide intervention development and evaluation. However, the research and intervention neglected to address co-parent relationship and only minimally considered child characteristics and social support on intervention development and outcomes. Belsky's (1984) MDP and updated models of the determinants of parenting (Day et al., 2020; Taraban & Shaw, 2018) highlight the importance of the co-parenting relationship, characteristics of the child and the social and cultural context in determining parenting and child outcomes. Indeed, the systematic review indicated that co-parent conflict may be an important mediator of the influence of personality disorders on parenting. Wider literature reliably demonstrates the impact of co-parent conflict and limited social support on parent and child outcomes (Condon et al., 2022; Jean & Elizabeth, 2022; Stover et al., 2013, 2016). As interpersonal difficulties are a core experience of parents recruited to this trial, not including and considering co-parenting support is a limitation of this project. This limitation is further highlighted by a number of parents suggesting support for co-parents as an area for intervention improvement.

Similarly, characteristics of the child and bi-directional nature of parent-child interactions could have been considered further, particularly due to the considerable heritability of significant emotional and interpersonal difficulties (Torgersen, 2009). Further consideration of co-parenting situation and needs, social support and characteristics of the child is required for intervention development and systematic evaluation of impact of personality disorders on parenting.

7.3 Implications and future directions

This PhD has many clinical implications, generated from strengths of this study in incorporating stakeholder perspectives and working closely with the clinical teams who deliver peer-led parenting interventions and interventions for parents with significant emotional and interpersonal difficulties. First, the project identifies the value, acceptability and feasibility of developing and evaluating support which centres on the parent's experience. This non-diagnostic approach may also have increased access for parents who were experiencing challenges but who were not involved in mental health services. The approach normalised and validated without stigmatising parent's experience and facilitated motivation for change. Furthermore, the project identifies that parents can reliably self-identify as experiencing significant emotional and interpersonal difficulties, indicating autonomy and choice should be encouraged when offering support focused predominantly on parenting and child wellbeing. The feasibility and acceptability of the non-diagnostic and inclusive recruitment approach has implications for both research, indicating non-diagnostic recruitment can facilitate and support recruitment of eligible participants for research, and clinical practice. Research on family-focussed practice in adult mental health services calls for service-level interventions to boost awareness and confidence of professionals in discussing parenting need and better interagency collaboration (Gregg et al., 2021; Tuck, Wittkowski, Allott, et al., 2023; Tuck, Wittkowski, & Gregg, 2023). It may be that by using non-diagnostic support and language which focus on parent's experience (e.g., parents with strong emotions) could help facilitate family-focused conversations and strengthen recruitment to evidence-based parenting support through clinical services.

Second, the project identifies the value of group and individual relationships in facilitating participation in research and intervention engagement for parents with

significant emotional and interpersonal difficulties. These findings reinforce well-established evidence and theory which demonstrates that supportive, purposeful and connected partnerships between family and practitioner are key for prevention, early intervention and management of difficulties and challenges (Day & Harris, 2013). The findings indicate adopting a family-partnership approach may be vital for supporting retention and engagement in parenting research and interventions for parents with significant emotional and interpersonal difficulties.

Third, the project identifies that parent's with significant emotional and interpersonal difficulties are open to and seeking support, and have the capacity to demonstrate warmth, sensitive parenting using positive parenting strategies (Barnicot et al., 2022; Dunn et al., 2020; Eyden et al., 2016). However, higher levels of stress and negative affect, co-morbidity, challenging co-parent relationships, family and wider social environments may increase the likelihood of negative, inconsistent parenting practices, challenging parent-child relationships and intervention non-completion. These patterns may be amenable to change using peer-led, group support which focuses on existing strengths, problem-solving and reflection and both emotion-focused and behaviour-focused positive parenting and coping strategies. These findings have clinical implications for developing and funding evidence-based, strength-focused, group, peer-led and reflective parenting interventions for parents with significant emotional and interpersonal difficulties to improve parent & child outcomes and potentially prevent the intergenerational transmission of mental health difficulties.

Fourth, whilst parents with significant emotional and interpersonal difficulties are open to and actively seeking parenting support, many of these parent's struggle to access support due to practical barriers related and unrelated to the parenting groups. This has implications for further intervention refinement and development, indicating

that giving parent's options, flexibility in delivery and using a waiting list to keep parents in mind for future groups can support engagement. Furthermore, other methods of engagement were also considered. This project suggesting a brief one-to-one structure engagement session may improve low intervention completion through identifying and discussing the practical and psychological barriers and motivations of the parents, managing expectations, and increasing parent autonomy and problem solving. Further research should identify, develop and test engagement strategies for this population of parents with high motivation but low intervention completion.

Finally, the use of the MRC framework (Skivington et al., 2021) and focus on iterative development, mixed-methods research and implementation is useful for identifying areas of uncertainty for future intervention development and research, outlined in the previous chapter. In particular, the project identifies key uncertainties around intervention fidelity measurement, with challenges implementing fidelity measurement in clinical practice. In addition, integration identified hypotheses and possible influences of participant's contexts which shaped intervention outcomes. Clinically, these findings also have implications as they suggest interventions for parents with significant emotional and interpersonal difficulties should balance flexibility to tailor to the individual's contexts and needs, whilst ensuring consistent delivery of the intervention's core components, replicating findings in the wider parenting literature (Butler et al., 2020). This flexible fidelity has implications for both practitioner training to ensure clear definitions of the intervention's core components and provide opportunities for flexibility, and for quality assurance and supervision in clinical practice. This project proposes stakeholder involvement to better develop fidelity measurement, further research and PGL training which identifies the intervention's core components and co-development of a library of extra resources

which can enable tailoring to the individual's contexts without jeopardising intervention fidelity.

Overall, this project presents the development and feasibility evaluation of an adapted peer-led, group format intervention, Being a Parent-Enjoying Family Life, for parents with significant emotional and interpersonal difficulties and children (aged 2-11 years) who's behaviour they are concerned about. Intervention development, incorporating stakeholder perspectives and evidence synthesis identified key targets for specialised interventions for parents with significant emotional and interpersonal difficulties. Intervention development also characterised content, delivery and facilitation materials and skills to develop the intervention's programme theory and adapt a well-established intervention for the target population. The project also identified the feasibility and acceptability of RCT trial methods, including randomisation to an active control arm and non-diagnostic, clinical and community recruitment for parents with significant emotional and interpersonal difficulties.

Initial estimates of effect indicate both BaP-Enjoying Family Life and the well-established intervention it was adapted from, BaP-Standard, show promise in improving parent and child outcomes. However, further evaluation of the effectiveness of either intervention using the same methods tested here would likely be undermined by intervention non-completion and poor measurement of fidelity. Therefore, prior to a full-scale effectiveness evaluation, further intervention refinement, development and feasibility testing is required to improve fidelity measurement and intervention completion. The project has clinical implications for (i) increasing family-focused practice in adult mental health services, (ii) increasing access and engagement with parenting research and interventions for this population through purposeful partnerships, (iii) developing effective and strength-based support targeted to the needs

of parent's with significant emotional and interpersonal difficulties, and (iv) directions for further intervention refinement to support intervention completion and tailoring to the individuals contexts whilst maintaining intervention fidelity.

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- Zhang, X., Beatty, A., Abela, K., Fernandes Melo, M., Kenny, M., Atkinson, L., & Gonzalez, A. (2023). Assessing parental emotion regulation in the context of parenting: A systematic review. *Developmental Review*, 69, 101092. <https://doi.org/10.1016/j.dr.2023.101092>
- Zimmer-Gembeck, M. J., Rudolph, J., Kerin, J., & Bohadana-Brown, G. (2022). Parent emotional regulation: A meta-analytic review of its association with parenting and child adjustment. *International Journal of Behavioral Development*, 46(1), 63–82. <https://doi.org/10.1177/01650254211051086>

Appendices

Appendix A: Completed PRISMA checklist

Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	Page 41
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	n/a
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	Thesis introduction & chapter introduction, page 41-45
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	Page 45
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	Eligibility: Page 46 & appendix C, Study grouping: page 48
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	Section 2.3.3., page 46
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	Appendix B, page 269
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	Section 2.3.5., page 46
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	Section 2.3.5., page 46
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g., for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	Section 2.3.6., page 48
	10b	List and define all other variables for which data were sought (e.g., participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	Section 2.3.6., page 48
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	Section 2.3.6., page 48
Effect measures	12	Specify for each outcome the effect measure(s) (e.g., risk ratio, mean difference) used in the synthesis or presentation of results.	N. A

Section and Topic	Item #	Checklist item	Location where item is reported
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g., tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	Section 2.3.7., page 48
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	Section 2.3.7., page 48
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	Section 2.3.7., page 48
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	Section 2.3.7., page 48
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g., subgroup analysis, meta-regression).	N.A.
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	N.A.
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	N.A.
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	N.A.
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	Section 2.4.1., page 49
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	Section 2.4.1., page 49 & appendix E
Study characteristics	17	Cite each included study and present its characteristics.	Section 2.4.1., page 49
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	Section 2.4.2., page 56
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimates and its precision (e.g., confidence/credible interval), ideally using structured tables or plots.	Section 2.4.3. and Table 5 page 61
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	Table 5, page 61
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g., confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	N/A
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	N. A
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	N.A.
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	N.A.

Section and Topic	Item #	Checklist item	Location where item is reported
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	N.A..
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	Section 2.5.1., page 79
	23b	Discuss any limitations of the evidence included in the review.	Section 2.5.2., page 80
	23c	Discuss any limitations of the review processes used.	Section 7.2., page 262
	23d	Discuss implications of the results for practice, policy, and future research.	Section 2.5.3, page 83
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	Page 2.3.1. page 45
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	Page 2.3.1. page 45
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	Page 43
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	N.A.
Competing interests	26	Declare any competing interests of review authors.	Page 12
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	n.a.

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ* 2021;372: n71. doi: 10.1136/bmj. n71

For more information, visit: <http://www.prisma-statement.org/>

Appendix B: Search strategy for each database, including any filters or limits used (PRISMA, 2020)

Embase Search:

#	Query	Results from 17 Oct 2022
1	"personality difficult*".ab,kw,ot,ti.	119
2	"Personality disorder*".ab,kw,ot,ti.	30,266
3	personality pathology.ab,kw,ot,ti.	1,338
4	1 or 2 or 3	30,730
5	"parent*".ab,kw,ot,ti.	627,859
6	"mother*".ab,kw,ot,ti.	346,960
7	maternal.ab,kw,ot,ti.	393,949
8	paternal.ab,kw,ot,ti.	33,472
9	"father*".ab,kw,ot,ti.	68,230
10	"caregiv*".ab,kw,ot,ti.	122,608
11	"guardian*".ab,kw,ot,ti.	13,781
12	5 or 6 or 7 or 8 or 9 or 10 or 11	1,309,942
13	4 and 12	2,117
14	"Interview*".ab,kw,ot,ti.	545,412
15	"Experience*".ab,kw,ot,ti.	1,865,777
16	qualitative.ab,kw,ot,ti.	372,157
17	"qualitative research".ab,kw,ot,ti.	36,608
18	14 or 15 or 16 or 17	2,472,650
19	"Quantitative*".ab,kw,ot,ti.	1,059,087
20	Cross-sectional.ab,kw,ot,ti.	616,163
21	"cross sectional".ab,kw,ot,ti.	616,163
22	community.ab,kw,ot,ti.	746,175
23	clinical.ab,kw,ot,ti.	6,178,651
24	longitudinal.ab,kw,ot,ti.	418,249
25	retrospective.ab,kw,ot,ti.	1,152,238
26	cohort.ab,kw,ot,ti.	1,219,179
27	"observation*".ab,kw,ot,ti.	1,390,062
28	randomized controlled trial.ab,kw,ot,ti.	134,629
29	Clinical trial.ab,kw,ot,ti.	277,950
30	survey.ab,kw,ot,ti.	863,864
31	questionnaire.ab,kw,ot,ti.	727,164
32	19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31	11,084,566
33	18 or 32	12,182,387
34	13 and 33	1,513

PsycINFO Search:

#	Query	Results from 17 Oct 2022
1	personality difficult*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	279
2	personality disorder*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	58,779

3	personality pathology.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	2,072
4	1 or 2 or 3	59,315
5	parent*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	333,973
6	mother*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	148,072
7	maternal.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	71,354
8	paternal.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	12,717
9	father*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	54,351
10	caregiv*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	75,922
11	guardian*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	5,602
12	5 or 6 or 7 or 8 or 9 or 10 or 11	500,316
13	4 and 12	5,885
14	interview*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	466,097
15	experience*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	775,650
16	qualitative.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	211,788
17	qualitative research.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	45,667
18	14 or 15 or 16 or 17	1,160,108
19	quantitative*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	127,754
20	cross-sectional.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	127,984
21	"cross sectional".mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	127,984
22	community.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	313,422
23	clinical.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	628,828
24	longitudinal.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	157,673
25	retrospective.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	58,501
26	cohort.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	92,477

27	observation*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	191,870
28	randomized controlled trial.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	23,040
29	clinical trial.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	17,666
30	survey.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	322,455
31	questionnaire.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	410,366
32	19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31	1,799,799
33	18 or 32	2,387,676
34	13 and 33	4,044

PubMed search terms

Query	Search Details	Results
1 ("personality difficult*" OR "personality disorder*" OR "personality pathology") AND ("parent*" OR "mother*" OR "maternal" OR "paternal" OR "father*" OR "caregiv*" OR "guardian*") AND (("interview*" OR "Experience*" OR "qualitative" OR "qualitative research") OR ("Quantitative*" OR "cross-sectional" OR "cross sectional" OR "community" OR "clinical" OR "longitudinal" OR "retrospective" OR "cohort" OR "observation*" OR "Randomized controlled trial" OR "Clinical Trial" OR "survey" OR "questionnaire"))	("personality difficult*[All Fields] OR "personality disorder*[All Fields] OR "personality pathology"[All Fields]) AND ("parent*[All Fields] OR "mother*[All Fields] OR "maternal"[All Fields] OR "paternal"[All Fields] OR "father*[All Fields] OR "caregiv*[All Fields] OR "guardian*[All Fields]) AND ("interview*[All Fields] OR "experience*[All Fields] OR "qualitative"[All Fields] OR "qualitative research"[All Fields] OR ("quantitative*[All Fields] OR "cross-sectional"[All Fields] OR "cross-sectional"[All Fields] OR "community"[All Fields] OR "clinical"[All Fields] OR "longitudinal"[All Fields] OR "retrospective"[All Fields] OR "cohort"[All Fields] OR "observation*[All Fields] OR "Randomized controlled trial"[All Fields] OR "Clinical Trial"[All Fields] OR "survey"[All Fields] OR "questionnaire"[All Fields]))	2,740

Print Search History: EBSCOhost - Google Chrome
 web.s.ebscohost.com/ehost/searchhistory/PrintSearchHistory?vid=14&sid=e85a6b2e-33d4-46e6-bc4d-35c09d85e664%40redis&theSearchHistoryIds=

EBSCOhost

Monday, October 17, 2022 1:05:43 PM

#	Query	Limiters/Expanders	Last Run Via	Results
S9	S1 and S2 and (S4 OR S6)	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	941
S8	S3 AND S7	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	941
S7	S4 OR S6	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	3,190,402
S6	questionnaire OR S5	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	2,869,684
S5	quantitative* OR cross-sectional OR cross sectional OR community OR clinical OR longitudinal OR retrospective OR cohort OR observation* OR randomized controlled trial OR clinical trial OR survey	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	2,687,480
S4	interview* OR qualitative OR experience* OR qualitative research	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	856,316
S3	S1 AND S2	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	1,260
S2	Parent* OR mother* OR maternal OR paternal OR father* OR caregiv* OR guardian*	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	447,477
S1	Personality difficult* OR Personality disorder* OR Personality pathology	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	14,430

Type here to search

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Appendix C: Systematic review detailed eligibility criteria

Black= prospectively registered eligibility; Purple = further clarification written 23/08/2021; Orange= further changes 23/09/21

Inclusion criteria:

- Population: Primary studies collecting data about a parent with a personality difficulty or personality difficulty symptoms
 - Personality difficulty or symptoms of personality difficulty must be identified using standard assessment procedure Defined as assessments which aim to identify personality pathology/disorders and which have been psychometrically validated against standard PD measures.
 - E.g. SCID-II, SAPAS, SASPD, PID-5, Iowa Personality disorder screen, MCMI, borderline symptoms list
 - The assessment of personality difficulty must correspond to either DSM-III, IV or 5 or ICD-10/11 diagnostic criteria which capture core components of personality difficulties e.g. disturbances interpersonal, self and cognitive/emotional functioning.
 - Study participants must identify as parents, but can be mother or father, biological or non-biological (e.g. step-parent). They must provide or have provided some sort of caregiving role.
 - Parent must be 18 or older.
 - Mean age of children in the study must be between the ages of 2-12 at time of first assessment of parenting behaviour.
- Outcomes/Phenomena of interest: Primary studies must assess parenting characteristics (empathy, attachment, parenting behaviour) and/or experience of parenting.
 - We define parenting characteristics as characteristics in the context of parenting e.g. empathy towards their child, emotion regulation in the context of parenting stressors. Studies measuring general adult characteristics such as adult attachment will be excluded unless they are measured in the context of the parent-child relationship.
 - Choices about care e.g. immunisations, exposure to smoking are also not included as a “parenting” variable.
- Setting/context: Studies may use participants recruited from clinical or community contexts and inpatient or outpatient settings.
- Design: The studies must collect primary data from quantitative, qualitative or mixed-method studies where quantitative and qualitative data can be easily extracted.
 - Qualitative studies must use a recognised qualitative method (defined as a method with an appropriate reference to a methods paper published in a peer-reviewed journal)
- Studies must be in English.
 - Studies published from: 1980-2021

Exclusion criteria

- Reviews, expert opinions, case studies
- Studies only collecting **professional** (clinician/caseworker) report data (ineligible respondents)
 - Studies collecting both parent and clinician will be included but analysis must be separate for patient and clinician reports.
- Studies which combine data on participants with personality difficulties and participants other mental health (e.g. parents with severe mental health), unless they carry out separate analysis on parents with personality difficulties.
- Studies which combine personality disorder measures with other measures (e.g. criminal records) are excluded.
- Studies which only focus on a trait/symptom of personality disorder (e.g. Grandiosity (Narcissistic PD); Psychopathy (ASPD))
- Studies of treatment effectiveness only (e.g. pre to post treatment change). *These studies do not compare parenting variables to a control population/cut off/standard criteria or look dimensionally at how personality disorder characteristics are related to parenting variables- therefore limited conclusions about the impact of personality difficulties on parenting is unclear.*
- Studies which report secondary data
- Studies which report child removal- *no implications for parenting behaviour or informing intervention*
- Studies only collecting data on treatment experience.
- Studies of parents of adult children (retrospective report)
- Grey literature

Appendix D: Title and Abstract screening tool

Version 3.

1. Was it published post 1980?
 - a. Yes- continue.
 - b. No- exclude.
2. Is it a primary study? (i.e., no reviews, expert opinions, case studies)
 - a. Yes- continue.
 - b. No- exclude.
3. Is the study about people with personality difficulty/mental health?
 - a. If personality difficulty- Include
 - b. If “mental health” or “severe mental health” including personality disorders/with no mention of diagnoses, continue but flag for full text screen.
 - c. No- exclude.

N.b., Personality difficulties including diagnosis of personality disorder; defined by any measurement of personality disorder (Clinical interview or trait-based measures including level of severity e.g., PID-5); If unsure at this stage, include for full text screen.

Include if mentions antisocial traits/behaviour unless indicates only measuring crime/adolescent onset antisocial behaviour (Moffit & Caspi, 2001)

If analyse severe mental health including PD collectively, and no separate for PD, don't include.

N.b. multiple personality disorder is currently viewed as a dissociative/trauma-related disorder, thus will not be included in this study.

4. Is the study about parents/caregivers and are they over the age of 18? (*incl. stepparents, mothers, fathers- if grandparents, flag for full text screen to see if they provide direct caregiving role*)
 - a. Yes- continue.
 - b. No- exclude.

N.b. if clinician or teacher reporting on parenting behaviour, and there is not parent-report data- exclude. If child report on parent behaviour, continue.

N.b. including pre-natal parents and outcomes at this stage.

5. Does **the parent** have personality difficulty/mental health?
 - a. Yes- continue.
 - b. No- exclude.

N.b. lots of studies are about parents/parenting of adolescents/patients with personality disorder- unless there is explicit mention of parent having personality disorder AND it's of adolescent (not adult) children, don't include.

6. If child data is reported, is the average age of the sample under 18?
 - a. Yes- continue.

b. No-exclude.

7. Does the study collect data about parenting as an outcome? (include self-report, qualitative, experimental and observational data: exclude data just on treatment experience)
- a. Yes-continue.
 - b. No- exclude.

N.b. think about research question, does it help answer in some way? Could the study have data which helps answer “how does having a personality disorder affect parenting?”

N.b. include prenatal outcomes e.g. parenting stress, prenatal care- parenting behaviour.

8. Is the study in English and published in a peer-reviewed journal?
- a. Yes- continue.
 - b. No- exclude.

If not peer-reviewed (i.e. grey literature) but has met all of the above criteria- keep a record of reference.

Appendix E: Additional information regarding ineligible articles for review

A large majority of the studies excluded during the initial full text screen did not measure parenting behaviours (n=48) but associated adult characteristics and parent choices such as (i) characteristics of an adult parent e.g. adult attachment, which may influence parenting but is not parenting itself (e.g. Dittrich et al., 2020; Gratz et al., 2014; Macfie et al., 2014) (ii) prenatal parenting outcomes (e.g. Berthelot et al., 2020; Handelzalts JE et al., 2012) (iii) parent contact (e.g. Dolan et al., 2013; Poinso et al., 2002; Tapscott et al., 1996) or (iv) choices made about care e.g. whether a parent vaccinates their children (Osam et al., 2020), exposure to smoking in the environment (Conroy et al., 2010; Massey et al., 2016).

The second most common reason that studies were ineligible was that personality disorders were not measured using standardized assessment tools (n=42). A proportion of these studies focused on individual symptoms/dimensions associated with personality disorders e.g. psychopathy (Beaver et al., 2014; Mendoza Diaz et al., 2018), grandiosity (Sened et al., 2020). However, the current study aims to establish broadly how the core symptoms of personality disorders affect parenting. Additionally, 19 studies included parents with personality disorders and measured a parenting outcome, but did not report the association between personality disorders and parenting (e.g. Macfie et al., 2014) instead focusing on links between parental personality disorder and child outcomes or parenting across parents with severe mental health difficulties including personality disorder diagnoses without separately analysing the impact of personality disorder. Finally, 13 studies used secondary data (e.g. analysis of court records, GP data linkage) to measure outcomes such as filicide (e.g. Friedman et al., 2005; Kauppi et al., 2012), child removal or maltreatment (e.g. Laulik et al., 2016; O'Donnell et al., 2015). Whilst these studies provide reliable quantitative evidence of outcomes, they did not characterize specific, targetable parenting behaviours to inform intervention development.

Twelve studies investigated parenting across the ages 0-12 years, combining measurements of parenting of infants and toddlers with parenting in early childhood/middle childhood. Similarly, six studies also considered parenting across 0-18 years. Whilst these studies did measure parenting of parents of children aged 2-12 years, they did not describe how many parents of children aged 2-12 years were included or report specific associations between personality disorders and parenting across early and middle childhood. As parenting changes across development, it was hard to identify how relevant the study's findings would be for identifying targetable parenting behaviours for interventions developed for parents of 2-12 years age group. Therefore, these studies were excluded.

Eight qualitative studies were identified at full text screen level (Bartsch et al., 2016; Dunn et al., 2020; Geerling et al., 2019; Lumsden et al., 2018; Shariati et al., 2018; Wilson et al., 2018; Zacharia A et al., 2020; Zalewski et al., 2015). However four qualitative studies included parenting of both child & adult children and so were excluded (Bartsch et al., 2016; Dunn et al., 2020; Shariati et al., 2018; Zalewski et al., 2015a). Out of the remaining 4 qualitative studies, only one selectively investigated parenting experiences across early and middle childhood (Wilson et al., 2018). The remaining three focused on early infancy (Geerling et al., 2019; Lumsden et al., 2018; Zacharia et al., 2020). Again, as the experiences and challenges of parenting change

across development, these studies may struggle to shed light on identifiable targets for parenting interventions for parents of children aged 2-12 years. Therefore, these studies were excluded.

Appendix F: Systematic review summary of demographics by study publication date

Author Country	Ethnicity	Marital status	Household income	Education	Other SES	Number of children	Gender (child)	Ethnicity (child)
Cross sectional study								
Bonfig et al. 2022 Germany	Not reported	Not reported	Not reported	Not reported	Intelligence measure (Mini Q): BPD group= 27.08 (SD= 9.7), Control group= 29.54 (SD=8.9), Non-sig.	Not reported	BPD group= 11 males, 14 females. Control group= 14 male, 15 females	Not reported
Macfie & Kurdziel 2020 ^a USA	Not reported	57% mothers had partner	M= \$31,841 (SD=27,854)	81% of BPD and 97% of comparison mothers graduated high school	None	M= 2.47 (SD= 1.16)	50% female (53% female in BPD, 47% in control)	11% Hispanic, 11% minority ethnic background
Trupe et al. 2018 ^a USA	Not reported	57% mothers had partner	M= \$31,841 (SD=27,854)	89% mothers had high school diploma	n/a	M= 2.47 (SD= 1.16)	50% female (53% female in BPD, 47% in control)	11% minority ethnic background, 11% Hispanic
LeMoine et al. 2018 GER	89% Caucasian	83% married or cohabiting with child's mother	US\$ 156,230.10, (SE= \$14,628.11)	68% university or higher	n/a	Not reported	76% male	87% children Caucasian
Kluczniok et al., 2018 GER	Not reported	45.8% cohabiting with child's father in total sample	Not reported	Not reported	IQ: rMDD only M= 106.1 (SD=10.5); BPD M=101.4 (SD=8.9) $p<.05$	Not reported	54.8% female	Not reported

Dittrich et al., 2018 GER	90% German	50.9% married/ partner to father of child; 13.2% married/partner not father of child	Not reported	17.2 years (SD=3.6)	n/a	Not reported	58.8% female	Not reported
Macfie et al., 2017 ^a USA	Not reported	57% has partner	M= \$31,841 (SD=27,854)	89% graduated high school: 81% in BPD, 97% non-BPD (t(69)=4.71, p<.05)	N/a	M= 2.47 (SD= 1.16)	50% female	11% Hispanic, 11% minority ethnic background
Robinson et al., 2015 USA	Not reported	65% married/living with partner	Not reported	Median education of 2 years of college	N/a	Not reported	100% male	47% Caucasian; 49% AA; 3% Asian American 1% Hispanic
Schacht et al., 2013 UK	60% white ethnic group	61.5% living with a partner	Not reported	10 mothers in both groups had A-level or higher	22/39 mothers were currently employed	18/39 first born	68% female	Not reported
Bornovalova et al., 2013 USA	98.5% Caucasian	78.8% married 15.6% divorced/ separated from the biological father. 5.6% were either never married or widowed	Not reported	Mothers 13.7 years Fathers= 14.0 years ^b	n/a	Not reported	51% female	97.9% Caucasian ^b
Harvey et al., 2011 USA	Mothers: European American 62.6% ; Latina 23.1% ; African American 11.5% ; Asian American 0.5% ; Multi-ethnic 2.1%.	Mothers= 70% married or living with child's father figure; 84% of fathers were married or living with child	Not reported	Mother= 13.45 years (SD= 2.48) Fathers 13.66 years (SD= 2.76)	n/a	Not reported	Not reported	Not reported

	Fathers: European American 67.5%; Latino 19.8% ; African American 11.1%; Asian American 0.7%; Multi-ethnic 0.7%	mother; 105 co-parents in study						
Wilson & Durbin., 2012 USA	Mothers: Caucasian 73%; Hispanic 8%; African American 7%; Asian 4%, Biracial or another minority 8%. Fathers: Caucasian 74%; Hispanic 9%; African American 8%; Asian 3%; Biracial or another minority 6%	Not reported	Median income \$61,000-\$100,000	72% mothers and 73% fathers had completed college/graduate degree	n/a	Not reported	47% female	Not report
Van Santvoort et al., 2012 NED	86.1% born in Netherlands	54 children lived with 2 parents (44.3%); 53 with one parent (43.4%); 10 with parent and new partner (8.2%) and 5 not at home (4.1%)	55.7% Low income (<€16,800pa) 21.3% medium income (€16,800-27,600pa) and 18% high income (>€27,600)	48.4% less than secondary; 36.1% higher-secondary or lower tertiary, 13.1% higher tertiary education, 2.5% unknown	73% unemployed	Not reported	32% (n=39) male, 68% (n=83) female	Not reported
Kim-Cohen et al., 2006 ^b UK	Not reported	Average months without partner: Comparison= -0.12 (SD=0.88), Depressed= -0.04 (SD=0.93), Antisocial= 0.18 (SD=1.15), Co-	Percentage of mothers with income <€10,000 pa: Comparison= 4.6% Depression only= -3.8%, Antisocial	Percentage with no educational qualifications: Comparison= 12% Depression only= 14% Antisocial only= 22%	Percentage of teen mothers: Comparison= 40%; Depression only= 52% Antisocial only= 63% Comorbid= 67%	Not reported	Not reported	Not reported

		morbid= 0.40 (SD=1.27)	only= 4.8%, Co-morbid only= 15.3%	Comorbid= 20%	$\chi^2(3)= 57.84,$ $p<.001$			
		F(3,1100)= 9.81, $p<.001$	$\chi^2(3)= 23.56,$ $p<.001$	$\chi^2(3)= 8.89,$ $p<.05$				
Stewart et al., 2006 USA	Caucasian families 85% ; African American 15%	All Married (intact families)	Not reported	14 years	Hollingshead criteria- score of 46.0	Not reported	42% female	Not reported
Famularo et al., 1992 USA	White: 41-43%; Black: 41-42%; Hispanic: 8% (in both groups) Other 8-11%	Not reported	Not reported	Not reported	54% maltreating and 43% control mothers receiving public assistance	Not reported	Not reported	Not reported
Cohort studies								
Russotti et al., 2022 USA	Black= 59.8% White = 37.7% Hispanic= 19.3% Biracial= 1.6% Native American= 0.8%	39.8% single mothers	Median income \$17,000, with >99% receiving some form of public assistance	Fathers' education: 26% fathers completed high school, 30.5% partial or full college education.	Not reported	Not reported	51% of infants were females	Not reported
Davies et al., 2012 USA	Family: African American 56% White 23%; Hispanic 11% ; Multiracial 7%; Another 3%	All had male partner	Median= \$18,300	30% mothers, 24% did not complete high school	95% received public assistance: 99.5% impoverished	Not reported	44% female	Not reported
DeMulder et al., 1995 ^c USA	Caucasian 85%; Hispanic 1% African American 12% Asian 2%	92% families were intact	Not reported	Not reported	9 lower SES families, predominantly middle & upper middle class families	Not reported	Not reported	Not reported

^a Uses the same sample ^b Demographic information taken from Iacono et al. (1999) ^c Demographic information taken from Radke-Yarrow et al. (1992)

Appendix G: GUIDED checklist – a guideline for reporting for intervention development studies.

Item description	Explanation	Page in manuscript
1. Report the context for which the intervention was developed.	Understanding the context in which an intervention was developed informs readers about the suitability and transferability of the intervention to the context in which they are considering evaluating, adapting or using the intervention. Context here can include place, organisational and wider socio-political factors that may influence the development and/or delivery of the intervention (15).	Section 3.3, understanding context.
2. Report the purpose of the intervention development process.	Clearly describing the purpose of the intervention specifies what it sets out to achieve. The purpose may be informed by research priorities, for example those identified in systematic reviews, evidence gaps set out in practice guidance such as The National Institute for Health and Care Excellence or specific prioritisation exercises such as those undertaken with patients and practitioners through the James Lind Alliance.	Section 3.1. Chapter summary Section 3.4 Programme theory. Chapter 1. Introduction
3. Report the target population for the intervention development process.	The target population is the population that will potentially benefit from the intervention – this may include patients, clinicians, and/or members of the public. If the target population is clearly described then readers will be able to understand the relevance of the intervention to their own research or practice. Health inequalities, gender and ethnicity are features of the target population that may be relevant to intervention development processes.	Section 3.1 chapter summary, Chapter 1. Introduction, section 1.4.
4. Report how any published intervention development approach contributed to the development process.	Many formal intervention development approaches exist and are used to guide the intervention development process (e.g. 6Squid (16) or The PersonBased Approach to Intervention Development (17)). Where a formal intervention development approach is used, it is helpful to describe the process that was followed, including any deviations. More general approaches to intervention development also exist and have been categorised as follows (3):- Target Population-centred intervention development; evidence and theory-based intervention development; partnership intervention development; implementation-based intervention development; efficacy-based intervention development; step or phased-based intervention development; and intervention-specific intervention development (3). These approaches do not always have specific guidance that describe their use. Nevertheless, it is helpful to give a rich description of how any published approach was operationalised.	Section 3.2.2: MRC framework, GUIDED and o' cathain.
5. Report how evidence from different sources informed the intervention development process.	Intervention development is often based on published evidence and/or primary data that has been collected to inform the intervention development process. It is useful to describe and reference all forms of evidence and data that have informed the development of the intervention because evidence bases can change rapidly, and to explain the manner in which the evidence and/or data was used. Understanding what evidence was and was not available at the time of intervention development can help readers to assess transferability to their current situation.	Section 3.3. Method Chapter 2- systematic review Chapter 1- Introduction, sections 1.3. & 1.4.
6. Report how/if published theory informed the intervention development process.	Reporting whether and how theory informed the intervention development process aids the reader's understanding of the theoretical rationale that underpins the intervention. Though not mentioned in the e-Delphi or consensus meeting, it became increasingly apparent through the development of our guidance that this theory item could relate to either existing published theory or programme theory.	Section 3.4.1. Programme theory
7. Report any use of components from an existing intervention in the current intervention development process.	Some interventions are developed with components that have been adopted from existing interventions. Clearly identifying components that have been adopted or adapted and acknowledging their original source helps the reader to understand and distinguish between the novel and adopted components of the new intervention.	Section 3.2.1 and 3.4.2
8. Report any guiding principles, people or factors that were prioritised when making decisions during the intervention development process.	Reporting any guiding principles that governed the development of the application helps the reader to understand the authors' reasoning behind the decisions that were made. These could include the examples of particular populations who views are being considered when designing the intervention, the modality that is viewed as being most appropriate, design features considered important for the target population, or the potential for the intervention to be scaled up.	Section 3.4.1. Programme theory and section 3.4.2.

Item description	Explanation	Page in manuscript where item is located.	O
9. Report how stakeholders contributed to the intervention development process.	Potential stakeholders can include patient and community representatives, local and national policy makers, health care providers and those paying for or commissioning health care. Each of these groups may influence the intervention development process in different ways. Specifying how differing groups of stakeholders contributed to the intervention development process helps the reader to understand how stakeholders were involved and the degree of influence they had on the overall process. Further detail on how to integrate stakeholder contributions within intervention reporting are available (19).	Section 3.3- stakeholder involvement and Section 3.5.1 Impact of stakeholder involvement. Appendix I.	
10. Report how the intervention changed in content and format from the start of the intervention development process.	Intervention development is frequently an iterative process. The conclusion of the initial phase of intervention development does not necessarily mean that all uncertainties have been addressed. It is helpful to list remaining uncertainties such as the intervention intensity, mode of delivery, materials, procedures, or type of location that the intervention is most suitable for. This can guide other researchers to potential future areas of research and practitioners about uncertainties relevant to their healthcare context.	Table 8 compares original BaP-Standard to BAP-EFL	
11. Report any changes to interventions required or likely to be required for subgroups.	Specifying any changes that the intervention development team perceive are required for the intervention to be delivered or tailored to specific <u>sub-groups</u> enables readers to understand the applicability of the intervention to their target population or context. These changes could include changes to personnel delivering the intervention, to the content of the intervention, or to the mode of delivery of the intervention.	Section 3.4.2 outlines key adaptations in content, delivery and training	
12. Report important uncertainties at the end of the intervention development process.	Intervention development is frequently an iterative process. The conclusion of the initial phase of intervention development does not necessarily mean that all uncertainties have been addressed. It is helpful to list remaining uncertainties such as the intervention intensity, mode of delivery, materials, procedures, or type of location that the intervention is most suitable for. This can guide other researchers to potential future areas of research and practitioners about uncertainties relevant to their healthcare context.	Section 3.5.2 - remaining key uncertainties	
13. Follow Tidier guidance when describing the developed intervention.	Interventions have been poorly reported for a number of years. In response to this, internationally recognized guidance has been published to support the high quality reporting of health care interventions ¹⁴ . This guidance should therefore be followed when describing a developed intervention.	See Appendix O	
14. Report the intervention development process in an open access format.	Unless reports of intervention development are available people considering using an intervention cannot understand the process that was undertaken and make a judgement about its appropriateness to their context. It also limits cumulative learning about intervention development methodology and observed consequences at later evaluation, translation and implementation stages. Reporting intervention development in an open access (Gold or Green) publishing format increases the accessibility and visibility of intervention development research and makes it more likely to be read and used. Potential platforms for open access publication of intervention development include open access journal publications, freely accessible funder reports or a study web-page that details the intervention development process.	N/A at this stage- it is our intention to publish the intervention development chapter.	

Appendix H: Outline for Patient Public Involvement

Context: The BaP-EFL feasibility trial was initially conceptualised with Patient and Public Involvement (PPI) prior to it becoming a PhD project. The project was adapted to a PhD project and the PhD researcher developed skills in trial design and participatory research through reading, workshops and seminars with the survivor research networks and Peer Hub. The research team were able to use previous PPI to inform initial adaptations to the PhD project, and conducted further stakeholder and PPI involvement activities, as outlined below.

The following document outlines (i) a summary of the initial PPI consultation carried out prior to the project being adapted to a PhD project and (ii) the PPI plan, developed using the Public Involvement Impact Assessment Framework (PiiAF; Popay and Collins, 2014), and the PPI toolkit developed by Bagley and colleagues (2016).

Glossary:

- **Clinical team:** The clinical team is made up of:
 - Parent group leader (PGLs)- parents who have been trained to deliver the BaP-EFL (intervention arm) or BaP-Standard being a parent (control arm) group. These parents have previously attended a BaP-Standard group and are highly skilled and experienced in delivering BaP-Standard.
 - Clinicians- Trained mental health and/or social care professionals with expertise in parenting. Clinicians are involved in the supervision of the groups and supporting PGLs.
- **Service user:** The target parents of the intervention, including trial participants. That is, parents who experience complex emotional and interpersonal difficulties, including diagnoses of personality disorder.
- **Research team:** Clinical researchers who are involved in trial design and management, data collection and informed consent procedures, and data analysis and write up.

1. Pre-PhD project approval PPI:

Summary of findings

Parents attending specialist parental mental health services, BaP-EFL and experienced service user group facilitators in group discussions and individual consultation contributed to (i) study conceptualisation, design and methods and (ii) BaP-Enjoying Family Life content and methods as follows:

1. **Conceptualisation:** The rationale for a stepped care approach was supported as a way to offer service users intervention choice. The involvement of service users in providing a parenting intervention was thought to offer greater legitimacy and reduce stigma.
2. **BaP-Enjoying Family Life content:** Intervention service user co-production resulted in content focussed on helping parents manage their behaviour and emotional reactions alongside parenting content, additional session time to validate parent progress, share personal challenges and concurrent life events, and an extra intervention session to accommodate this additional content.
3. **Research design:** Some service users felt that random allocation may restrict intervention access and risk feelings of parent rejection. We have retained a

randomised design as it provides the most robust method for evaluating outcome in the definitive trial. Service user concerns are reflected in our commitment to examine (a) the impact of randomisation, particularly for comparison condition participants, and (b) use of highly specified study retention, recruitment and consent procedures.

4. **Recruitment pathways:** Concerns were expressed in restricting recruitment to specialist services because of under-recognition of need, narrow participant access and stigma. This is reflected in the inclusion of community and specialist recruitment pathways.
5. **Inclusion criteria:** Consultation highlighted potential stigmatising and pejorative impact of eligibility based on personality disorder diagnosis, particularly for community recruitment. This is reflected in inclusion based on severe personality difficulties and use of the SAPAS screening measure.
6. **Clinical outcomes:** Service users recommended meaningful primary and secondary outcomes focussed on parenting and child outcomes rather than adult mental health. This is reflected in our selection of outcome measures.
7. **Intervention conditions:** Concern was expressed about the nature of the comparison condition. After serious deliberation of alternative approaches, including a waitlist condition with progression to BaP-EFL at trial conclusion, we initially concluded that Treatment as Usual (TAU) as comparator provides the best way to determine the effectiveness of BaP-EFL. Re-evaluation as part of the PhD project highlighted that treatment as usual in the locations we plan to recruit from was the standard BaP groups. Post- PhD award PPI focus groups will assess the acceptability of this.

2. PhD-related PPI:

2.1. Proposed PPI timeline developed during early intervention development.

PPI planning activities involved formulation of a PPI plan using the Bagley et al. (2014) PPI toolkit and completion of the PiiAF impact assessment.

Stage of trial	Methods	Aim
Pre-trial: Research design development and evaluation of trial materials	Focus group. Individual feedback Online Surveys	<ul style="list-style-type: none"> - Adaptation of BAP-EFL manual for the trial - Evaluate acceptability of control condition - Evaluate relevance of outcomes - Assess readability of trial materials - Consider retention strategies and trial dissemination. - Evaluate informed consent procedures and materials (including eligibility procedures) - Evaluate recruitment pathways and materials, including recruitment to process evaluation interviews. - Highlight any concerns on risk or ethical concerns the participants may have
Trial: Term one (first wave of interventions)	Focus group x1	<ul style="list-style-type: none"> - To review recruitment statistics and discuss whether any changes in strategy are needed. - Consider retention strategies

Trial: Term two (second wave of intervention)	Focus group x1	<ul style="list-style-type: none"> - To review recruitment statistics and discuss changes in strategy. - To review retention across term 1 - Consider information to be shared at midway point, and whether PPI want to contribute to any content
Trial: Term three (third wave of intervention)	Focus group x1. Written feedback	<ul style="list-style-type: none"> - To develop mid-way trial newspaper - To review pre-post and 6 month retention and consider strategies. - To consider initial feasibility findings and interpretations - To discuss initial ideas for dissemination - To assess readability of mid-way newspaper for research participants
End of trial: Analysis and write up, dissemination of findings with research participants and wider research and clinical community	Focus groups. Written feedback	<ul style="list-style-type: none"> - To discuss interpretations of process evaluation and quantitative feasibility findings - To discuss dissemination strategies to research participants and wider research, clinical and service user communities - To assess readability and understandability of dissemination materials

Appendix I: Public involvement impact assessment framework (PiiAF)

Whilst planning PPI, the PhD student completed the PPI record card developed by the PiiAF.

PPI Record Card (adapted from PiiAF)	
Values	<p>The general consensus across the research and clinical team, service users and organisation (Centre for Parent and Child Support) is that PPI is crucial for a number of different reasons. For researchers, PPI is valued in informing recruitment strategies and ethical procedures such as informed consent, as well as ensuring analysis of results is valid, relevant and helpful to service users. Furthermore, input from parents can inform retention strategies to support participants remain in the trial. For clinicians and service users, PPI is valued for evaluating the language used to describe this population of parents who may not be seeking individual help for mental health but who's distress may be interfering with their parenting. PPI also ensures trial is relevant and necessary to evaluate service provision for the service users. Across the Organisation, there is an emphasis on peer-led delivery models which are the foundation of EPEC interventions. The value at the core of EPEC interventions is that they are "by parents, for parents." Potential conflict may arise as service users and clinicians do not view themselves as "experts", potentially leading them to devalue their opinion. Research team will ensure to value and reinforce the importance of their contribution throughout PPI. They will also use lay language and ensure time to explain research methodology/terminology.</p>
Approaches to PI	<p>The development of the BAP-EFL feasibility trial originated from observations and feedback from a previous trial of an individual parenting intervention for parents with personality difficulties (Day et al., 2020).</p> <p>Focus groups with parents with lived experience of mental health who have attended the BaP-Standard group have and will continue to inform research conceptualisation, manual development, research design, analysis and dissemination. Parents will be involved in recruitment and delivery of the intervention during the trial.</p>
Research Topic and study design	<p>The research focus is the feasibility of a larger RCT of BaP-EFL. Both quantitative and qualitative methods will be used to evaluate this. The aim is to have service user involvement for all stages of the trial, in particular study design and clinical outcomes, informed consent, recruitment (materials and methods). Parents will also be consulted on interpretation of qualitative data of parents' experiences, interpretation of quantitative results and developing dissemination materials e.g. newsletters to send to participants.</p> <p>Barriers may be parent discomfort in discussing topics (a discomfort agreement will be used to ensure focus groups are safe spaces) and lack of confidence in research methods and clinical psychology (addressed by emphasising the team's value, shared aims and the valuable contributions they can give, and provide training where required).</p>
Practical issues	<ul style="list-style-type: none"> • <i>Geography and maintaining input throughout the study:</i> Addressed through offering online meetings and arranging groups at times

	<p>which are within school hours for parents so child-care is not a barrier.</p> <ul style="list-style-type: none"> • <i>Recruitment to PPI:</i> EPEC and the CPCS has a pool of parents who are willing to engage with research activities and can support reimbursement for PPI. For a wider recruitment, social media networks and contacts with other organisations e.g. the recovery college can help gather PPI feedback. • <i>Training and support:</i> parents will be given training to deliver groups via EPEC. Any additional informal training in research methods can be supported by the research team. • <i>Conflicts between PPI desires and methodological needs:</i> e.g. randomisation; parents may feel that randomisation could cause some parents to miss out on the additional support BaP-EFL provides. This may cause conflict with requirements of a RCT design; however PPI consultations will be used to find compromises which meet their concerns whilst balancing the methodological requirements.
Identifying the impacts of PI in research	<ul style="list-style-type: none"> • Parents involved- increased knowledge, skills and confidence in research design, feeling their contributions are valued and heard. • Researchers (as individuals)- increased knowledge of PPI, more relevant, clinically useful and valuable research project • Research- more appropriate research design (this can be evaluated through the process evaluation), relevant clinical outcomes (indicated by change in outcomes), improved recruitment and retention, increased willingness to participate in future research as a result of dissemination

Assessment of impact:

Formative and process assessments will evaluate the impact of PPI, through offering space to feedback on PPI processes after each meeting for members of the PPI panel. The project also aims to conduct a summative assessment in the discussion to identify positive and negative aspects of trial design and consider how PPI involvement informed these choices. Although hard to separate impact of PPI pre and post any changes in recruitment/retention strategies, feasibility outcomes may also be used as a summative assessment to indicate some of the impact of PPI involvement.

Appendix J: Stakeholder involvement findings

Activity	Aim	Outcome
<p>Meetings with Prof. Crispin Day, EPEC Clinical Lead (Jo Nicoll) and HFT clinical Lead (Dr Joanna Gibbons)</p> <p>Dec 2020- Mar 2021</p>	<ul style="list-style-type: none"> To understand service and context factors in delivery of BaP-Standard To build connections with clinical teams who may implement BAP-EFL To plan intervention development steps and feasibility trial. To develop programme theory underpinning intervention adaptations 	<ul style="list-style-type: none"> Plan developed and identified clinical psychologists (supervisors of BaP-Standard groups) and Parent group leaders (deliverers of BaP-Standard) to support development. Plan to establish researcher contract at SLAM so the researcher can integrate self in clinical teams, observe BaP-Standard and conduct PPI work with a group of parents with lived experience of mental health difficulties. Initial programme theory developed.
<p>Focus group with 4 PGLs.</p> <p>25th Mar 2021</p>	<ul style="list-style-type: none"> Adaptation of BaP-Standard manual to BaP-EFL Highlight any concerns on risk or ethical concerns the participants may have 	<ul style="list-style-type: none"> Increased number of sessions to cover content. Increased focus on emotion regulation strategies early on in sessions Discussed procedures if missed session, recaps and contact around sessions. Currently trying to problem solve some of the issues identified to present back to panel for written feedback. Adapted goal setting activity to support parents set parenting related rather than mental health goals. Increased facilitation guidance in the manual to support with group containment. Increased focus on parenting guilt Increased training for PGL facilitators around mental health Identification of topics which may cause discomfort for parents or PGLs in the manual
<p>Individual consultations with PGL with lived experience of mental health</p>	<ul style="list-style-type: none"> Develop recruitment materials 	<ul style="list-style-type: none"> Language viewed as appropriate.

Mar-May 2021		<ul style="list-style-type: none"> • Use of cartoons in recruitment materials (supported by later focus groups)
Meetings with Prof. Crispin Day (EPEC developer)	<ul style="list-style-type: none"> • Familiarise self with manual development. 	<ul style="list-style-type: none"> • Reviewed reading on Fidelity, TIDieR checklist and MRC framework. • Developed 5 key intervention targets based on reading and stakeholder feedback.
Feb-Jun 2021	<ul style="list-style-type: none"> • Identify core BaP-Standard components and targets for change. • Develop intervention outline. • Initial session plan edits 	<ul style="list-style-type: none"> • Reviewed BaP-Standard outline. • Developed BaP-EFL session outline. • Developed new session structure of Offload, settle in and quick win. • Reviewed session plan content for BaP-Standard and identified areas which were appropriate for target population and areas which could be further developed to meet intervention targets
Meetings with Susannah & Lynsey (Clinical Psychologists from EPEC/Helping Families team) & Emelia (PGL)	<ul style="list-style-type: none"> • To review session plans • To identify and develop additional content 	<ul style="list-style-type: none"> • Session plans reviewed with intervention targets in mind. • Additional content suggested, developed and integrated into session plans. In particular, warm authoritative parenting and firefighting introduced from the Helping Families programme.
Feb-Jun 2021		<ul style="list-style-type: none"> • Feedback on language in session plan content- simplicity • Feedback around delivery skills, training and support for PGLs. In particular PGLs concerns around managing challenging conversations led to the addition of a section on managing challenging conversations in manual introduction.

Focus group with four parents with mental health difficulties.

14th June 2021

- Consider retention strategies and trial dissemination.
- Evaluate recruitment pathways and materials, including recruitment to process evaluation interviews.
- Highlight any concerns on risk or ethical concerns the participants may have.
- Content- firefighting really important and helpful from Helping Families Programme (Day et al., 2020)
- Complete measures in person together rather than via links
- Identified the importance of using outcomes to feedback and identify areas where the family may still need support- *not sure how ethical this may be or how to incorporate into trial design just yet.*
- Identified the importance of newsletters in retention to stay in touch with service and help with ending process.
- Reinforced the importance of peer practitioners.
- Use of cartoons favoured in recruitment materials.
- Identified the importance of indicating in recruitment material that the group is not a typical parenting group, about developing specific skills.
- Identified key recruitment locations e.g. sure start centres, schools, nurseries, SEN.
- Feedback on possibility of changing name- like this idea
- Language of materials identified as appropriate

Individual phone calls with two parents with mental health difficulties who have attended a being a parent with mental health difficulties group.

23rd June 2021

- Evaluate relevance of outcomes
- Evaluate informed consent procedures.
- Consider retention strategies and trial dissemination.
- Highlight any concerns on risk or ethical concerns the participants may have
- Content:
 - Describing behaviour and play particularly helpful.
 - Not quite the “elephant in the room” but parent knew everyone was experiencing mental health challenges and felt that this could be talked about/discussed more. “it was there but not discussed” and “on the periphery”.
 - acknowledged the sensitivity of the topic.
 - felt important to discuss to break the stigma.
 - Suggested topics:
 - What a different mental health conditions present different challenges to parents (information); how do other parents feel their mental health influences their experiences
 - How other parents manage/discussing coping strategies felt important.

- Recognised that everyone in the group is in very different positions and felt it would be helpful to know people's position. even from an intersectional view e.g. being a black parent with mental health difficulties
(from a place of shared learning and interest)
 - Really positive about the whole experience, the service and group. Felt that people would spend a lot of money for it.
 - Feedback on outcomes:
 - Parents change in confidence was critical area of change.
 - Also parenting with a more considered approach, more mindful of what's going on underneath, and how to cope and parenting strategies.
 - Include a measure which considers how specific situations for the individual have improved.
 - Would appreciate interview/chatting over filling in forms- gives the parent reassurance they are doing a good job and/or identify areas for improvement.
 - Recognised the possibility of feeling judged/assessed by observations/interviews.
 - Dissemination:
 - View the 6 months as opportunity to reflect, giving back information about measures.
 - Use of technology to remind parents at a time that works for them.
 - Mid-way meets ups for research participants to meet face to face (from online groups)
 - Give parents choice in voucher/how paid for not only participation but also PPI.
 - No ethical concerns, understand that that's the way research has to be done- lots of trust in NHS.
-

Meeting with Clinical leads of Helping Families team and Empowering Parents Empowering communities to review manual adaptations.

Jun 2021

- To review development so far
- To identify and develop additional content

- Separated My emotions as a parent and child's emotions into two separate sessions.
- Reviewed and agreed on session structure.
- Reviewed settle in activities.
- Discussed handouts.
- Agreed 2 PGLs would run the EFL intervention, as opposed to 1 PGL and 1 clinician.
- Discussed language

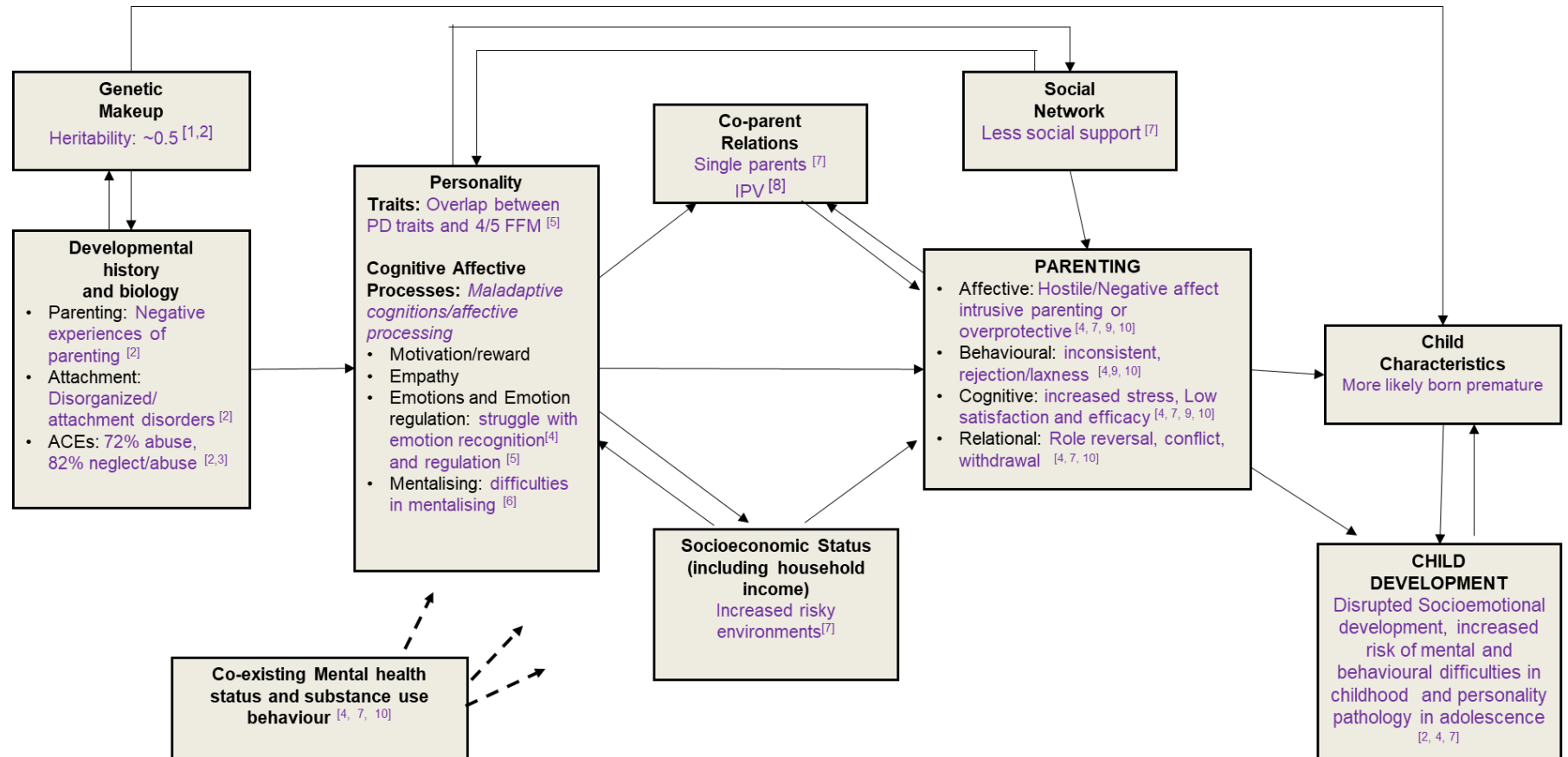
Meeting with Charlotte (original manual developer)

July 2021- Nov 2021

- To review development so far
- To identify and develop additional content.
- To develop a plan for training PGLs in additional BAP-EFL content and facilitation skills

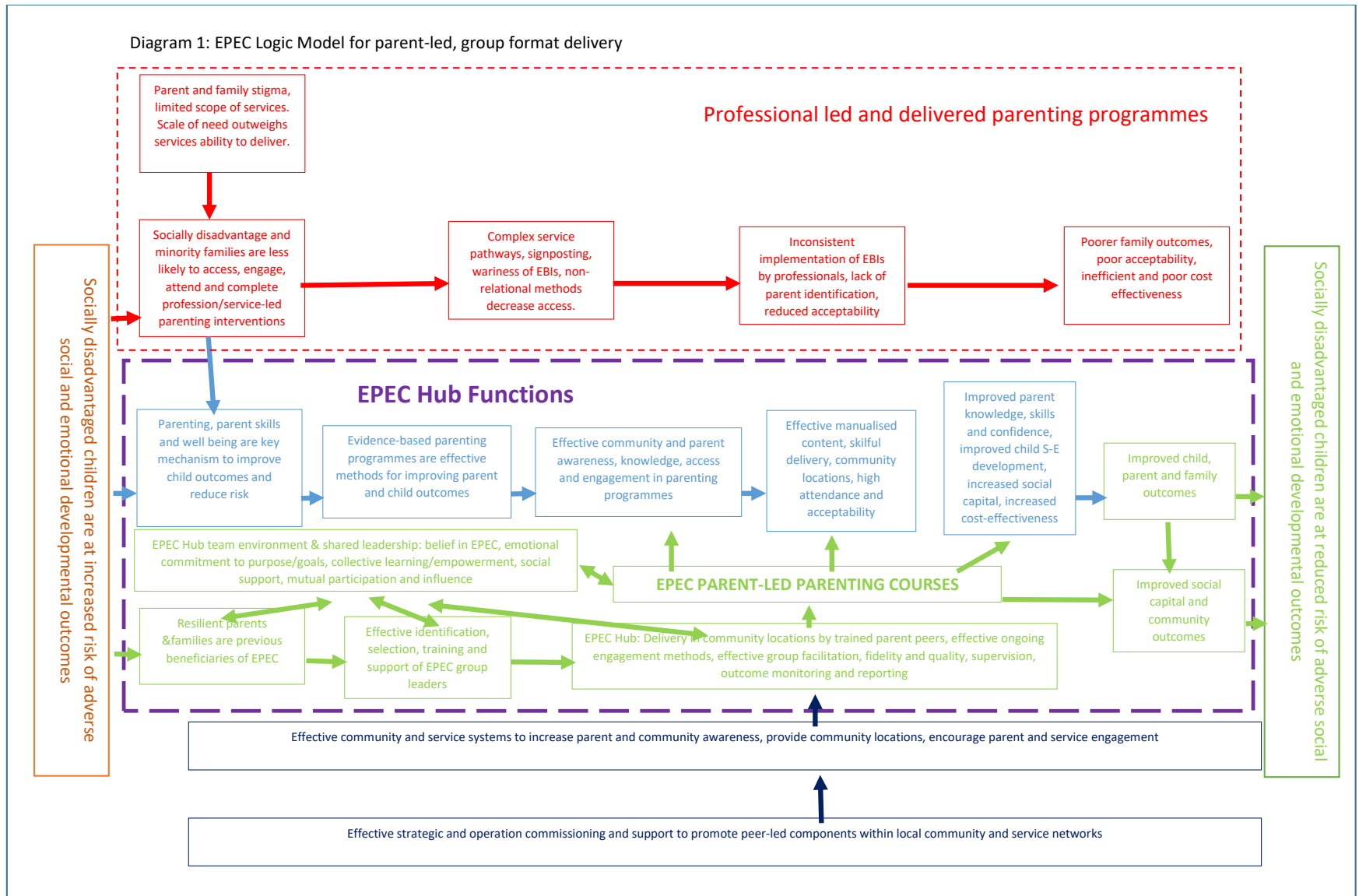
- Worked on content related to "withdrawing attention" and expanding CLOSE to CLOSER – emphasising reconnecting.
 - Introduced a few more visualising activities around parent and child emotion to help with experiential learning.
 - Introduced and ensured coherence and clarity in objectives of each session for PGLs.
 - Developed training plan and activities to support PGLs, particularly with handling strong emotions and challenging conversations.
-

Appendix K: Adapted multiple determinants of parenting model including findings from evidence synthesis on personality disorders, parenting and child development in purple.



References. [1] Torgeson, 2009; [2] Steele et al. 2019; [3] Battle et al., 2004; [4] Eyden et al., 2016 [5] Bach & First, 2018; [6] Fonagy & Bateman, 2008 [7] Petfield et al. 2015 [8] Stepp et al. 2011 [9] Laulik et al. 2013 [10] Chapter 2 – systematic review

Appendix L: BaP-Standard Logic model



Appendix M: BaP-EFL intervention summary with intended outcome

Session	Session content			Intended outcome		
	Topics	Key skills learnt	Take away	Parent	Parent-child	Child
Introduction Coffee morning Content target: ER, RF Delivery target: W&S, B&R, GP	<ul style="list-style-type: none"> Introduction to facilitators, intervention and group members Exploring parenthood Quick wins 	<ul style="list-style-type: none"> Quick wins 	<ul style="list-style-type: none"> Quick wins 	<ul style="list-style-type: none"> Social support Validation Identifying and connecting with PGLS Hope and motivation. Exploring own and other problems (RF) Self-care (ER) 		
Session 1: Being a parent Content target: ER, RF Delivery target: W&S, B&R, GP	<ul style="list-style-type: none"> Group agreement Goals, strengths, motivators and cheerleaders Full vs. empty jug Doing things for yourself Good enough vs. perfect parent 	<ul style="list-style-type: none"> Distraction Goal setting Doing things for yourself 	<ul style="list-style-type: none"> Soothe and re-energise box 	<ul style="list-style-type: none"> Reduce stigma. Identify support networks. Safeness and belonging (GC) Exploring own and other problems (RF) Self-care (ER) 	<ul style="list-style-type: none"> Parent more able to consistent, calm and attentive to child's needs (W&S) 	<ul style="list-style-type: none"> Increase secure attachment. Child learns emotion regulation through modelling.
Session 2: My Feelings Content target: ER Delivery target: RF, W&S, B&R, GP	<ul style="list-style-type: none"> Naming feelings Noticing feelings Feelings as parents Expressing feelings Firefighting 	<ul style="list-style-type: none"> Spotlight of attention Noticing and naming feelings Acknowledging feelings Firefighting 	<ul style="list-style-type: none"> Noticing and naming feelings 	<ul style="list-style-type: none"> Notice and acknowledge emotions. (ER) Break down and manage challenges of parenting (ER) Exploring own and other problems (RF) 	<ul style="list-style-type: none"> Separate own and child's emotion from one another. (RF) Able to be more consistent and calmer (W&S) 	<ul style="list-style-type: none"> Increase secure attachment. Child learns emotion regulation through modelling.

<p>Session 3: My Child's Feelings</p> <p>Content target: ER, W&S Delivery target: W&S, B&R, GP</p>	<ul style="list-style-type: none"> • My feelings and my child's feelings • Pushing away feelings • Acknowledging feelings • Don't vs. saying what you want 	<ul style="list-style-type: none"> • Positive talk • Acknowledging child's feelings • Don't vs. saying what you want 	<ul style="list-style-type: none"> • Naming child's feelings • Saying what you want 	<ul style="list-style-type: none"> • Identifying, acknowledging and communicating own and child's emotions (ER; W&S) 	<ul style="list-style-type: none"> • More consistent and calm P-C interactions (W&S) 	<ul style="list-style-type: none"> • Improves expression and later regulation of emotions
<p>Session 4: Child-led play</p> <p>Content target: W&S, PPS Delivery target: B&R, W&S, GP</p>	<ul style="list-style-type: none"> • Why play and barriers to play. • Non-child and child-led play • Barriers to child-led play • Role play and practice 	<ul style="list-style-type: none"> • Soothing breathing • Child-led play 	<ul style="list-style-type: none"> • Child-led play 	<ul style="list-style-type: none"> • Feel confident parenting and gain enjoyment from child (PPS; W&S; RF) 	<ul style="list-style-type: none"> • Connecting and strengthening P-C relationships (W&S) 	<ul style="list-style-type: none"> • Improves child Self-esteem, learning and expression of emotions in developmentally appropriate way.
<p>Session 5: Celebrating my Child</p> <p>Content target: W&S, PPS, RF Delivery target: B&R, W&S, GP</p>	<ul style="list-style-type: none"> • Labels exercise • Describing behaviour • Building up "I" statements • Why praise • Descriptive praise • Building the positive 	<ul style="list-style-type: none"> • Muscle relaxation • Describing behaviour • "I" statements • Praise 	<ul style="list-style-type: none"> • Descriptive praise (positive reinforcement of behaviour) 	<ul style="list-style-type: none"> • Understand the impact of labels and practice describing behaviour (PPS) • Separate child and behaviour (RF) 	<ul style="list-style-type: none"> • Positive reinforcement for good behaviour. Consistency and support. (PPS; B&R) 	<ul style="list-style-type: none"> • Improves self-esteem and possibly child behaviour. • Motivation and reward system activated-prosocial skills.
<p>Session 6: Understanding Children's behaviour</p> <p>Content target: RF, PPS, W&S Delivery target: B&R, W&S, GP</p>	<ul style="list-style-type: none"> • Needs and behaviour. • Competing and changing (developmental) needs • Withdrawing attention 	<ul style="list-style-type: none"> • Mindfulness • Identifying needs behind behaviour • Withdrawing attention • Reconnecting after conflict 	<ul style="list-style-type: none"> • Withdrawing attention 	<ul style="list-style-type: none"> • Understanding of needs and emotions behind behaviour(RF) • Knowledge of developmental stages 	<ul style="list-style-type: none"> • Separation of self and other in P-C relationships. Reduced hostile interactions (RF; W&S) 	<ul style="list-style-type: none"> • Increase secure attachment and build child self-esteem.

	<ul style="list-style-type: none"> Reconnecting with your child 	<ul style="list-style-type: none"> Learn negative reinforcement strategy (PPS)
<p>Session 7: Boundaries and Routines</p> <p>Content target: PPS, B&R Delivery target: B&R, W&S, GP</p>	<ul style="list-style-type: none"> Exploring boundaries Saying No Commands Rewards Barriers to establishing boundaries. Family agreement 	<ul style="list-style-type: none"> Relaxing place Saying No Commands Rewards Family agreement
		<ul style="list-style-type: none"> Family agreement
<p>Session 8: Communication</p> <p>Content target: W&S, PPS, RF Delivery target: B&R, W&S, GP</p>	<ul style="list-style-type: none"> Parental communication styles Warm assertive communication Listening/not listening Reflective listening 	<ul style="list-style-type: none"> Compassionate memory Warm, assertive communication reflective listening
		<ul style="list-style-type: none"> Reflective listening
<p>Session 9: Review and support</p>	<ul style="list-style-type: none"> Safety plan Reviewing goals Celebrating achievements 	<ul style="list-style-type: none"> Family safety and crisis planning
		<ul style="list-style-type: none"> Improve self-esteem and efficacy Increased W&S parenting
		<ul style="list-style-type: none"> Clear and consistent boundaries established (C&B; PPS) Reduced conflict and hostile interactions (W&S) Child feels safe and expectations of them are clear and explicit.
		<ul style="list-style-type: none"> Parents learn to communicate in clear authoritative ways (W&S) Reduced conflict and increased W&S parenting Increase secure attachment and build child self-esteem.

Note. ER= Emotion Regulation; RF= Parent Reflective Function; W&S= Warmth and Sensitivity; PPS= Positive Parenting Strategies; B&R= Boundaries and Routine; GP= Group Processes

Appendix N: Participant information sheet & child information sheet
Being a Parent (BaP)- Enjoying Family life: researching a new group for
parents and caregivers with significant emotional and interpersonal
needs.

We are inviting you to take part in a research study of a new parenting intervention. Before deciding, it is important that you understand why the research is being done and what it involves. Please read the information below, discuss it with others and take time to decide whether or not you wish to take part. If you do wish to take part, you will be asked to sign a consent form.

This study is being conducted for educational purposes as part of a PhD project at King's College London. Further information and summary of the trial can be found here: <https://www.isrctn.com/ISRCTN10950727>

Please ask the researcher if anything is not clear or you would like further information.

What's involved?

BaP-Enjoying Family Life is for parents and caregivers with long-standing emotional and/or relationship difficulties and who have children aged between 2-11 with emotional and/or behavioural difficulties. BaP-Enjoying Family Life is a new version of the established parenting programme, Empowering Parents Empowering Communities-Being a Parent (BaP-Standard) . Unlike BaP-Standard, BaP-Enjoying Family Life is not currently part of routine care.

Our research study aims to see what parents and caregivers think about our new parenting programme compared to BaP-Standard and the extent to which it helps them and their children. We also want to learn more about how best to use a method called a Randomised Controlled Trial (RCT) to study the impact and effectiveness of BaP-Enjoying Family Life. We are using a feasibility RCT method to compare our new parenting programme, BaP-Enjoying Family Life, with our standard BaP-Standard parenting programme. By taking part, you have a 50% chance of receiving BaP-Enjoying Family Life and a 50% chance of receiving BaP-Standard.

Why have I been asked to take part?

You have been asked to take part because you have shown interest in attending the BaP-Enjoying Family Life programme. You are eligible to take part if:

1. You look after a child aged 2-11 years who lives at home with you.
2. The child experiences emotional and/or behavioural difficulties AND
3. You experience long-standing difficulties with managing emotions and/or relationships.

What will taking part involve?

The steps involved in research are described below. Please read through and write down any questions you may have. You may discuss these with a research assistant.

Step 1: Am I eligible to take part?

Time commitment: 10

minutes

Activity and purpose: If you agree to take part and sign the consent form, you will be asked to fill out an online questionnaire about your feelings in general. The researcher will review your answers using the eligibility criteria above and tell you whether you are able to take part.

What will happen if I'm not eligible: If you are not eligible, you will not be able to continue in the research study but will still be able to receive parenting support. The researcher will provide you with information about other parenting support available.

Step 2: Completing the first set of questionnaires about you and your child.

Activity and purpose: If you are eligible and would still like to take part, our researcher will arrange another meeting at your home. The purpose is to learn how things are for you and your family in more detail before you begin with research. There will be two parts to this meeting. These can take part on the same or separate days.

Questionnaires (*Time commitment: 45-60 mins*): You will be asked to fill out some questionnaires online about you and your child. Questions will ask about your child's behaviour, your parenting, parenting satisfaction and wellbeing. You will also complete some background information about you and your family, for example the ages of people living at home. A researcher will be present to help you with the forms, if needed. If you have more than one child aged between 2-11, you will be asked to focus on the child you are most concerned about.

Home Interview (*Time commitment: 1 hour- 1 hour 30*): The researcher will also ask you and your child to talk them through what happened yesterday, starting in the morning when you and your child got up. This will give us an idea of your family's day-to-day life, what's going well and what is challenging.

You can choose not to answer any of the questions in the interview and questionnaires. You will be reimbursed for your time with a voucher worth £25.

Step 3: Which parenting group will I be offered?

Activity and purpose: This step will decide which parenting group you will be offered for the research. You will have an equal (50:50) chance of being offered either BaP-Enjoying Family Life or BaP-Standard groups. You will be given a unique, anonymous ID number. This number will be entered into a computer system independent from our researchers. The computer will decide at random which group you join. The outcome will be shared with you within 1 week of completing Step 2. A member of either the BaP-Enjoying Family Life or BaP-Standard team will be in touch to let you know the computer's decision.

Step 4: Taking part in the parenting group: *Time commitment: 2 hours/wk. for 9/10 weeks.*

Activity and purpose: You can then take part in the parenting group option that you have been offered. Groups will be run in person in accessible locations such as libraries and community centres in your London borough. Some groups will be run online via Zoom. A creche will be available for in-person groups.

BaP-Enjoying Family Life is a weekly group run over 10 weeks with a break in the middle for half term. Topics include parents' wellbeing, communication, boundaries, play and praise. In addition, the content helps parents/caregivers understand and explore the impact of emotional wellbeing on parenting and provides skills to manage relationship conflict, strong feelings in you and your child, and strengthen warm family relationships. Each session involves small and large group activities and discussions, as well as practical activities to do at home.

BaP-Standard is a weekly group run over 9 weeks and includes a break for half term. Each week also covers parenting strategies including routines, play, praise, positive discipline and communication, with less focus on the impact of emotional wellbeing on

parenting and family life. BaP-Standard also uses small and large group activities and practical activities to do at home.

Step 5: Completing the second set of questionnaires about you and your child.

Activity and purpose: Towards the end of your group, a researcher will be in touch to arrange a time to meet to complete the same questionnaires (60 mins) and at-home interview (1hr-1hr 30 mins) from Step 2. There will be an additional 2 questionnaires about your experience of the parenting group you joined. The questionnaire and interview can take part on the same or separate days. They will help us see the extent to which things have changed for you and your children after your group. You will be reimbursed for your time with a £25 voucher.

Step 6: Completing a one-off interview about the parenting group and research.

Activity and purpose: You may be invited to take part in an extra one-off interview (45-60 mins) to learn about your experience of your parenting group and our research. If you agree to this interview, the interview will be recorded for research purposes, so that the researcher can listen back to what you said. This will help us learn to learn more about any improvements we can make. You will be reimbursed a £10 voucher for your time.

Step 7: Completing a third set of questionnaires about you and your child.

Activity and purpose: We will arrange to meet you 6-months after Step 5 to ask you to complete the same questionnaires (45-60 mins) and at-home interview (1hr-1hr 30 mins) for a third and final time. The information you give will help us to see how things are for you and your child six months later. You will be reimbursed for your time with a £25 voucher.

Does my child take part in the research?

Your child will be invited to the at-home interview conducted before (Step 2), after (Step 5) and 6 months after finishing the group (Step 7). You can decide whether you want your child to take part. You can still attend the groups if you choose for your child not to take part in the interviews. You and your child can choose not to answer any questions and can take a break at any time.

Does my child take part in the parenting groups?

No. The parenting groups are just for parents/caregivers and do not require your child attend. You will be encouraged to practise what is covered in your group with your child.

Can other adults join me in the parenting groups?

The research study is open to parents and caregivers who meet the eligibility criteria listed above. Friends and family members who are not be eligible will not be able to take part.

What are the benefits for me? Are there any risks for me taking part in this study?

The parenting group you take part in offers information, advice and support intended to help you and your child. Taking part helps us learn more about the experience and impacts of the two parenting groups and the research methods we are using. This research helps us to make changes, if needed, to the parenting groups before starting a larger study with other families. You will also receive a small monetary benefit for completing the questionnaires.

There are no known risks from the parenting groups we are using in this research. The questionnaires might cause discomfort, and you can choose not to answer any questions. A researcher will be present to talk through any questions with you.

Do I have to take part?

No, taking part is entirely voluntary. You can change your mind at any time and leave the study without giving a reason. You can still take part in the groups if you wish. Leaving the research will not affect any other help you receive.

Will I still be able to see other mental health/social services?

Yes. You can continue to see your usual keyworker, your child's keyworker and receive any additional mental health and social care as needed whilst taking part in this research and attending the parenting group you were assigned to.

Who is involved in running the study?

The person leading the research is Dr Crispin Day, who is a Consultant Clinical Psychologist at South London and Maudsley (SLaM) NHS Foundation Trust and Visiting Professor at King's College London. He can be contacted by email at crispin.1.day@kcl.ac.uk.

Both parenting groups in this research will be delivered by Parent Group Leaders and practitioners from the Centre for Parent and Child Support, part of SLaM. The research is run and funded by King's College London. Parents, practitioners and Parent Group Leaders have helped develop our recruitment, information materials and advised on the content and methods of the two parenting groups. They will continue to be a part of running and evaluating the study.

The study is co-sponsored by SLaM and King's College London. They will monitor the study. This project has been reviewed and approved by Camden and King's Cross Research Ethics Committee on 30th July 2021.

What information will you gather and how will you use it?

The information you provide will be used for research purposes and to make sure research is done properly. This involves contacting you to arrange research meetings, sending reminders and writing reports. The information collected and who will be able to see it is listed below:

	PGLs	Researchers	Research monitors	Transcription service	Reports
Name and contact details	X	X			
Demographic information (e.g., age, gender, income)		X	X		X
Family information (e.g., number of children)		X	X		X
Questionnaire & home interview		X	X		X
Records of phone calls	X	X	X		
Records of attendance	X	X	X		X
Audio recorded interview		X		X	

Your name and other personal details will be stored separately from the other information you give us. The other information will be given a code number that cannot be linked to you ("anonymised"). We will write our reports in a way that no-one can work out you took part in the study. We will keep all information about you safe and secure. You can find out more about how we use your information by (i) asking one of the research team (see below), (ii) using the following link: www.hra.nhs.uk/information-about-patients/ or (iii) by contacting King's College London's Data Protection Officer, Mr Albert Chan at info-compliance@kcl.ac.uk

Will my taking part be kept confidential?

Yes. All information about you will be handled in confidence. We will not share information about your participation with other organisations unless you request us to.

Information from research assessments and parenting sessions will only be shared with others outside of the study under exceptional circumstances; for example, when your safety, or that of your child, appears to be at risk. Wherever possible we will discuss this with you first.

What are my choices about how my information is used?

You can stop being part of the study at any time, without giving a reason. We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the information we hold about you while the research is going on.

How will my information be stored?

The information that you provide in research assessments will be stored securely at King's College London in line with the Data Protection Act. An internet-based platform called Qualtrics will be used to collect your response to questionnaires. More information on Qualtrics' Privacy statement can be found here: <https://www.qualtrics.com/privacy-statement/>. Questionnaire data will be stored on Qualtrics until study completion. Electronic data will be downloaded and backed up on a secure computer network throughout the study. Paper records will be kept in locked cabinets. All data will be destroyed after a period of seven years.

If you take part in the post-group interviews (Step 6), the interview will be audio recorded on encrypted devices. The audio recordings will be manually uploaded onto password protected computers and stored anonymously. The recordings will be securely transferred to a transcription service in line with Data Protection Act and will be written up word for word. The audio recordings will be deleted from recording devices and university computers once written up. Interview responses will be anonymised so that any names or places that can be used to identify you and your family will be changed.

How will my information be kept safe in online groups?

Online groups will be run using Zoom. Each parenting session will have a different log in and passcode which you must not share. End-to-end encryption will be used during the meetings to avoid data being read by other devices (See: <https://zoom.us/trust/security>). Information on Zoom's Privacy statement can be found here: https://zoom.us/privacy#_Toc44414835

What if something goes wrong?

This research has been carefully designed to be respectful and responsive to your needs. If you feel concerned or upset at any point during a research assessment or parenting groups, please let the researcher or group leaders know. You are able to stop assessments or leave the group sessions at any time. If you feel you need extra support, the researcher or group leader can give you information about other services. It is up to you to follow their advice.

If you have any ongoing concerns after starting the research, the research leader (Dr Crispin Day) would be happy to speak with you (see page 3). If you remain unhappy and wish to complain formally, then the normal NHS complaints system can be used. You can contact the SLaM Patient Advice and Liaison Service (PALS) via email pals@slam.nhs.uk or the phone number: 0800 731 2864. If you continue to feel concerned after speaking to SLaM PALS, you can contact Dr Gill Dale, Director of Research Quality via email at slam-ioppn.research@kcl.ac.uk or call 020 7848 0790.

If something does go wrong and you are harmed during the research you may have grounds for legal action for compensation against SLaM NHS Foundation Trust, but you may have to pay your legal costs. The normal NHS complaints system will still be available to you.

What if relevant new information becomes available during the study?

Any new relevant information to your participation, such as research findings, will be communicated to you throughout the study.

Who do I contact for further information?

Ellie Baker (PhD student) is happy to talk to you to discuss the research further. Her email is ellie.baker@kcl.ac.uk



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NHS
South London
and Maudsley
NHS Foundation Trust

Being a Parent- Enjoying family life. A group for Mums, Dads and caregivers.



Date created 12/03/2021

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Version 3.

Iras ID: 297116

Being a Parent- Enjoying family life. A group for Mums, Dads and caregivers.

Information for children aged 9-11 years





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Common Questions:

1. What if I don't want to answer a question?

- ⇒ The questions have been asked to families before. There may be a few questions you do not like.
- ⇒ You do not have to answer a question if you don't want to



2. What if I feel upset or want to stop?

- ⇒ You can let me or your mum/dad know you are unhappy
- ⇒ We can take a break at any time
- ⇒ We can stop at any time.

3. Will other people know I am part of your project?

- ⇒ Only the people running the project will know
- ⇒ Your answers will be secret.
- ⇒ I will talk to someone else if I am worried you or someone else is not safe
- ⇒ We will talk to your parents if this happens.



4. What happens to my answers?

- ⇒ Your answers will be given a number
- ⇒ The numbers will be kept safe on a computer
- ⇒ They will be used to help other mums, dads and children



5. What if I have any questions?

- ⇒ You can ask me questions at any time.
- ⇒ You can ask your mum or dad if you have questions after I go.



Appendix O: Completed TIDIER checklist



The TIDieR (Template for Intervention Description and Replication) Checklist*:

Information to include when describing an intervention and the location of the information

Item number	Item	Where located **	
		Primary paper (Page or appendix number)	Other † (details)
	BRIEF NAME		
1.	Provide the name or a phrase that describes the intervention.	Title Page _	
	WHY		
2.	Describe any rationale, theory, or goal of the elements essential to the intervention.	Chapter 1, Figure 4	
	WHAT		
3.	Materials: Describe any physical or informational materials used in the intervention, including those provided to participants or used in intervention delivery or in training of intervention providers. Provide information on where the materials can be accessed (e.g., online appendix, URL).	Section 3.4.2. and 4.3.4, Table 7 and Figure 4	
4.	Procedures: Describe each of the procedures, activities, and/or processes used in the intervention, including any enabling or support activities.	_____	
	WHO PROVIDED		
5.	For each category of intervention provider (e.g., psychologist, nursing assistant), describe their expertise, background and any specific training given.	Section 4.3.4 _____	
	HOW		
6.	Describe the modes of delivery (e.g., face-to-face or by some other mechanism, such as internet or telephone) of the intervention and whether it was provided individually or in a group.	Section 4.3.4. _____	
	WHERE		
		Section 4.3.4	

7.	Describe the type(s) of location(s) where the intervention occurred, including any necessary infrastructure or relevant features.	_____	
	WHEN and HOW MUCH	Section 4.3.4	
8.	Describe the number of times the intervention was delivered and over what period of time including the number of sessions, their schedule, and their duration, intensity or dose.	_____	
	TAILORING	N/A	
9.	If the intervention was planned to be personalised, titrated or adapted, then describe what, why, when, and how.	_____	
	MODIFICATIONS	N.A.	
10.†	If the intervention was modified during the course of the study, describe the changes (what, why, when, and how).	_____	
	HOW WELL	Section 4.3.5	
11.	Planned: If intervention adherence or fidelity was assessed, describe how and by whom, and if any strategies were used to maintain or improve fidelity, describe them.	(planned) and 4.4.2.5.	
12.‡	Actual: If intervention adherence or fidelity was assessed, describe the extent to which the intervention was delivered as planned.	(actual), measure: Appendix O	

** **Authors** - use N/A if an item is not applicable for the intervention being described. **Reviewers** – use ‘?’ if information about the element is not reported/not sufficiently reported.

† If the information is not provided in the primary paper, give details of where this information is available. This may include locations such as a published protocol or other published papers (provide citation details) or a website (provide the URL).

‡ If completing the TIDieR checklist for a protocol, these items are not relevant to the protocol and cannot be described until the study is complete.

* We strongly recommend using this checklist in conjunction with the TIDieR guide (see *BMJ* 2014;348:g1687) which contains an explanation and elaboration for each item.

* The focus of TIDieR is on reporting details of the intervention elements (and where relevant, comparison elements) of a study. Other elements and methodological features of studies are covered by other reporting statements and checklists and have not been duplicated as part of the TIDieR checklist. When a **randomised trial** is being reported, the TIDieR checklist should be used in conjunction with the CONSORT statement (see www.consort-statement.org) as an extension of **Item 5 of the CONSORT 2010 Statement**. When a **clinical trial protocol** is being reported, the TIDieR checklist should be used in conjunction with the SPIRIT statement as an extension of **Item 11 of the SPIRIT 2013 Statement** (see www.spirit-statement.org). For alternate study designs, TIDieR can be used in conjunction with the appropriate checklist for that study design (see www.equator-network.org).

Appendix P: Fidelity measures for BaP-Enjoying Family Life and BaP-Standard

Being a Parent- Enjoying Family Life Facilitator weekly review forms

Instructions

The following review form should be completed together by both facilitators post group each week. Any disagreement should be discussed, and the following guidance reviewed to help with disagreements.

Fidelity items:

1. Most / all of content was delivered, with appropriate adjustments as necessary.	Yes	No	Unsure
2. Most / all of session kept to time limit, with appropriate adjustments as necessary.	Yes	No	Unsure
3. Most / all of the session was delivered using Being a Parent-Enjoying Family facilitation methods and skills, with appropriate adjustments as necessary.	Yes	No	Unsure
4. Most / all session content was delivered in a way that was consistent with Being a Parent- Enjoying Family Life theory and practice, with appropriate adjustments as necessary.	Yes	No	Unsure
Yes=The item was completed in accordance with manual expectations, with perhaps some deviation to tailor and adjust to circumstance	Unsure: Fidelity item delivered but in an imprecise way with substantial deviation from manual expectations, not appropriately tailored and adjusted		No=Fidelity item undertaken in ways that are not in accordance or contradict manual expectations

Scoring Guidance:

Q1. Most or all of content was delivered:

Look at the content checklist. Are most (i.e., 80%) of content delivered and was this delivered as described in the manual?

Q2. Most or all of session kept to time limit, with appropriate adjustments as necessary.

Were you able to cover all the content in the time given for each activity? The session does not have to have perfectly fitted to time but run in a way that's good enough so that no topics are skipped or rushed and there is enough time for parents to reflect/feedback.

Q3. Most or all of the session was delivered using Being a Parent-Enjoying Family facilitation methods and skills, with appropriate adjustments as necessary.

Did you use the following skills during the session:

- Validation & descriptive praise
- Self disclosure
- Warm, authoritative communication
- Active/reflective listening
- Clarifying
- encourage and provided opportunities for self-reflection e.g., using challenge/ negotiation
- Facilitated feedback from group
- Referred back to group agreement
- Keeping on task

Not all of the facilitation skills need be used in a session for an answer of “yes”. Instead, skills should be used where appropriate to model, to support learning and reflection and encourage group bonds and safety.

Q4. Most or all of the session content was delivered in a way that was consistent with Being a Parent- Enjoying Family Life theory and practice.

This statement focuses on what did you do in the group to specifically support parents who are experiencing significant emotional and relationship difficulties. For example, did you:

- Encourage parents to notice and acknowledge their feelings in a situation (ER)
- Explore barriers to using a particular parenting skill in terms of how the parent may be feeling & how child may feel (ER & RF)
- Encourage parents to set a quick win & reviewed previous quick wins (ER & C&B)
- Refer back or use settle in activities to help parents respond to their feelings (ER)
- Refer to manual content e.g., full cup, good enough parent, noticing and acknowledging feeling
- Modelled warm communication which was sensitive to individual’s needs.

Scoring guidance

Yes= 2, Unsure = 1, No =0

**EPEC- Being a Parent
Facilitator weekly review forms**

Instructions

The following review form should be completed together by both facilitators post group each week. Any disagreement should be discussed and the following guidance reviewed to help with disagreements.

Fidelity items:

5. Most / all of content was delivered, with appropriate adjustments as necessary.	Yes	No	Unsure
6. Most / all of session kept to time limit, with appropriate adjustments as necessary.	Yes	No	Unsure
7. Most / all of the session was delivered using Being a Parent-Enjoying Family facilitation methods and skills, with appropriate adjustments as necessary.	Yes	No	Unsure
8. Most/ all of the session content was delivered in a way that was consistent with EPEC-Being a Parent theory and practice, with appropriate adjustments as necessary.	Yes	No	Unsure
Yes=The item was completed in accordance with manual expectations, with perhaps some deviation to tailor and adjust to circumstance	Unsure: Fidelity item delivered but in an imprecise way with substantial deviation from manual expectations, not appropriately tailored and adjusted		No=Fidelity item undertaken in ways that are not in accordance or contradict manual expectations

Scoring Guidance:

Q1. Most or all of content was delivered:

Look at the content checklist. Are most (i.e., 80%) of content delivered and was this delivered as described in the manual?

Q2. Most or all of session kept to time limit, with appropriate adjustments as necessary.

Were you able to cover all the content in the time given for each activity? The session does not have to have perfectly fitted to time but run in a way that's good enough so that no topics are skipped or rushed and there is enough time for parents to reflect/feedback.

Q3. The session was delivered using Being a Parent-Enjoying Family facilitation methods and skills, with appropriate adjustments as necessary.

Did you use the following skills during the session:

- Validation & descriptive praise
- Self disclosure
- Warm, authoritative communication
- Active/reflective listening

- Clarifying
- Facilitated feedback from group
- encourage and provided opportunities for self-reflection e.g., using challenge/negotiation
- Referring back to group agreement
- Keeping on task

Not all of the facilitation skills need be used in a session for an answer of “yes”.

Instead, skills should be used where appropriate to model, support learning and reflection and encourage group bonds and safety.

Q4. Session content was delivered in a way that was consistent with Being a Parent theory and practice.

This statement focuses on what did you do in the group to remind parents of the core Being a Parent messages e.g.

- Good enough vs. perfect parent
- Full cup
- Descriptive praise
- “I” statements
- Labelling
- Child-led play

Scoring guidance

Yes= 2, Unsure = 1, No =0

Appendix Q: Content analysis of treatment acceptability ratings, including categories, subcategories, example codes and numbers of parents reporting feedback by arm.

Category & Subcategory	BaP-EFL n	BaP-S n
Category 1: Positive content	18	24
1a: Helpful & thankful for course	9	16
<ul style="list-style-type: none"> • No suggested changes 	7	8
1b: Parent-child communication and connection	6	4
<ul style="list-style-type: none"> • Play • Different styles of communication • Child developing emotional skills 		
1c: Boundaries and discipline	2	3
<ul style="list-style-type: none"> • Boundaries & consistency • Disadvantages of smacking 		
1d: Parent's emotions and wellbeing	5	2
<ul style="list-style-type: none"> • Looking after myself • Firefighting • Parent regulation 		
1e: Shifting perspectives and acceptance	5	6
<ul style="list-style-type: none"> • Making goals • Self-acceptance and perfect parent • Challenging behaviour as communication • Being present 		
Category 2: Positive delivery	15	18
2a: Group-format: Connection & safety	11	11
<ul style="list-style-type: none"> • Hearing from other parent- validation & normalizing • Safe space, openness and trust • Care and wondering what others feeling 		
2b: Leaders and supervisors	5	8
<ul style="list-style-type: none"> • Leaders engaging and open about their experience. • Supervisors input helpful. • Clear information 		
2c: Problem solving, reflecting & discussing with others to make changes	5	11
<ul style="list-style-type: none"> • Effort and commitment because got value from listening and contributing. • Doing and discussing instead of reading about • Consistency and having time and space to try strategies out. • Problem solving (in the short term) • Interactive examples helpful 		

2d: Handouts and videos- things to return to	3	3
<ul style="list-style-type: none"> • Video content and demonstrations memorable • Emails, videos and resources to return to 		
2e: Creche	0	2
<ul style="list-style-type: none"> • Having a consistent creche= invaluable 		
Category 3: Content changes	5	6
3a: Co-parenting and family dynamics	0	3
<ul style="list-style-type: none"> • Getting partners/dads involved • There's a pressure on mums to get dads involved. • Unpacking family dynamics e.g. siblings too 		
3b: Neurodiversity, EDI & signposting	0	5
<ul style="list-style-type: none"> • More support around neurodiversity • EDI training for group leaders • Course leader signposting – library of information • Services do not communicate together and parent's need to be signposted to support after group (linked up care) 		
3c: Other content: Mental health & older children	2	3
<ul style="list-style-type: none"> • More on mental health and keeping afloat over long period of time. • Age group and more on parenting older children • Advice on how to encourage child to talk 		
3d: Nothing new, not helpful for me or unable to complete	3	2
Category 4: Constructive feedback and delivery changes	17	16
4a: More publicity for groups	1	1
4b: Encouraging connection with others & group communication	4	5
<ul style="list-style-type: none"> • Didn't relate to peers or course content. • More time for socializing and connecting with more local parents. • Space to discuss if know other members. • Bigger group- more discussion and input from others • Smaller group helps to open up and be honest. • Others struggling to commit and impact. • Less break out groups due to social anxiety 		
4c: Pace, duration and information	3	0
<ul style="list-style-type: none"> • Shorter running time • Took a while to get going. • Wish it could continue. • A lot of handouts – overwhelming 		
4d: Flexibility and delivery method	7	8

- More support for working parents.
- More available days and flexibility when choosing groups.
- Offering hybrid & providing remote options
- Hard for me to attend yet it was the easiest way for me to attend.
- In person over online important for connection with parents
- Challenges of Zoom and communicating- overlap in speakers.
- Digital inclusion- support parents without access to their videos to use online groups & post handouts to parents online

4e: Delivery around challenging topics	1	1
<ul style="list-style-type: none"> • Emotional nature of content, pressure and needing space to process 		

Appendix R: Demographic characteristics of intervention completers in each arm

	BaP-EFL (n=15)	BaP-Standard (n=17)
Parent		
Age (Mean (SE))	38.4 (2.02)	35.9 (1.49)
Gender: Female N(%)	13 (86.7%)	18(100%)
Ethnicity (N(%))		
White British	3 (20%)	2 (11.1%)
Any other White background	6 (40%)	5 (27.7%)
Black or Black British Caribbean	4 (26.6%)	3 (16.7%)
Black or Black British African	0	3 (16.7%)
White and Black Caribbean	0	1 (5.6%)
Chinese	0	1 (5.6%)
Any other Asian background	1 (6.7%)	0
Any other mixed background	0	1 (5.6%)
Another ethnic group	1 (6.7%)	0
Missing	0	1 (5.6%)
Relationship status N(%)		
Married	5 (33.3%)	9 (50%)
Divorced	1 (6.7%)	0
Separated	1 (6.7%)	0
Single	4 (26.6%)	5 (27.7%)
Living with partner	2 (13.4%)	4 (22.4%)
In a relationship	2 (13.4%)	0
Co-parenting	13 (86.7%)	14 (77.8%)
Education		
Left school at 16 with qualifications	1 (6.7%)	0
Attended further secondary or college education	3 (20%)	4 (22.4%)
University education begun but not complete	1 (6.7%)	2 (11.1%)
University education complete	5 (33.3%)	3 (16.7%)
Postgraduate qualification	4 (26.6%)	6 (33.4%)
Any other qualification	1 (6.7%)	3 (16.7%)
Work		
Full time employed	3 (20%)	5 (27.7%)
Part time employed	2 (13.4%)	7 (38.9%)
Looking after family	4 (26.6%)	3 (16.7%)
Unemployed	3 (20%)	2 (11.1%)
Other	3 (20%)	1 (5.6%)
Mental health care		
Care coordinator	1 (6.7%)	2 (11.1%)
Short term treatment	1 (6.7%)	1 (5.6%)
Long term treatment	1 (6.7%)	1 (5.6%)
Medication	4 (26.6%)	5 (27.7%)
Previous parenting support		
Yes	6 (40%)	3 (16.7%)
BaP-Standard- Being a Parent	0	0

Index Child* (all biological children)		
Age	4.47 (0.52)	5.28 (0.55)
Gender: Female	6 (40%)	6 (33.4%)
Living status		
Lives with parent 100%	11 (73.3%)	17 (94.4%)
1-2 nights at another caregivers	3 (20%)	1 (5.6%)
> 1-2 nights with another caregiver	1 (6.7%)	0
Household composition		
Couple family with children	7 (46.7%)	11 (61.1%)
Blended/step-family	0	2 (11.1%)
One parent family with children	7 (46.7%)	5 (27.7%)
Other	1 (6.7%)	0
Type of housing		
Privately rented	6 (40%)	6 (33.4%)
Housing association	2 (13.4%)	3 (16.7%)
Local authority	0	2 (11.1%)
Owner	6 (40%)	4 (22.4%)
Shared ownership	0	1 (5.6%)
Temporary accommodation	1 (6.7%)	2 (11.1%)
Number of children	1.47 (0.13)	2 (0.29)
Number of adults	0.64 (0.17)	0.83 (0.12)
Household Income	£54,400 (£13,406.70)	£46,071.43 (£9275.0)

Appendix S: Subscale means and standard deviation

	Arm	N	Time 1		N	Time 2		N	Time 3	
			Mean	SD		Mean	SD		Mean	SD
BASE-6 Emotions subscale										
	BaP-EFL	33	12.82	4.28	28	9.89	5.45	24	11.83	5.48
	BaP-Standard	33	12.61	5.33	31	9.87	4.91	29	11.41	4.33
BASE-6 Impairments										
	BaP-EFL	33	15.58	5.93	28	12.68	7.26	24	13.96	6.75
	BaP-Standard	33	15.30	6.67	31	12.97	6.63	29	14.69	6.56
Concerns about my Child										
Concern 1	BaP-EFL	32	76.34	15.83	28	41.68	25.16	24	38.29	25.76
	BaP-Standard	33	78.91	17.68	31	48.94	26.84	29	43.03	24.95
Concern 2	BaP-EFL	32	70.63	14.94	28	38.89	24.39	24	34.04	23.65
	BaP-Standard	33	79.21	14.47	31	40.42	25.13	29	45.14	26.49
Concern 3	BaP-EFL	32	69.41	17.24	28	41.86	23.98	24	42.71	24.16
	BaP-Standard	33	80.52	20.18	31	46.29	26.07	29	44.66	26.88
Infant-Toddler HOME										
Responsivity	BaP-EFL	3	8.67	3.21	3	8.33	4.62	2	9.00	2.83
	BaP-Standard									
Acceptance	BaP-EFL	3	5.33	2.89	3	5.33	3.79	2	4.50	3.54
	BaP-Standard									
Organisation	BaP-EFL	3	4.33	2.08	3	5.00	1.73	3	5.00	1.73
	BaP-Standard									
Learning Materials	BaP-EFL	3	6.67	2.52	3	6.67	3.21	3	7.33	2.89
	BaP-Standard									
Involvement	BaP-EFL	3	3.67	1.53	3	4.33	2.89	3	3.67	3.21
	BaP-Standard									
Variety	BaP-EFL	3	3.33	1.53	3	3.33	2.08	3	3.67	1.53
	BaP-Standard									
Early Childhood HOME										
Learning Materials	BaP-EFL	10	7.50	1.51	7	8.14	0.90	6	7.50	1.52
	BaP-Standard	7	5.29	2.43	5	6.00	1.58	5	6.20	1.92
Language Stimulation	BaP-EFL	9	6.56	1.01	7	6.86	0.38	6	6.83	0.41

	BaP-Standard	7	5.57	1.72	5	5.80	1.64	5	6.40	0.89
Physical environment	BaP-EFL	10	5.40	1.90	7	5.71	1.89	6	5.67	1.21
	BaP-Standard	7	4.86	1.46	5	5.20	1.79	5	5.40	1.14
Responsivity	BaP-EFL	9	6.56	0.53	7	6.71	0.76	6	6.33	1.03
	BaP-Standard	7	4.29	2.36	5	6.00	1.22	5	6.60	0.89
Academic Stimulation	BaP-EFL	10	4.10	1.10	7	4.71	0.76	6	4.67	0.52
	BaP-Standard	7	3.43	1.27	5	3.00	1.22	5	4.40	0.55
Modelling	BaP-EFL	9	3.89	0.93	7	4.29	0.95	6	4.50	0.84
	BaP-Standard	7	3.29	1.38	5	4.20	0.84	5	4.20	0.84
Variety	BaP-EFL	9	7.33	1.22	7	7.43	1.27	6	7.00	1.41
	BaP-Standard	7	5.71	1.50	5	6.40	1.34	5	6.60	0.89
Acceptance	BaP-EFL	9	4.00	0.00	7	3.86	0.38	6	4.00	0
	BaP-Standard	7	3.71	0.49	5	3.60	0.55	5	4.00	0
Middle Childhood										
Responsivity	BaP-EFL	5	9.20	0.84	2	8.00	2.83	1	10.00	.
	BaP-Standard	5	7.00	1.22	5	7.80	0.84	5	7.40	1.95
Encouragement of maturity	BaP-EFL	5	4.40	1.82	2	6.50	0.71	1	7.00	.
	BaP-Standard	5	3.20	0.84	5	4.00	2.12	5	5.00	1.22
Emotional Climate	BaP-EFL	5	5.40	1.95	2	3.50	3.54	1	5.00	.
	BaP-Standard	5	6.00	1.58	5	6.20	1.10	5	6.00	1.58
Learning materials and opportunities	BaP-EFL	5	2.60	0.55	2	2.00	0.00	1	2.00	.
	BaP-Standard	5	4.20	1.79	5	5.40	1.67	5	4.40	1.14
Enrichment	BaP-EFL	5	4.40	1.67	2	5.00	2.83	1	5.00	.
	BaP-Standard	5	5.40	2.07	5	5.80	1.10	5	4.80	1.64
Family companionship	BaP-EFL	5	4.00	1.00	2	4.00	1.41	1	3.00	.
	BaP-Standard	5	4.00	2.35	5	3.20	1.10	5	4.00	1.87
Family integration	BaP-EFL	5	2.60	2.61	2	1.00	0.00	1	1.00	.
	BaP-Standard	5	1.40	0.89	5	1.60	0.89	5	1.40	0.89
Physical environment	BaP-EFL	5	5.60	2.30	2	5.50	0.71	1	5.00	.
	BaP-Standard	5	6.40	0.89	5	6.80	0.45	5	6.40	0.89

**Appendix T: Number, proportion, and example of parent's concerns, categorised
using five established categories from Day et al., 2022**

	N	%	Example
Being aggressive and naughty behaviour	94	44.8	<ul style="list-style-type: none"> • Not listening to what I say • My child's rudeness and talking back to me and her dad. • Anger e.g. flying off the handle from out of nowhere. • Shouting and swearing at caregivers • Hitting when things don't go his way. • Behaviours which trigger me such as acting out, not listening, shouting, jumping
Being anxious, low in mood and unhappy	31	14.8	<ul style="list-style-type: none"> • Being very attached to me e.g. going to nursery, impact on relationship with others in house • How much emotions affect her- the strength of her emotions and sensitivity- emotions squash her/consume her. • Understanding if my child feels secure and self-assured. • Very scared to stand up for herself. • The impact of trauma on his way of coping with stress/emotions • Moodiness and mood swings
Being overactive and concentration problems	27	12.9	<ul style="list-style-type: none"> • Risk taking - fear of running off or getting lost. • Her concentration - generally very easily distracted and forgets what she's doing very quickly. • Breaking things - not as a temper tantrum, more out of curiosity and inability to control impulse. • Too active and restless • Delayed response to what's asked of him
Having problems getting on with others	31	14.8	<ul style="list-style-type: none"> • Having a close relationship to the child • Friendship and relationships: managing friendships. • Sibling rivalry • Inability to understand the other persons perspective & boundaries e.g. personal space, when people say "no" • Selfishness • Controlling in play and conversation • She constantly chat a lot and it gets really annoying. • I'm concerned my son is afraid of me
Having difficulties with daily activities	27	12.9	<ul style="list-style-type: none"> • Food and fussy eating - refusing and no consistency in what she likes, presentation. • Sleep routine • Getting ready • He's just too rough and doesn't take care of himself.

Appendix U: Example Interview topic guide

Parents who attended BaP-EFL

Aim of interview: The aim of this interview is to find out the parent's experience of the trial methods and BaP-EFL intervention. The questions are open so that parent's feel able to bring up information that's important.

Ice breaker and introductions

- Remind aims of interview, no pressure to answer any questions if don't want to and option to withdraw, can choose to end any time you want.
- Remind of recording procedures; uploaded to secure computer and transcribed, all data anonymised.
- Give opportunity to ask any questions they have.

1. Trial implementation and acceptability

1.1. Recruitment and informed consent

- How did you find out about the study? What attracted you to the study?
 - **PROBE:** Was the information clear about who the study was for?
 - **PROBE:** How available and accessible is parenting support for parents in your community? Have you received support in the past?
 - **PROBE:** Are there further information or activities we could do to advertise the research to parents in your community?
- How did you find initial meetings to learn about the study? Was everything explained clearly?
 - **PROBE:** What were your concerns (if any) or worries about taking part in the study?

1.2. Randomisation

- When did you learn that there was an equal chance you would receive BAP-EFL versus the standard being a parent group? What were your thoughts about this?
 - **PROBE:** What are your thoughts about the offer of receiving either BAP-EFL or being a parent?
- When did you learn you would be receiving BAP-EFL? How did you feel about this?
 - **PROBE:** How were the researchers helpful or not helpful in explaining the group you were going to attend?

1.3. Data collection:

- How did you find completing the questionnaires?
 - **PROBE:** Were there any challenges to completing them?
 - **PROBE:** Any ways we could improve questionnaire appointments for you?
- How did you find the interview with you and your child?
 - **PROBE:** Were there any benefits or challenges to interview?
- What were the challenges (if any) to completing the questionnaires at each time point?
 - **PROBE:** is there anything we could do to make this better for you?
 -

2. Intervention Implementation

- Tell me a little about the groups you attended? Where were the groups and how many other parents went?

- **PROBE:** What were your thoughts of the location and size of the group?

2.1. Engagement and attendance

- How many sessions were you able to attend?
 - **PROBE:** If you feel comfortable, what were some of the reasons which prevented you from attending?
 - **PROBE:** How did you make the decision not to attend?
 - **PROBE:** Were there any challenges for you being able to attend? Were you able to overcome them and if so, how?
 - **PROBE:** Anything that would make attending easier?
 - **PROBE:** Were you able to catch up with any missed sessions?
- What were your thoughts on the homework?
- Did you ever feel unsure about continuing with the group?
 - **PROBE:** What do you think made you feel this way? Why did you carry on?
- The group is run on a weekly basis for 2 hours. What was this like for you? How did you find the frequency and timing of the sessions?

2.2. Intervention acceptability

- Were the groups enjoyable and helpful?
- How did you find being in a group with other parents?
 - **PROBE:** What was similar or different in their experiences of being a parent?
- Were there anything you found difficult or uncomfortable about the groups?
 - **PROBE:** How did this affect you? And your feelings toward the group?
 - **PROBE:** How do you feel about this now?
 - **PROBE:** Were there any ways we could make that better?

2.3. Intervention Content

- What did you think about the topics covered in the group?
 - **PROBE:** What were the most interesting or helpful topics?
- What did you think about having a coffee morning to introduce you to the group?
 - **PROBE:** Were you aware of the purpose of the coffee morning?
- In each session after the coffee morning, you started with an offload and feedback activity, followed by a settle in activity. Did this happen every week?
 - **PROBE:** What did you think of the structure of the sessions?
- What did you think about the balance between supporting you as a parent and thinking about the needs of your child and about family life?
- How did you feel about the handouts and tools used in the group?
 - **PROBE:** Were they clear?
 - **PROBE:** Did they match the content of the group?

2.4. Impact

- What were the benefits of the groups in your opinion? What were the biggest impact on you and your family?
 - **PROBE:** Why do you think they helped you and your family?
 - **PROBE:** Were there any unexpected changes to your life as a result of the groups? E.g. in your relationships with other adults
- What were your thoughts on the parent group leaders? Did you feel they shared similar values and experiences as you?

Appendix V: Member reflections workshop notes 04/07/23.

Themes presented	Parents reflections	Researcher reflection & action
Theme 1: The value of the BAP-EFL project	<ul style="list-style-type: none"> • Parent gender didn't come up as influencing experience of group – being a mum or dad doesn't make parenting different and parents have difficulties regardless of gender; there should be same topics in mum and dad groups. 	Reflections during break:
Subtheme 1: Integrating parent's hopes with research methods and parenting group.	<ul style="list-style-type: none"> ○ Timing of dad's group in evenings which suited dads more. ○ Resonated and related to dads on the course. ○ Recognised that there wasn't a male perspective in this workshop – mothers felt would benefit from a male perspective in their group. ○ Relating to others & using mixed group for different perspectives (<i>something about listening to others for different perspectives</i>) 	<ul style="list-style-type: none"> • Fact that parents surprised by gender and don't think it would've or may not have influenced the groups- have I made this into a bigger thing? • Timings of group and working parent- about match or mismatch – some of these barriers where situation meets needs of the group. • POSSIBLE improvement- having handouts even if not able to attend?
Subtheme 2: Separate by situation: the influence of family situations.	<ul style="list-style-type: none"> • Takes a bit to talk and share in group environment. • Ages of child- matched me at current age but may not match at different ages. • Discussion within the group of neurodiverse children and adapting to their situations. • <i>Continuity outside of course</i>: Reiterating the tools and listening to parenting podcast. 	Reflection post-group
Subtheme 3: Information sharing and knowing what to expect.	<ul style="list-style-type: none"> ○ Parenting is a continuous thing & sharing idea from other parents valuable. ○ Looking for other resources and continuity to apply strategies tough. • The course highlighted that I cared about how she feels- not just material impact but aware of her feelings (<i>something about more known</i>) • Knowing about creche and times of course in advance and being able to plan was very important- wanted to attend the course but not being able to because of times and dates and the quick 	<ul style="list-style-type: none"> • EVEN BETTER SOLUTION- choice over randomisation, and research meeting about selecting group which would think fit better. • Something being better than nothing- bring out more, also for parents who weren't able to attend? • RELATING to others- learning in the context of others • My language around separate by situations- deterministic/directional and perhaps not reflecting all situations.
		<p>Actions:</p> <ul style="list-style-type: none"> ○ Reconsider language e.g. Separate by situation. ○ Information and managing expectations right, but perhaps needs developing – is it really about the value of the course? ○ Similarly, do practical barriers come in match/mismatch?

	<p>turnaround not enabling time to plan (<i>Randomisation makes this difficult to have information well in advance</i>)</p> <ul style="list-style-type: none"> • Parent wanted to attend but not creche – would've liked handouts as didn't understand what was going on and having nothing to look back on, left feeling out of the loop if not able to attend. • Sharing information if really wanted to join and even if given handouts it would've been something – would've benefitted a little bit from handouts (<i>some things better than nothing</i>) • HOPE – wanted to join but not enough information about the groups to plan and join 	<ul style="list-style-type: none"> ○ Family situation heavily linked to relating and the relationship. ○ Value & MATCH hopes and expectations ○ Relating to content ○ Relating to others ○ Information and managing expectations
Theme 2: Interpersonal experience of the group and research	<ul style="list-style-type: none"> • Care was salient- parent's gave other examples of where they had experienced care from the group e.g. having lunch during sessions and parents checking when didn't have lunch. • Bond that developed because honest and safe space and everyone made a concerted effort to attend. 	My reflections post session.
Subtheme 1: Identification or alienation with others	<ul style="list-style-type: none"> • PGLs being through the course- didn't know what to expect but PGLS bringing personal experience helped. • Role playing with each other (<i>PGL relationship with each other was important</i>) • Challenges and stigma vs. humour and light heartedness • Everyone there for the same reason- comradery 	<ul style="list-style-type: none"> • CARE & BOND important • Repetitive nature and reiteration of safety very important - "mantra that enabled vulnerability" I LOVE THIS vs. when course changing lots, no connection. • Coming back to this idea about investment in others and investment in the course
Subtheme 2: Trust, being heard and responsibility to others.	<ul style="list-style-type: none"> • Always reiterated at the start of sessions that it was a safe space- mantra that enabled vulnerability. • Course tapped into parent's emotions and parent felt a real genuine sense of care- checked in on each other and individuals. • Parent's dropping out- I came in with a lack of confidence and to connect with someone else – I wanted to continue with that person but wasn't possible <i>and was demotivating?</i> 	Action
Subtheme 3: Giving and receiving: experiences of	<ul style="list-style-type: none"> • PGL connections- have children of different age group but could connect. Liked that parent's weren't scared to tell me and were direct – guidance. 	<ul style="list-style-type: none"> - Review CARE and Trust themes- something about the bond, and then what did parent's experience as enabling the bond- familiarity, repetitiveness & safety, sharing, - Missing & could bring out more about PGL personalities. - Missing & could bring out more the opportunity to learn from others and hear different perspectives – is this in the <i>Family situation subtheme?</i>

- care in the group.
- Learning different approaches from hearing other’s experiences- PGLs with older kids had made mistakes which perhaps helped them gain perspectives.
 - PGLs had different personalities- related to one more than the other but wasn’t about their personalities.
 - **Feeling valued and listened too- couldn’t connect because chasing a toddler.**
 - Small group which changed quite a bit – didn’t feel a sense of connection with other parents.
 - PGLs felt like doing it for the first time, it was formulaic, didn’t address when something *I was experiencing* didn’t fit in to their scheme

Theme 3:
Relating the research and parenting group to self and child.

Subtheme 1:
Learning:
Concrete knowledge, insight and flexibility

Subtheme 2:
Attending and Applying: when effort meets opportunity.

- Being able to attend the session- would’ve liked an overall assessment and honesty about the accessibility for me at the start- having a conversation at the start important
- Location of the sessions was a long way to travel- trying to get family members to help with childcare but also barrier of breastfeeding.
- Miscommunication at the beginning too- knowing the limits of the course and impact on attendance early was v. important.
- Q around wellbeing and whether the course covered things for self – focus on wellbeing was huge and the 1st time parent had heard of it in relation to parenting
- Parent suggested embedding an introductory expectations discussion on how to use the course- balancing with work and getting that SPACE to let soak in
- As useful tools and strategies are – if don’t have the headspace then you’re not going to apply it.
- Time and space or strong enough desire to create that.
- Parent life is hard.
- Talking about creating that space to take in bits from
- Exhaustion- not much reflection time and feeling exhausted later on in the group.

Post group reflections

- I really like the idea of an overall assessment of accessibility, idea of having all the information before and being able to choose ... don’t know whether can draw out in analysis.
 - **WORKING** with parents who want the group to plan access.
 - Miscommunication and things we can do better too around giving parents all the information – again the problem of randomisation and “messiness” of setting up the groups.
 - **LIKE** the idea of introductory expectations discussion around balancing with work and getting space to let things soak in...
 - **SPACE** being really important- **SPACE** to apply and space to think.
 - **FLEXIBILITY** for connecting with others – less about learning more about interpersonal bits... but then it’s also about learning from others.
-

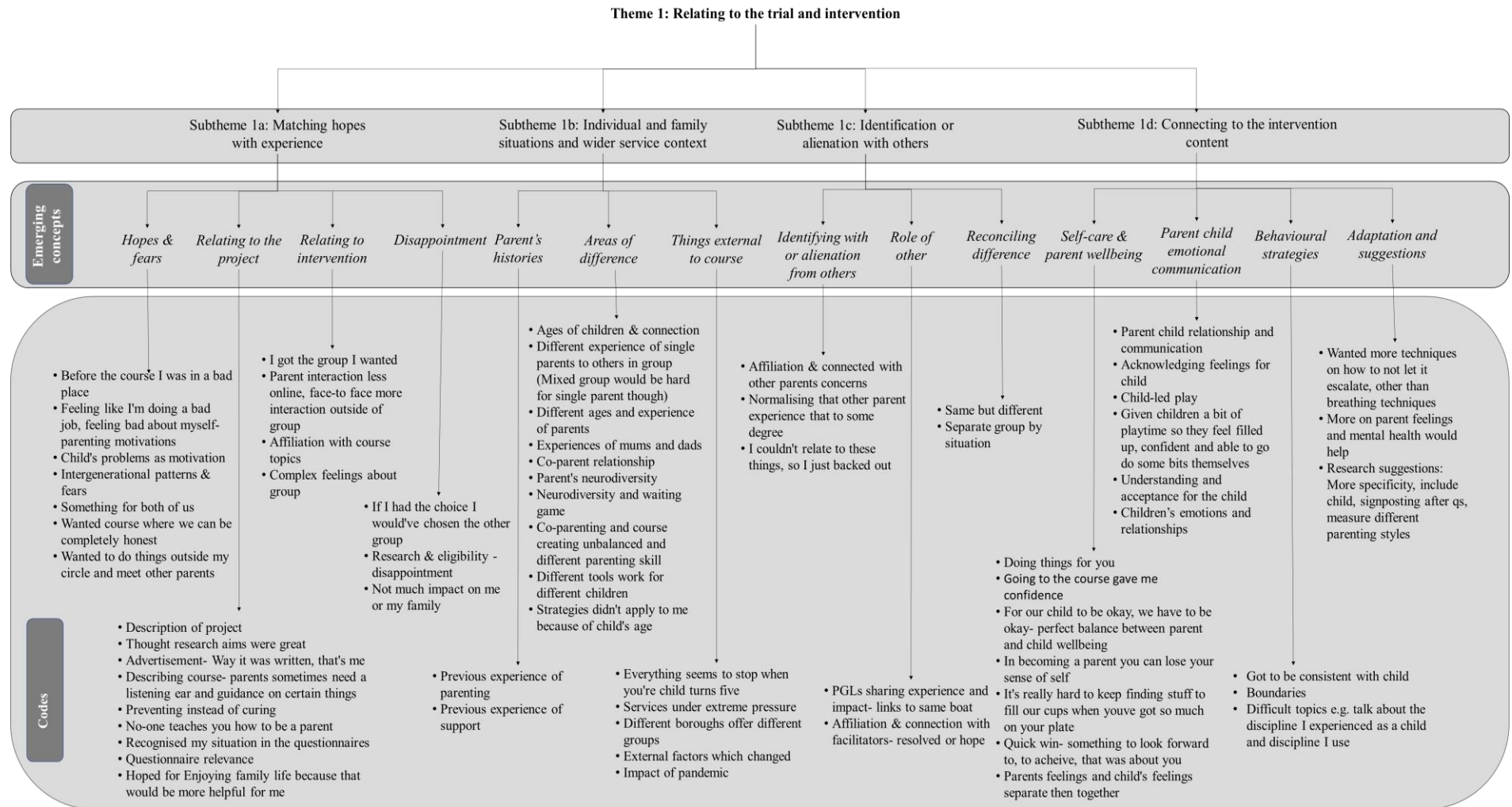
- Super practical and quick
 - Flexibility was what's missing- encouraging people to connect- no room for anything else but the course and prevented people from connecting.
 - Didn't get learning tools and didn't have anything to reflect on
 - Misinformed – not able to follow on from course then learning is wasted- extending learning beyond the course. Not having handouts felt half-heartedly done- things to carry on conversation after.
 - Towards the end juggling sessions- perhaps one week off one week on would be more manageable
 - Full on commitment
 - INTENSITY- meet new people hard for me.
 - *I floated that part of rationale for this group was idea that “groups are lower intensity than one-to-one support” but perhaps not the case.*
 - One parent said would really appreciate one-to-one meetings and loved the one-to-one sessions with me.
 - Another said would really struggle on one-to-one and much preferred group.
- ALSO flexibility in what's offered to allow more choice and parents to work around barriers.

Action:

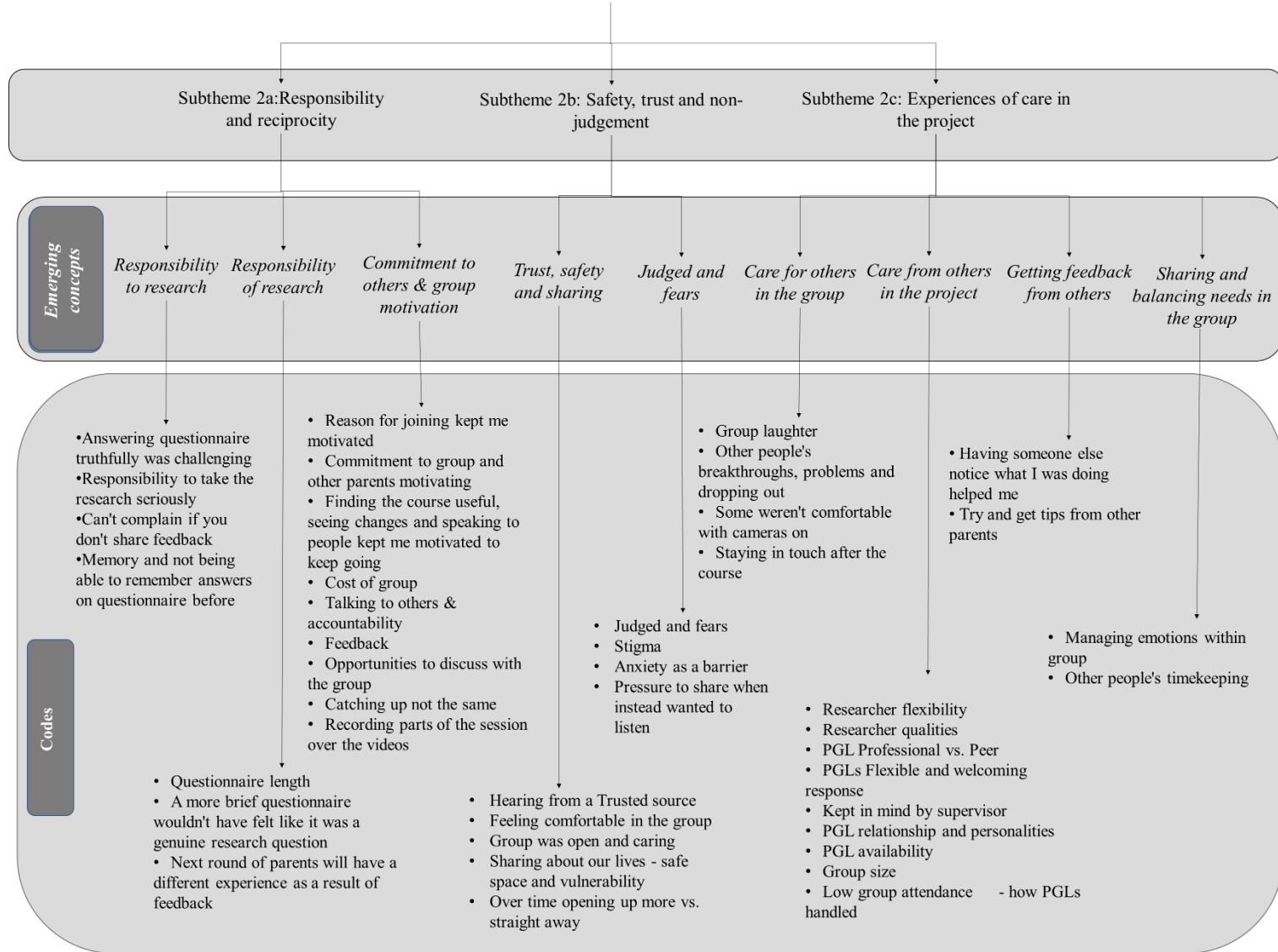
- Consider a third subtheme about space and emotional investment/boundaries.

Note. Red text indicates feedback from a parent comparing to another parenting group she had attended after the course had finished.

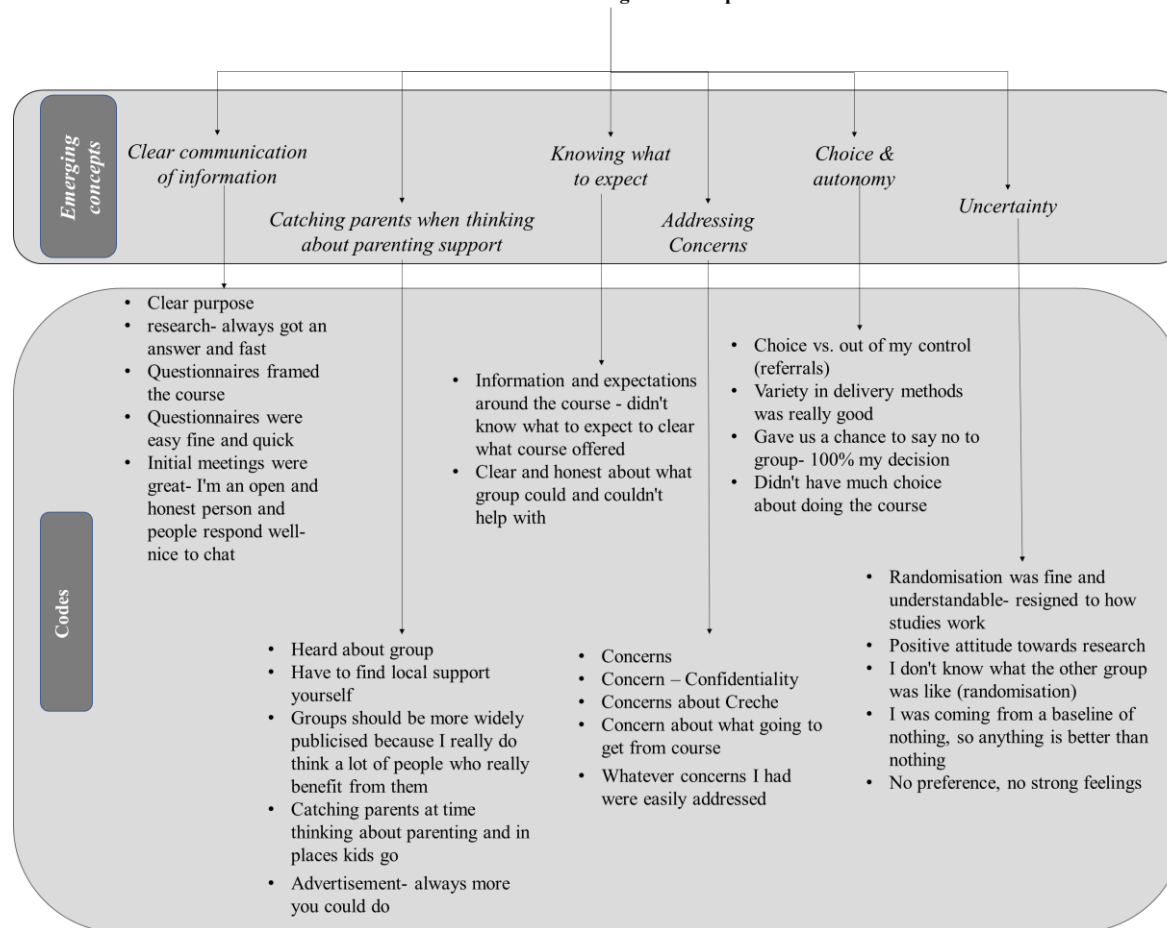
Appendix W: Reflexive thematic analysis with themes, subthemes, emerging concepts and codes.



Theme 2: The value of relationships



Theme 3: Knowing what to expect



Theme 4: Creating space to take in the course

