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Caregivers' perspectives about engagement in a group psychological intervention for emotional disorders in school-age children

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Abstract

The present study analyzed the engagement of caregivers and children in a child-centered cognitive-behavioural intervention for emotional disorders. A semi-structured interview was used to collect data from a sample of 17 Portuguese caregivers from 12 families of school-aged children that participated in a group cognitive-behavioural intervention (child-centered version of the Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders in Children). Data was analyzed using content analysis. It was possible to identify facilitators (e.g., motivation, practical reasons) and barriers (e.g., practical reasons, characteristics of the tasks) to caregivers' engagement regarding in and out-of-session activities. Similarly, from the caregivers' report, we identified facilitators (e.g., therapeutic alliance, contingencies) and barriers (e.g., children's characteristics, characteristics of the tasks) to children's engagement in the sessions and with home tasks. These results suggest important factors to consider in the context of child-centered group psychological interventions for emotional disorders.

Keywords: parent engagement; child engagement; obstacles and facilitators; anxiety; depression.

Resumen

Perspectivas de los cuidadores sobre la participación en una intervención psicológica grupal para trastornos emocionales en niños con edad escolar. El presente estudio analizó la participación de cuidadores y niños en una intervención cognitivo-conductual centrada en el niño para el tratamiento de los trastornos emocionales. Se utilizó una entrevista semiestructurada para recopilar datos de una muestra de 17 cuidadores portugueses de 12 familias de niños en edad escolar que participaron en una intervención cognitivo-conductual grupal (versión centrada en el niño del Protocolo Unificado para el Tratamiento Transdiagnóstico de Trastornos Emocionales en Niños). Los datos se analizaron mediante análisis de contenido. Se identificaron factores facilitadores (e.g., motivación, razones prácticas) y barreras (e.g., razones prácticas, características de las tareas) para la participación de los cuidadores en las actividades dentro y fuera de las sesiones. De igual forma, a partir del informe del cuidador, se identificaron factores facilitadores (e.g., alianza terapéutica, contingencias) y barreras (e.g., características de los niños, características de las tareas) para la participación de los niños en las sesiones y en las tareas domésticas. Estos resultados sugieren factores importantes a considerar en el contexto de las intervenciones psicológicas grupales centradas en el niño para trastornos emocionales.

Palabras clave: participación de los padres; participación de los niños; obstáculos y facilitadores; ansiedad; depresión.

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Highlights

- Participants' engagement is an essential condition for the effectiveness of psychological interventions.
- When working with children, it is crucial to consider the caregivers' influence on children's engagement.
- The present study analyzed the engagement of caregivers and children in a group cognitive-behavioural intervention for emotional disorders.
- It was possible to identify facilitators (e.g., caregivers' motivation; children's therapeutic alliance) and barriers (e.g., lack of time; child inhibition) to the engagement in both the sessions and out-of-session activities.

Puntos clave

- La participación de los participantes es una condición esencial para la eficacia de las intervenciones psicológicas.
- En las intervenciones infantiles, la influencia de los cuidadores es fundamental en su participación.
- El presente estudio analizó la participación de cuidadores y niños en una intervención cognitivo-conductual grupal para trastornos emocionales.
- Fue posible identificar facilitadores (e.g., motivación de los cuidadores; alianza terapéutica de los niños) y barreras (e.g., falta de tiempo; inhibición de los niños) para la participación en las sesiones y en las actividades fuera de ellas.

The effectiveness of psychological interventions requires participants' engagement, attendance, and adherence to the intervention (Haine-Schlagel & Wash, 2015; Nock & Ferriter, 2005; Piotrowska et al., 2017). Child and family engagement in mental health interventions has gathered attention from theoretical and empirical research (Chacko et al., 2016; Ingoldsby, 2010). When working with children, it is important to consider parents' influence (Haine-Schlagel & Wash, 2015; Nock & Ferriter, 2005) and the fact that parent's commitment to the therapy may not always guarantee the children's sufficient motivation to engage in it (O'Reilly & Parker, 2013).

Problems regarding participant engagement in evidence-based interventions can occur at various phases. The search for help proves to be lower than the actual needs presented by children and their families (Pereira & Barros, 2019), with about 50% of youth needing clinical intervention actually requesting it (Merikangas et al., 2010). A previous systematic review on engagement with behavioral parent training for youth with disruptive behavior disorders revealed that about 25% of potential participants do not enroll in behavioral parent training interventions, with 26% of participants who initiate treatment not completing the intervention (Chacko et al., 2016). In a meta-analysis, mean dropout rates were between 35.8% and 44.5%, depending on the definition of dropout (i.e., based on therapists' opinions or the predetermined number of completed sessions) (De Haan et al., 2013).

Client engagement is a multifaceted construct and may comprise different levels, stages, or components (King et al., 2014; Piotrowska et al., 2017; Staudt, 2007). For example, engagement may not only have a behavioral component (e.g., attendance, active participation in the intervention) but also an attitudinal one (e.g., expectations of the participants about the intervention and their motivation and commitment) (Haine-Schlagel & Walsh, 2015; Staudt, 2007). King and colleagues (2014) define client engagement as a "motivational commitment" state or process on the client role that involves three different components that occur in the context of a relationship between client and therapist – affective, consisting of involvement with the therapist and therapy process of an emotional nature; cognitive, including beliefs about the need to participate in treatment and its effectiveness; and behavioral, operationalized through participation in the sessions, behavioral collaboration, and self-efficacy beliefs about the ability to complete tasks outside of the session.

Client engagement can also be understood as an evolving process. The Connect Attend Participate Enact Model (CAPE; Piotrowska et al., 2017) distinguishes several interdependent engagement phases. The Connect phase refers to the initial contact with the clients and their decision to participate in the intervention; the second phase, Attend, is related to the participant's sustained presence in the session. In this model, participation is related to the client's active engagement in the intervention through the completion of the session's activities and home tasks. The last phase, Enact, refers to applying the learned strategies. The current study will focus on the third phase of the Piotrowska et al.'s model and explore in-session and out-of-session active participation, also known as *participation engagement* (Haine-Schlagel & Walsh, 2015).

Facilitators and barriers to engagement in clinical interventions experienced by parents

Multiple obstacles increase the risk of lower engagement/dropout and, consequently, diminished therapeutic changes. The Barriers-to-Treatment Model (Kazdin et al., 1997) identifies barriers related to participating in therapy: practical obstacles, such as lack of transportation (Becker et al., 2018); perceptions that the intervention is excessively demanding, long, confusing, expensive, or complex; perceptions that the treatment is not significantly relevant to the children's problem; and poor therapeutic alliance (Kazdin et al., 1997).

Similarly, Staudt (2007), discussing families of at-risk children, summarized that a lack of engagement may be a result of the experience of barriers, such as 1) cognitions about the intervention, necessity, and potential for transformation; 2) poor relationship with the therapist; 3) stress related to a deficiency of primary resources, conflicts within the family and social systems, low social support and personal difficulties, such as mental health problems.

Koerting and colleagues (2013) reviewed 12 qualitative studies about parents' perceptions regarding access and engagement in clinical interventions for behavioral problems in children. The results identified various barriers to their engagement: the perception that the intervention is not helpful, displeasure with group activities, difficulties following the intervention, and changes in participants' lives. The fact that aspects related to the program met the real needs of families, a positive group experience, between-session contact, and other factors related to the therapist, like positive personal qualities, skills, and training, were identified as facilitators.

The current study

Client engagement is crucial for achieving positive outcomes in evidence-based interventions (Haine-Schlagel & Wash, 2015). The literature on participation engagement in children's psychological interventions for emotional problems is scarce. Emotional disorders (e.g., anxiety, depression, obsessive-compulsive disorder [OCD]) involve the intense and frequent experience of negative emotions, followed by aversive reactions and efforts to escape them (Bullis et al., 2019). These disorders can pose specific problems with the client's engagement (e.g., avoidant patterns). The current study aimed to analyze caregivers' perspectives regarding their and their children's engagement in a cognitive-behavioural group intervention for emotional disorders, a child-centered version of the Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders in Children (UP-C/C). The study's specific objectives were to identify the facilitators and obstacles to the active participation of children and caregivers through the latter's perceptions. Given the lack of research on factors influencing homework completion, we examined the facilitators and barriers to engagement, considering both session and out-of-session activities.

Method

Participants

The sample consisted of 17 caregivers (*M* = 43.50 years old, *SD* = 4.54; 65% female) of 12 children aged seven to 12 years old (*M* = 9.67 years old, *SD* = 1.97; 41.67% male). The children were recruited in the context of a pilot study of the UP-C/C to examine its acceptability and viability (see Appendix A for more information about the intervention and its pilot study). Most of the children presented complaints related to anxiety symptoms. The symptoms of anxiety were diverse and mainly existed in comorbidity with other internalizing or externalizing difficulties (see Table C1 in Appendix C for a more detailed description).

Measures

Semi-structured interviews enable the deep exploration of experiences and perspectives of participants in an intervention (Dejonckheere & Vaughn, 2019; Gill et al., 2008), appropriate for the study aims. The script (see Table B1 in Appendix B), composed of open-ended questions, was designed by the first and last authors. The interview protocol was based on the model of Piotrowska et al. (2017) and informed by previous empirical findings (e.g., Mytton et al., 2014).

A sociodemographic questionnaire was used to characterize the participants.

Data Collection Procedures

The Ethics and Deontology Committee of the Faculty of Psychology of the University of Lisbon approved this study. All the families who completed the UP-C/C intervention (defined as having participated in 70% of intervention sessions) were invited by the group's facilitators to participate in a final interview about their experiences. The invitation was done by e-mail and face-to-face during the last intervention session, and all except one agreed.

The semi-structured interviews were conducted by the first three authors of the paper, two weeks to two months after the intervention was concluded. Two of the three interviewers had previously interacted with participants as the intervention facilitators. After signing the informed consent, caregivers were interviewed. Seven interviews were conducted individually, five were conducted with a current or former partner (three were cohabiting). Four of the 12 interviews were conducted in person, at a university clinic, and the remaining interviews were conducted via video call.

The interviews lasted, on average, 90 minutes. Only the researchers were present at the interviews and had access to the data, with all identifying information replaced by codes to ensure confidentiality.

Data Analysis

The 12 interviews were audio recorded and transcribed verbatim. The data was analyzed through a content analysis, at the interview/level. The transcripts were examined sentence by sentence and coded in alignment with the study objectives. Codes were grouped into categories based on identified patterns. Some categories emerged a priori through the literature, while others arose from the analysis, and were subjected to constant refinements. The subjective nature of the analysis imposes a risk, and this risk is potentially increased in this study, given the involvement of one of the coders in the intervention. To reduce that risk, the first and second authors of this study analyzed half of the interviews and later reviewed all the categories that emerged. If disagreements in the codification of data occurred, a consensus was sought by the intervention of the fourth author of this study. The QSR Nvivo 12 software was used to organize the data and analyze the interviews.

Results

Results regarding facilitators and obstacles were organized considering the agent (caregiver or children) and the engagement focus (session or out-of-session activities). Below, we describe the categories identified by at least 25% of the sample to highlight the most relevant patterns within the data. Tables present the categories and their absolute and relative frequency. The categories and their most significant subcategories are described in the text, with representative quotes for each. Since only the most significant categories were examined and they are not mutually exclusive, their aggregated percentages may not total 100%.

Facilitators of participants' engagement

Facilitators of caregivers' engagement – sessions

Concerning caregivers' engagement in the sessions, as presented in Table 1, the importance of *motivation* was emphasized. The caregivers' motivation originated from perceiving the child's motivation, "(...) feeling that she wanted to come (P4)", and desiring to improve the child's life "(…) that's what always moved me to participate and to be there, is thinking that this is part of getting to C1 better and being able to improve his life too, right? Maybe he won't have as many questions in the future as I once had (…) he can learn sooner to deal with emotions and these issues (…) (P1)". In three interviews, caregivers *did not identify* any facilitator for their engagement in the sessions.

Facilitators of caregivers' engagement – out-of-session activities and materials

Regarding the engagement of caregivers in the program's out-of-session activities and materials (Table 1), in half the interviews, caregivers mentioned *motivation* as a facilitator. Several dimensions related to motivation emerged, namely the perception of commitment, "I think I really wanted to see this through to the end. Because I think it is extremely important and I feel privileged to have been able to participate. And that was always my motivation. (P1)"; the comprehension of the necessity to carry out the task, "(…) the feeling of necessity, the necessity to do this because we need to be helped. The issue of obligation and necessity are often here... (PP5)", and the necessity to change for bettering the child's life, "and the fact that it was a good starting point was a motivation to start doing something. (PP5)". *Practical reasons* were also mentioned by some of the caregivers (33% of the interviews), namely those related to the professional context, "From the moment I switched my professional activity, it made it easier, it coincided with the exposure phase, which was very good because it also allowed us to have more time to apply this. (P11)", and to the caregivers being available "(…) I have many times (where I think) 'Oh, I don't remember what this is, I'm going to reread it soon, I have a little bit of time, I'll reread a little bit'. (PP2)". The development of a *habit/routine* was also pointed out as an important facilitator in a quarter of the total interviews, namely because of the materials being sent to the parents every week: "the way it was transmitted to us, so every week there is something that is for parents… (P1)".

Table 1. Caregivers' identified facilitators of engagement in the sessions and out-of-session activities and materials

Category	Absolute Frequency	Relative Frequency $N = 12$
Sessions		
Motivation	5	42%
Did not identify any	3	25%
Out-of-session activities and materials		
Motivation	6	50%
Practical Reasons	4	33%
Habit/Routine	3	25%

Facilitators of children's engagement – sessions

Regarding children's engagement in the session from the caregivers' perspective, as presented in Table 2, aspects related to the *therapeutic alliance* were mentioned in half of the interviews: "And he liked it, so he created one right away… you managed to create a connection with them right away, and I think that it's also fundamental (…) being loving with them, I believe that this is very important because you managed to captivate them right at the beginning oh and he speaks fondly of you. Therefore, I see that it is something that he liked. (P6)". The caregivers referred to the importance of the encouragement from the psychologist, "Okay, being able to encourage him there, I think it was a facilitator... (P1)". Also, in 33% of the interviews, caregivers also referred to the importance of *safety* regarding the children's engagement in the sessions, describing the importance of having a safe therapeutic space, "There was a feeling of security for her, she was very comfortable (…) Always very comfortable. (P3)".

In a quarter of the interviews, caregivers described the *characteristics of the program* as facilitators of children's engagement, namely its group format, whether it was more heterogenous "(referring to the child being the oldest of the group) (…) I think it ended up having (…) this positive effect because, maybe, he felt more comfortable talking and collaborating and participating in activities (…). (P8)" or homogeneous, "I think it made it easier to be just girls because she with the boys… is a whole complication with the boys. (P5)".

Some caregivers (25% of the interviews) also referred to the importance of *motivation* namely the child's perception of their need for help, "I think that in an unconscious way (…) she can identify some things that she feels (…), and I think she also needed to overcome them, deal with things. (P4)", also recognizing the importance of the novelty of the experience, "but while (…) it's new, she's here, she stays. (PP9)", of committing, "She made the effort, she committed himself as we asked. (P9)", and of the child's intrinsic motivation "No, I think it has a lot to do with his personality. It has a lot to do with his wanting. (P6)".

In a quarter of the interviews, children's sense of *autonomy* was considered relevant to the engagement of caregivers in the session, namely, the fact that caregivers were not present in the totality of the children's sessions: "Well there… (laughs) There is one thing that is for me to leave the room (laughs) because it gives him this autonomy (…) and objectively he has to respond and not take refuge in his mother, because at times I know he does it too. I avoid it, but I know he does it. (P1)".

Facilitators of children's engagement – out-of-session activities

Regarding the engagement of children with the out-of-session activities (Table 2), caregivers (in 42% of the interviews) described the importance of using *contingencies*, namely in the form of rewards "What made it easier… (…) clearly the rewards. (PP9)", as well as expressed in the desire to share (achievements) and to meet expectations: "(…) for her it was very important – 'I have even to do this because I want to get there and I want to tell them, and since I want to tell Therapist 1 and Therapist 2 I have to do this' (P3)".

Table 2. Children's identified facilitators of engagement in the sessions and out-of-session activities

Category	Absolute Frequency	Relative Frequency $N = 12$
Sessions		
Therapeutic Alliance	6	50%
Safety	4	33%
Characteristics of the program	3	25%
Motivation	3	25%
Autonomy	3	25%
Out-of-session activities		
Contingencies	5	42%
Intervention of the caregivers	4	33%

According to some caregivers (in 33% of the interviews), another relevant factor for the engagement of children with the home tasks was the *intervention of the caregivers*, namely the support provided by them in carrying out the tasks: "Sometimes the mother's insistence (laughs). The mother's insistence, remembering the rewards that could come from there, right, (that) it was also an expectation you had of him and, therefore, the need to fulfill it... And that it was beneficial for him also to internalize what he was learning, that that exercise was for him to reinforce what he had learned. (P1)".

Obstacles to participants' engagement

Obstacles to caregivers' engagement – sessions

As presented in Table 3, in five interviews, caregivers *did not identify* any obstacles to their engagement in the sessions. In the exact number of interviews, caregivers identified barriers related to *practical reasons*, mainly related to their lack of availability - lack of time: "Yes (…) the parenting sessions and, then (…) what we did at home, what made it difficult it's actually the lack, I feel, the lack of time. (P10)" and work "In the first part of the program, I was at another job and, therefore, I had some difficulty keeping up with so much. (P11) ".

Finally, in 25% of the interviews, caregivers also mentioned the *program's characteristics* as an obstacle, mainly the format of the children's sessions, in which the caregivers were only present for two moments: "if the sessions were longer, maybe the person would end up participating more, right? Because we have a tight schedule, we only have that one hour, and the parents have to be there for a little while and then leave. (P7)".

Obstacles to caregivers' engagement – out-of-session activities and materials

As for the obstacles related to the out-of-session activities and materials, presented in Table 3, in more than half of the interviews caregivers mentioned *practical reasons* of a diverse nature. In most interviews, caregivers refer to the lack of availability or difficulties in organizing time: "Sometimes... I don't know, I don't know how to explain... My week flies by and I always think I have time to do everything (...) And then sometimes I end up doing things a little bit in a hurry. (P10)"; some parents also referred to difficulties related to demands and working hours: "I am working from home and, as everyone knows, those who work from home work longer hours, (…) and therefore, I'm working an average of 12 hours or more a day and it's crazy. (P8)". Other caregivers mentioned difficulties related to family logistics: "We have to organize ourselves, whether it is transferring information from PP9 (the other parent) to me, from me to PP9, so that we can always follow things logically. (P9)".

The *characteristics of the tasks* were also mentioned in 42% of interviews as obstacles to their engagement in the materials/home tasks, recognizing difficulties in using the written materials, "I found the papers very confusing; the papers were delivered many times separately and (…) at first, I had a lot of difficulty understanding what I had to do, that I had to fill in. (PP5);" as well as difficulties resulting from lack of knowledge: "Of course, at the beginning the tasks were, were, could be more difficult because we didn't have the knowledge. (P6)".

Finally, some caregivers (in 33% of the interviews) *did not identify any* obstacles to their engagement with the out-of-session activities/materials.

Obstacles to children's engagement – sessions

With regard to the obstacles to the children's engagement in the sessions (Table 4), in half of the interviews, caregivers referred to the difficulties brought about by the *child's characteristics*, namely their shyness/social inhibition: "fear of failing or of saying something that might not go well in front of others and there being some mocking. (P6)". Caregivers also mentioned attentional difficulties "There were times when I even thought that C8 was not so focused because he also has this concentration problem. (P8)". Some *characteristics of the program* were also referred to as obstacles in 33% of the interviews, mainly the heterogeneity of the group: "(…) he was in an age group (…) different from the other children (…) and I think that in the case of C8, the fact that he didn't have other children in his age group, may not have stimulated him so much, because I felt that he was on a different level. (P8)".

Table 3. Caregivers' identified obstacles to engagement in the sessions and out-of-session activities and materials

Category	Absolute Frequency	Relative Frequency
		$N = 12$
Sessions		
Did not identify any	5	42%
Practical Reasons	5	42%
Characteristics of the program	3	25%
Out-of-session activities and materials		
Practical Reasons	9	75%
Characteristics of the tasks	5	42%
Did not identify any	4	33%

Obstacles to children's engagement – out-of-session activities

Regarding the barriers to the engagement of the children in the out-of-session activities identified by the caregivers, presented in Table 4, the *characteristics of the task* were highlighted in 42% of the interviews, mainly related to difficulties in understanding: "(…) He had some difficulty in perceiving the use (P8)". In three interviews, caregivers referred to the lack of *motivation*, specifically the lack of availability or willingness shown by the child (referred to by the parents of a child): "Despite having done all the tasks, there was never (…) initiative on her part to do one. (PP9)"; and the child not recognizing the usefulness of the strategies, mentioned by the father of a child: "He didn't want to do it, for him, for him there was no sense. (P12)".

Table 4. Children's identified obstacles to engagement in the sessions and out-of-session activities

Category	Absolute Frequency	Relative Frequency
		N=12
Sessions		
Child's characteristics	6	50%
Characteristics of the program	4	33%
Out-of-session activities		
Characteristics of the task	5	42%
Motivation	3	25%

Discussion

The present study explored the facilitators and barriers to caregivers' and children's engagement in a group cognitive-behavioural intervention. Given their role in the therapeutic process (Kendall, 2006), the caregivers' perspective was used to explore the children's and caregivers' experiences in the intervention (Kendall, 2006). Caregivers perceive their motivation as the main facilitator of their engagement in the sessions and out-of-session activities. Regarding the latter, these processes appear mainly focused on the caregiver and, in part, related to the caregivers' perception of their need to change to improve the child's life and, thus, the importance of carrying out the task and the commitment to do so. Overall, these results are congruent with previous empirical results (e.g., Burney et al., 2024; Stadnick et al., 2016), which highlight the importance of variables related to motivation on participant engagement and previous conceptual models which highlight the importance of clients perceiving the intervention as pertinent to their needs (e.g., Staudt, 2007).

The results concerning children's engagement with the sessions show the importance of a solid therapeutic alliance. From the caregivers' perspective, the children's engagement appears to be facilitated not only by the existence of the alliance itself but also through the encouragement from the therapist. These results seem consistent with frameworks like Becker and colleagues (2018), which identify the therapeutic alliance as a relevant aspect of client engagement, and previous empirical research (e.g., Mcleod et al., 2014), suggesting a reciprocal relationship between therapeutic alliance and children's involvement in intervention sessions for anxiety disorders.

In the caregivers' view, contingencies are considered relevant to the child's engagement, especially with the out-of-session activities. The results support current cognitive-behavioural practices for anxious children, highlighting the importance of using tangible and social reinforcements to maintain motivation and engagement in therapy tasks (Patriarca et al., 2022).

Caregivers mentioned the importance of specific practical reasons, such as their work life or the perception of lack of time as barriers to their engagement in the sessions. More unanimously, caregivers identified practical barriers concerning the out-of-session assignments, specifically their lack of time or difficulties with time management, the demands and schedule of their work life and family logistics. The data is congruent with the importance of the therapist addressing practical problems (Burney et al., 2024; Staudt, 2007), consistently identified as relevant barriers by previous models and research in different stages of engagement (e.g., Burney et al., 2024; Butler et al., 2020; Kazdin et al., 1997; Koerting et al., 2013; Mytton et al., 2014).

Caregivers also mentioned the task characteristics as significant obstacles to their engagement with out-of-session activities, namely difficulties in using the written materials and a lack of perceived sufficient knowledge to finish the assignments. This result seems congruent with previous research highlighting difficulties with following the program as essential barriers to parental engagement in clinical interventions for behavioural problems in children (Koerting et al., 2013).

Regarding the barriers to the child's engagement during the sessions, caregivers identify the impact of specific characteristics of the child (e.g., shyness/inhibition, attentional difficulties). Various children in the sample experienced symptoms of social anxiety – previously related to poorer outcomes in group psychological interventions (Hudson et al., 2015). These results may be, in part, related to the influence of the program characteristics, specifically being a group program, and of the group heterogeneity (i.e., different age groups, co-morbidities, and symptom's severity). This heterogeneity may further contribute to a lack of sense of security resulting from feeling little closeness to other group elements, which might further interact with the child's characteristics, influencing and being influenced by the child's inhibition. The demandingness of the task (e.g., difficulties in understanding the task) was appointed as an obstacle to the children's engagement in the home assignments. These results seem congruent with previous work, which identifies patient barriers to homework compliance, namely clients forgetting how tasks should be completed (e.g., Bunnell et al., 2021; Kazantzis & Shinkfield, 2007).

The results from this study highlight certain factors related to the in-session and out-of-session engagement of the child and caregivers that should be targeted to improve the effectiveness of child-centered interventions. Several factors should be considered, such as reducing accessibility barriers, informing caregivers on how the intervention tailors to the family's needs, and exploring expectations related to the intervention, suggested as potentially efficacious strategies by previous research (Chacko et al., 2009). Similarly, Ingoldsby's (2010) review, which focused on methods to improve family engagement and retention in child mental health interventions, highlighted that using specific brief strategies to balance the initial practical (e.g., making transport of the participants available) and psychological barriers (e.g., identification of beliefs related to the process) and, later, using motivational interviewing, and addressing family systems, and family stressors, was related to a higher initial and long-term engagement in the intervention sessions, respectively.

Future studies on caregivers' engagement could continue to consider differences between mothers and fathers, given that engaging fathers in clinical interventions and trials has proved difficult (Gonzalez et al., 2023; Piotrowska et al., 2017) and may be subjected to different challenges (Jukes et al., 2024), and seek to implement effective engagement strategies targeting fathers (Gonzalez et al., 2023). It is also not always guaranteed that the children will participate in the sessions and out-of-session activities as expected (O'Reilly & Parker, 2013). Future studies may consider factors related not only to the caregivers' participation engagement but also to the children's and explore possible interrelationships between those, which may unveil proper intervention pathways on participation engagement for the whole family to be explored.

This study presents various limitations that hinder the impact of results, which must be cautiously interpreted. Firstly, although possibly sufficient (Guest et al., 2006), the sample size is small and lacks diversity. Secondly, the study only focuses on the caregivers' perspectives regarding their own and their children's engagement, making it necessary to be careful when drawing conclusions regarding the children's experience. The interviews were conducted after the conclusion of the intervention, which also could have affected the data quality. It is relevant to consider collecting and analyzing data from the children and parents during the intervention. The conduction of interviews both in person and via video chat, although having facilitated the sample recruitment, could have influenced the results. A more natural setting in the in-person interviews could be conducive to greater involvement. Given that two interviewers and one coder had prior knowledge of the participants, there's a possibility of bias in the results. Although a second researcher with no previous contact with the caregivers was also present in the interviews, there is a possibility that the interviewee's shared views may have been tainted by social desirability. Nevertheless, and in sum, the results of the present study contribute to the engagement literature, identifying significant and/or supporting previously identified barriers and facilitators regarding caregivers and their children.

Conflicts of interest

The authors report no conflicts of interest.

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Appendix A

UP-C and UP-C/C

The UP-C (Ehrenreich-May et al., 2017) is a manualized group program for school-aged children with emotional disorders. The program's modules target mechanisms responsible for maintaining emotional disorders, related to neuroticism (Ehrenreich-May et al., 2017; Moreira et al., 2024). The UP-C has demonstrated positive results in the efficacy studies carried out so far (Bilek & Ehrenreich-May, 2012; Kennedy et al., 2019). This study uses a child-centered version of the UP-C (the UP-C/C), adapted by the first and last authors, consisting of 15 weekly 90-minute sessions for children and three sessions for parents. The parents are involved as co-therapists – they have weekly access to psychoeducational material in written and video format, support the children's tasks at home, and participate in the beginning and at the end of the children's sessions.

The caregivers were recruited for a pilot study of the UP-C/C through a university community service (i.e., caregivers seeking support for their children's emotional difficulties were presented and given the option to integrate the study) and social media posts. Family participation in the intervention was dependent on the following inclusion criteria: 1) the presence of elevated anxiety symptomology in the child. This was assessed through a clinical interview and the Revised Child Anxiety and Depression Scales - Child version (RCADS-C; Chorpita et al., 2000) and Parent version (RCADS-P; Ebesutani et al., 2011); 2) the caregivers and children being fluent in Portuguese; and exclusion criteria: 1) previous diagnosis of a psychotic, bipolar or autism spectrum disorder or cognitive deficit; 2) current suicidal or homicidal ideation; 3) caregivers and children not fluent in Portuguese; 4) the child being enrolled on a psychological intervention; 5) the child being subjected to an not already stabilized psychopharmaceutical intervention. 6) not possible to guarantee the presence of one caregiver on most procedures. One grandmother, given she provided full-time care of a child, was allowed to participate. Three therapeutic groups were formed. Of the 14 families initially involved in the program, 93% finished the intervention, showing overall satisfactory levels of completion.

All children's and caregiver sessions were led by two master-level clinical psychologists who received training from the author of the UP-C and supervision from the project's principal researcher.

Appendix B

Table B1

Interview protocol

Examples of questions

1) Facilitators of caregivers' engagement in the sessions
   a) What facilitated a more active participation from you during the sessions?
2) Facilitators of children's engagement in the sessions
   a) What facilitated a more active participation from the child during the sessions?
3) Facilitators of caregivers' engagement with the out-of-session activities and materials
   a) What helped your involvement with the home tasks?
4) Facilitators of children's engagement with the home tasks
   a) What helped the child's involvement with the home tasks?
5) Barriers to caregivers' engagement in the sessions
   a) What made it (caregivers' active involvement) difficult?
6) Barriers of children's engagement in the sessions
   a) What made it (children's active involvement) difficult?
7) Barriers to caregivers' engagement with the out-of-session activities and materials
   a) What made it (caregivers' active involvement) difficult?
8) Barriers of children's engagement with the home tasks
   a) What made it (children's active involvement) difficult?

Appendix C

Table C1

Participant Characteristics

ID Child	Age	ID Caregiver(s)	Age[a]	Therapeutic Group	Child's main difficulties	Total Anxiety and Depression Scale (RCADS-C)	Total Anxiety and Depression Scale (RCADS-P)
C1 (M)	10	P1 (F)	44	1	Social anxiety Anger	34	56
C2 (M)	12	P2 (F)/ PP2 (M)	NR/NR	1	Difficulty in recognizing self and other's emotions Anger	18	25
C3 (F)	9	P3 (F)	43	2	Social anxiety Specific phobia Anger	48	30
C4 (F)	12	P4 (F)	43	2	Social anxiety Sadness Anger	70	79
C5 (F)	12	P5 (F)/ PP5(M)	43/43	2	Specific phobia Social anxiety	54	26
C6 (M)	8	P6 (F)	42	3	Generalized anxiety Specific phobia	55	44
C7 (F)	10	P7 (F)	57	2	Social anxiety Anger	21	39
C8 (M)	12	P8(F)/ PP8(M)	44/46	3	Obsessions and compulsions Generalized Anxiety	46	70
C9 (F)	9	P9 (F)/ PP9 (M)	40/40	3	Social anxiety	52	53
C10 (F)	9	P10 (F)	42	3	Specific phobia Generalized anxiety Anger	24	29
C11 (F)	7	P11 (F)/ PP11 (M)	43/46	3	Separation Anxiety Specific phobia Anger	7	24
C12 (M)	7	P12 (M)	37	3	Specific phobia Anger	49	48

Note. NR = No response. [a] *Participants P2 and PP2 did not report age.*

Appendix D

Table D1

Definition of emerged categories

Category	Definition
Parents	
Motivation	Factors related to the internal drive and willingness to participate in the intervention
Practical Reasons	Array of external and tangible factors that limit or heighten the capacity to participate in the intervention
Habit/Routine	Set of automatized behaviors that impacts participation in the intervention
Characteristics of the program	Features of the intervention's design or content that impact participation in the intervention
Characteristics of the task	Features of the home assignments, such as difficulties in understanding and/or handling the materials provided, that impact participation in the intervention
Children	
Therapeutic alliance	Behaviors related to the positive therapeutic relationship between the child and the psychologist, such as the therapist's encouragement and warmth towards the child, that impacts participation in the intervention.
Safety	Secure and non-judgmental therapeutic environment marked by a sense of comfort that facilitates the willingness to engage in intervention.
Characteristics of the program	Features of intervention's design or content that impact participation in the intervention
Motivation	Factors related to the internal drive and willingness to participate in the intervention

Category	Definition
Autonomy	Opportunity to experience therapy activities without caregiver support or presence that impacts participation in the intervention
Contingencies	Tangible or social reinforcements that follow behaviors consistent with expectations and goals of the intervention that impact participation in the intervention
Intervention of the parents	Caregivers' behaviors that support and/or encourage children's behaviors consistent with expectations and goals of the intervention that impact participation in the intervention
Child's characteristics	Children's intrinsic features or difficulties that may result in difficulties with active participation or may appear specially challenging considering intervention characteristics (i.e., group format)
Characteristics of the task	Features of home assignments, such as difficulties in understanding and/or handling the materials provided, that impact participation in the intervention