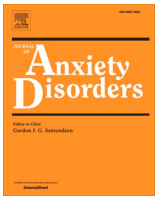
Journal of Anxiety Disorders 98 (2023) 102742

Contents lists available at ScienceDirect

Journal of Anxiety Disorders

journal homepage: www.elsevier.com/locate/janxdis



What caregivers like the most (and least) about cognitive behavioral therapy for youth anxiety: A mixed methods approach

Lesley A. Norris [a,b,*], Jonathan C. Rabner [a], Margaret E. Crane [a,c], Matti Cervin [d], Julia S. Ney [a], Kristen G. Benito [b], Philip C. Kendall [a], Hannah E. Frank [b]

[a] Department of Psychology, Temple University, Philadelphia, PA, USA
[b] Department of Psychiatry and Human Behavior, Warren Alpert Medical School of Brown University, Providence, RI, USA
[c] Department of Psychiatry, Weill Cornell Medicine, New York City, NY, USA
[d] Department of Clinical Sciences Lund, Lund University, Lund, Sweden

ARTICLE INFO

Keywords:
Child Anxiety
Cognitive Behavioral Therapy
Mixed Methods
Exposure

ABSTRACT

Cognitive behavioral therapy (CBT) is an efficacious therapy for youth anxiety disorders. Caregivers are key stakeholders in youth therapy, and their feedback on treatment can help to inform intervention personalization. This mixed-methods study applied a systematic inductive thematic analysis to identify themes among most- and least-liked CBT features reported by caregivers using open-ended responses on the Client Satisfaction Questionnaire (CSQ-8). The sample included 139 caregivers of youth ages 7–17 ($M = 12.21$, $SD = 3.05$; 59% female; 79.1% Caucasian, 5.8% Black, 2.9% Asian, 2.2% Hispanic, 7.9% Multiracial, 2.2% Other) with principal anxiety diagnoses who completed 16-sessions of CBT. CSQ-8 quantitative satisfaction scores ($M = 29.18$, $SD = 3.30$; *range*: 16–32) and survey-based treatment response rates (responders $n = 93$, 67%) were high. Most-liked treatment features included: coping skills (i.e., exposure, understanding/identifying anxiety, rewards, homework), therapist factors (interpersonal style/skill, relationship, accessibility), caregiver involvement, one-on-one time with a therapist, structure, consistency, and personally tailored treatment. Least-liked treatment features included: questionnaires, logistical barriers, telehealth, need for more sessions, non-anxiety concerns not addressed, insufficient caregiver involvement, and aspects of exposure tasks. Proportional frequencies of most- and least-liked themes differed by treatment responder status (e.g., responders cited exposure and homework as most-liked more frequently).

Cognitive behavioral therapy (CBT) for youth anxiety disorders is an efficacious intervention that has been examined in numerous randomized clinical trials (James, Soler, & Weatherall, 2005; James, Reardon, Soler, James, & Creswell, 2020). Considerable evidence supporting CBT for youth anxiety makes it a prime candidate for personalized, or precision, medicine (Cohen & DeRubeis, 2018; Cohen, Delgadillo, & DeRubeis, 2021; Hamburg & Collins, 2010; Ng & Weisz, 2016). Personalized medicine uses "evidence-based methods for tailoring treatments to individuals" (Ng & Weisz, 2015), akin to the way that oncological treatments are recommended based on individual genetic profiles. The underlying assumption of personalized intervention science is that tailoring treatments to the individual will improve treatment outcomes, although evidence is mixed as to whether this bears out (e.g., Chorpita et al., 2017; Ghaderi, 2006; Weisz et al., 2012).

As the science of personalized intervention is applied to CBT for youth anxiety, it will be beneficial to learn from the well-documented research-to-practice gap (e.g., Stirman et al., 2016). The gap between treatment efficacy in laboratory clinics and treatment effectiveness in community mental health clinics has been attributed in part to lack of stakeholder involvement (Kessler & Glasgow, 2011; Rothwell, 2005). Historically, most treatment development occurs within the research community and is informed by theory, often without inclusion of stakeholder perspectives. One of the key stakeholders in youth treatment are caregivers (Becker, 2015). Caregivers typically initiate treatment, manage associated logistics (e.g., payment, driving), and are involved in treatment in some capacity (e.g., encouraging participation, check-ins with the therapist and individual caregiver sessions, ensuring homework completion). However, there has been limited effort to involve caregivers as key stakeholders in the development or personalization of youth anxiety interventions and limited focus on mixed

* Correspondence to: Temple University, Department of Psychology, Weiss Hall, 1701 N. 13th Street, Philadelphia, PA 19122, USA.
E-mail address: Lesley.norris@temple.edu (L.A. Norris).

https://doi.org/10.1016/j.janxdis.2023.102742
Received 4 December 2022; Received in revised form 29 May 2023; Accepted 14 June 2023
Available online 16 June 2023

methods, with the majority of mixed methods studies in youth anxiety interventions (n = 11) working to clarify treatment effectiveness, feasibility and acceptability (Fàbregues et al., 2022). Caregiver involvement will be important in extending a pragmatic science approach (Thorpe et al., 2009; Tunis et al., 2003) to personalized intervention science, and may aid in dissemination and implementation efforts (Damschroder, Reardon, Widerquist, & Lowery, 2022). For example, a personalized algorithm recommending use of a particular youth anxiety treatment feature for a particular individual may be of little use if the treatment feature is not tolerated by a subset of caregivers. Caregivers can also offer unique insight into what worked or did not work and under which circumstances, thus informing intervention updates.

Using a mixed methods framework (Fetters, Curry, & Creswell, 2013), the current exploratory study applied a systematic inductive thematic analysis to open-ended caregiver responses on the Client Satisfaction Questionnaire (CSQ-8; Attkisson & Greenfield, 2004; Larsen, Attkisson, Hargreaves, & Nguyen, 1979) to identify key themes among most- and least-liked CBT treatment features reported by caregivers. Mean treatment satisfaction scores were calculated using concurrently collected CSQ-8 quantitative data, as satisfaction is an infrequently examined outcome for youth anxiety treatment (Olsson et al., 2021) but widely used by insurers and providers as an indicator of service quality (Edlund, Young, Kung, Sherbourne, & Wells, 2003). In addition, it was hypothesized that most- and least-liked treatment features may differ by treatment responder status, so proportional code frequency was examined separately for youth identified as responders [i.e., Clinician Global Impressions-Improvement Scale (CGI-I; Guy, 1976) $\leq$ 2] and non-responders (CGI-I > 2)].

1. Methods

1.1. Participants

The sample included 139 caregivers of youth with principal anxiety diagnoses ages 7–17 (M = 12.21, SD = 3.05; 59% female, 39.6% male, 0.7% transgender man, 0.7% non-binary; 79.1% Caucasian, 5.8% Black, 2.9% Asian, 2.2% Hispanic, 7.9% Multiracial, 2.2% Other) who completed CBT either in person (n = 63) or $\geq$ 1 telehealth session (some fully virtual and others hybrid care) following the COVID-19 pandemic (n = 76) in an outpatient research clinic. Baseline principal youth diagnoses included generalized anxiety disorder (GAD; n = 70), social anxiety disorder (SoP; n = 50), separation anxiety disorder (SAD; n = 10), specific phobia (n = 6), panic disorder (n = 2) and agoraphobia (n = 1). Estimated annual household income was high ($10,000-$19,999 n = 3; $20,000–29,9999 n = 4; $30,0000–39,999 n = 3; $40,000–49,9999 n = 10; $50,000–59,999 n = 3; $60,000–69,999 n = 8; $70,000–80,000 n = 15; > $80,0000 n = 88; missing n = 5).

During pre-treatment assessments, caregivers provided information on "Caregiver A" (i.e., "the primary caregiver who will be completing all of the questionnaires for the evaluations and treatment,") and "Caregiver B" (i.e., "the secondary caregiver who will not be completing questionnaires"). Demographic information on both caregivers is provided in Table 1. For the CSQ, 33.8% of informants were Caregiver A and 12.2% were Caregiver B, with high missingness (54%).

Table 1
Caregiver demographic information.

	Caregiver A n (%)	Caregiver B n (%)
Race		
White	115 (82.7)	110 (79.1)
Black	11 (7.9)	9 (6.5)
Asian	3 (2.2)	5 (3.6)
Hispanic/Latinx	3 (2.2)	5 (3.6)
Multiracial	3 (2.2)	1 (0.7)
Other	2 (1.4)	2 (1.4)
Missing	2 (1.4)	7 (5.0)
Relationship		
Biological mother	130 (93.5)	5 (3.6)
Biological father	5 (3.6)	112 (80.6)
Stepmother	0 (0)	0 (0)
Stepfather	0 (0)	5 (3.6)
Foster parent	0 (0)	0 (0)
Adoptive parent	0 (0)	4 (2.9)
Other	2 (1.4)	2 (1.4)
Missing	2 (1.4)	11 (7.9)
Education		
Graduate school training	67 (48.2)	54 (38.8)
College graduate	55 (39.6)	38 (27.3)
Partial college training	9 (6.5)	20 (14.4)
High school graduate/GED	5 (3.6)	14 (10.1)
Partial high school training	0 (0)	2 (1.4)
Other	2 (1.4)	2 (1.4)
Missing	1 (0.7)	9 (6.5)

Note. All categories appear as written in questionnaire text.

2. Measures

2.1. Client Satisfaction Questionnaire (CSQ-8; Attkisson & Greenfield, 2004; Larsen et al., 1979)

The CSQ-8 was completed by caregivers alone to assess caregiver satisfaction with treatment (one per child). A portion of the sample completed a paper/pencil version of the CSQ-8, and the remainder completed the CSQ-8 online using Research Electronic Data Capture (REDCap; Harris et al., 2009; Harris et al., 2019). The CSQ-8 included quantitative (close-ended Likert scales) and qualitative (open-ended) sections. The quantitative section asked caregivers to respond to eight items assessing caregiver treatment satisfaction (e.g., "*If a friend were in need of similar help, would you recommend our treatment program to him or her?*" and "*How satisfied are you with the amount of help you received?*") along 4-point Likert scales (quite dissatisfied–very satisfied; no, definitely not–yes, definitely). An overall satisfaction score was generated by summing all responses, with higher values indicating higher satisfaction.

Consistent with previous studies (e.g., Acosta, Castillo-Sánchez, Garcia-Zapirain, De la Torre Diez, & Franco-Martín, 2021; Pedersen et al., 2022), three open-ended questions were included with CSQ-8 quantitative data: (1) "*What feature of the treatment program did you like the most?*" (2) "*What feature of the treatment program did you like the least?*" and (3) "*What would you suggest we consider to try to improve the treatment program?*" Data for qualitative analyses were drawn from the first two open-ended questions (most- and least-liked treatment feature) in line with study focus on caregiver preferences and due to a preponderance of responses to question three indicating no specific suggestions for improvement (>50%). The CSQ-8 has commonly been used in treatment research to assess satisfaction, and psychometric analyses of its quantitative items indicate internal consistency (α = 0.93) and convergent validity (r = −0.40 to 0.23; Attkisson & Zwick, 1982). Cronbach's α in this sample was 0.91.

2.2. Anxiety Disorders Interview Schedule for DSM-5 Child and Parent Versions (ADIS-5-C/P; Albano & Silverman, 2016)

The ADIS-5-C/P is a semi-structured interview that generates youth diagnoses using the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013) criteria. The ADIS-5-C/P was administered separately to youth and caregivers at pre- and post-treatment by diagnosticians trained to reliability; information from both interviews was used to generate composite youth diagnoses. Although psychometric properties of the ADIS-5-C/P have not yet been reported, the ADIS-IV-C/P (Silverman, Albano, & Barlow, 1996) has demonstrated favorable psychometric properties (e.g., Silverman, Saavedra, & Pina, 2001; Wood, Piacentini,

Bergman, McCracken, & Barrios, 2002). Inter-rater reliability in the present sample was high in a subset ($n = 20$) of consecutive interviews presented to clinic diagnosticians for review (youth-reported GAD *ICC* = 0.82, caregiver-reported GAD *ICC* = 0.89; youth-reported SoP *ICC* = 0.91, caregiver-reported SoP *ICC* = 0.93; youth-reported SAD *ICC* = 0.94, caregiver-reported SAD *ICC* = 0.93).

2.3. Clinician Global Impressions-Improvement Scale (CGI-I; Guy, 1976)

Diagnosticians used information collected during post-treatment ADIS-5-C/Ps to complete the CGI-I, rating total improvement due to treatment in youth anxiety along a 7-point scale. Youth with a rating of 1 (very much improved) or 2 (much improved) were considered responders (e.g., Walkup et al., 2008); youth with a score of 3 (minimally improved) or greater were considered non-responders. Inter-rater agreement on treatment responder status identification was 94.1% in a subset ($n = 15$) of post-treatment assessments. The CGI-I has been positively correlated with self-reported and clinician-administered assessment of improvements in symptom severity and functional impairment (Zaider, Heimberg, Fresco, Schneier, & Liebowitz, 2003).

2.4. Procedures

All study procedures were approved by Temple University's Institutional Review Board. Recruitment occurred primarily through community referrals in the greater Philadelphia area. Youth were eligible to receive treatment at a specialty anxiety clinic if they (a) were ages 7–17, (b) met DSM-5 criteria for a principal anxiety diagnosis and (c) were English-speaking and could provide informed consent/assent. During the data collection period for this project, a subset of participants completed CBT with an additional component on parental accommodation as part of a dissertation study (Kagan et al., 2023) and were excluded. Eligibility was determined following multiple gating. First, caregivers completed a preliminary phone screen with trained study staff for identification of a potential anxiety disorder. The pre-treatment assessment included (a) informed consent and assent procedures, (b) a semi-structured diagnostic assessment administered by reliable diagnosticians separately to caregiver and youth, and (c) completion of a pre-treatment questionnaire battery. Eligible youth completed 16 weeks of CBT (*Coping Cat* for children or *C.A.T. Project* for adolescents; Kendall et al., 2002; Kendall, 2002, Kendall et al., 2006) involving 9 sessions of psychoeducation/coping skills introduction and 7 sessions of exposure. Therapists were clinical psychology doctoral students with specialized training in both protocols. Families paid on a sliding scale based on income and number of dependents. Prior to the pandemic, caregivers paid for treatment using cash or check; following the pandemic, caregivers paid for treatment using a credit card in an online portal. If requested, they were provided with documentation to request reimbursement from insurance companies, but direct assistance with reimbursement was not provided. As part of their participation in a research clinic, caregivers and youth were asked to complete a pre- and post-treatment battery and weekly questionnaires, which included but were not limited to current study measures. Weekly questionnaires were standard procedure in the clinic but not part of the treatment protocol. At post-treatment, youth and caregivers completed another semi-structured diagnostic assessment, which included the ADIS-5-C/P, the CGI-I, and a questionnaire battery that included the caregiver-reported CSQ-8. Questionnaires were administered by diagnosticians or clinic staff and were completed without the therapist present to minimize social desirability biases.

2.5. Qualitative data collection and management

Original data were stored using SPSS Version 28.0.1.0 or REDCap and coded in Excel. To avoid bias, all identifying information was removed prior to coding (IDs changed, youth and therapist names removed).

2.6. Data analysis

A systematic inductive thematic qualitative analysis (Guest, MacQueen, & Namey, 2012) generated themes and codes separately for most-liked and least-liked treatment features, as research objectives were primarily exploratory in nature and fell towards the "small q" end of the qualitative research spectrum (i.e., broadly within a quantitative disciplinary framework; Braun & Clarke, 2022; Kidder & Fine, 1987). As such, code frequencies are presented, although the goal of qualitative approaches is typically not to count or quantify (Morse, 2007; Strauss & Corbin, 1998). The first five authors independently read through responses from each of the two open-ended questions and generated an initial list of response themes for most-liked and least-liked treatment features using techniques outlined by Ryan and Bernard (2003). Authors then met as a group to discuss identified themes, with an emphasis on engaging in reflexivity (i.e., a discussion of personal biases – including therapeutic orientation, belief systems, and judgments) at the outset of coding and throughout discussion. Consistent themes identified during discussion were translated into a thematic codebook by the first author, formatted to include all codebook core structural components (Bartholow, Milstein, McLellan-Lemal, & MacQueen, 2008) with code labels interpretable independent from the data. First and second authors then followed a process of consensus coding to double-code all responses; any discrepancies were reviewed and resolved recursively, with the first author updating the codes and codebook, as needed. The finalized codebook is presented in supplemental materials.

Mixed methods integration followed a QUAL + quant structure with an expansion function, merging qualitative and quantitative datasets for analyses (Palinkas et al., 2010). Quantitative findings were used to expand on qualitative findings by exploring differences in qualitative response based on treatment responder status. We examined whether satisfaction with treatment was influenced by treatment "success" in reducing youth symptoms/functional impairment (i.e., treatment responder status). Proportional code frequency (percentage of caregivers who cited each code) is presented for each code in Tables 2 and 3 and separately for youth identified as responders (CGI $\leq$ 2) and non-responders (CGI $>$ 2) in Fig. 1.

2.7. Research team and reflexivity

Information is presented in line with the Consolidated criteria for Reporting Qualitative research (COREQ) checklist (Tong, Sainsbury, & Craig, 2007; see supplemental materials). Authors one through five were involved in coding, but information on all authors is presented. All authors identified as White and Non-Hispanic and the majority were female ($n = 5$). All described themselves as predominantly cognitive-behavioral in therapeutic orientation, had or were earning a PhD, and had $\geq$ 1 years of experience delivering CBT. One author was involved in the development of the protocol under study and was recused from coding. At the time of coding, authors involved in codebook development or coding were clinicians in a clinical psychology doctoral program. All coders except one provided CBT in the clinic, and consequently may have either provided therapy to participants in the dataset or administered the ADIS-C/P-V, although all identifying information was masked. Participants were informed during consent that their responses were collected in an effort to improve youth anxiety treatments broadly and in the clinic.

3. Results

3.1. Missingness

Within the study timeframe, 57 families completed intake but did not return for a session, 18 dropped out of treatment before completing 16

Table 2
Thematic Codes, Definitions, Examples and Proportional Frequencies for Most-Liked Treatment Features.

Code name	Abbreviated definition	Quote	Frequency (%)
Coping skills and other treatment techniques	Specific or general reference to skills and techniques in Coping Cat	*It taught my child skills to apply in stressful situations (P46)*	41.98
Exposure*	Exposure tasks completed during treatment	*The exposure part seemed most effective for my son. Before he started doing exposure therapy… I did not notice a lot of change. Once he began completing challenges… I noticed a big change in his self-confidence. (P52)*	19.08
Understanding and identifying anxiety*	Learning about how anxiety works and how to identify it	*The educational component for our child – for them to know why anxiety exists, what it does to us, when it's unhealthy,* etc. *(P42)*	11.45
Rewards*	Reward use	*Using rewards more frequently to work through difficult situations (P64)*	5.34
Homework*	Out-of-session work	*That my child had homework and the therapist seemed to hold her to it. (P98)*	3.05
Therapist factors	The therapist	*Therapist! (P5)*	38.17
Interpersonal style and skills*	Therapist as a personable and skilled professional	*Therapist's very personable attitude and her dedication to child. Plus her ability to help [my] child. (P35)*	22.90
Relationship with therapist*	Therapeutic alliance	*The fact my kid feels so positive and motivated by his relationship with his therapist (P30)*	9.92
Accessibility*	Accessibility of the therapist to families	*I valued how accessible and flexible [the] therapist has been, in between appointments and as different things have arisen with [my] child. (P83)*	6.87
Caregiver involvement…	Caregivers as active participants in treatment	*The parent meetings because I learned how to respond to my child during anxious times. It was imperative to treatment success. (P3)*	11.45
… but not too much (one-on-one time with therapist)	Therapist meeting with child alone	*private sessions so she can express her feelings (P39)*	7.63
Structure	Emphasis on Coping Cat as a structured protocol	*I liked that it was structured. There were specific topics covered each week, with specific goals… (P78)*	5.34
Consistency	Regular sessions that helped family to feel accountable	*The pace is really important to ensure the work child had to do was consistent. (P57)*	10.69
… but tailored (personally tailored treatment)	Ability to adjust treatment to the individual	*Treatment is customized to my daughter's needs (P16)*	6.11

* indicates sub-code; P = participant

Table 3
Thematic Codes, Definitions, Examples and Proportional Frequencies for Least-Liked Treatment Features.

Code name	Abbreviated definition	Quote	Frequency (%)
Nothing	No changes suggested	*I honestly see no negative parts of the program itself. It actually helped me to manage my own anxiety as well! (P86)*	17.21
Questionnaires	Filling out questionnaires	*Filling out the surveys. It is a statistical nightmare. Plus we do not know the results (P31)*	34.43
Cost and payment logistics	Cost or insurance difficulties; wanting a more streamlined payment system	*That my insurance did not cover any part of the expense. (P114)*	9.02
Telehealth	Not receiving services in person	*Difficulty holding [patient's] attention due to Zoom meetings. (P107)*	7.38
Distance	Getting to the clinic	*The lengthy drive here (P18)*	6.56
More sessions	Wanting more than 16 sessions	*… needed more weeks with guidance through more difficult exposures (P37)*	5.74
Other concerns not addressed	Focus primarily on anxiety and not other concerns	*Child's control and anger issues in the home were not really addressed. (P24)*	4.92
More caregiver involvement	Caregiver wanting more involvement in treatment	*As a parent I didn't feel like I knew much at all that was being taught to my child. I don't know what they learned. (P42)*	4.10
Aspects of exposures	Parts of exposures that were difficult for the caregiver or child	*Seeing him get upset (P63)*	3.28

sessions, and 4 completed 16 sessions but did not complete a post-treatment assessment. Families who completed treatment and a post-treatment assessment were compared to families who presented for at least one session but did not complete treatment and/or a post-treatment assessment. These families did not differ by youth age [$t(160) = 0.59$, $p = 0.56$], race [$\chi^2(5) = 3.92$, $p = 0.56$], gender [$\chi^2(4) = 9.11$, $p = 0.06$], primary diagnosis [$\chi^2(8) = 8.56$, $p = 0.38$] or family income [$\chi^2(7) = 13.02$, $p = 0.07$]. Regarding missingness within CSQ open-ended questions, 8 caregivers did not complete the most-liked feature question and 17 did not complete the least-liked feature question.

3.2. Overview of qualitative findings

Caregivers liked many aspects of treatment. Specifically, they liked that their children learned a range of coping skills and strategies to use in anxiety-provoking situations in a way that felt both structured, consistent, and tailored to their children's needs. Caregivers frequently highlighted the importance of the therapist and the therapeutic relationship. They liked being involved in their child's treatment, but also recognized the importance of their child having one-on-one time with their therapist. Overall, caregiver responses to the least-liked treatment feature question did not indicate a need to remove anything in particular from treatment. Instead, caregivers often suggested treatment additions, such as including more sessions, focusing on a broader spectrum of child concerns, and increasing caregiver involvement. Logistical concerns associated with treatment more generally, and with participation in a research clinic specifically, were described, in addition to difficulties

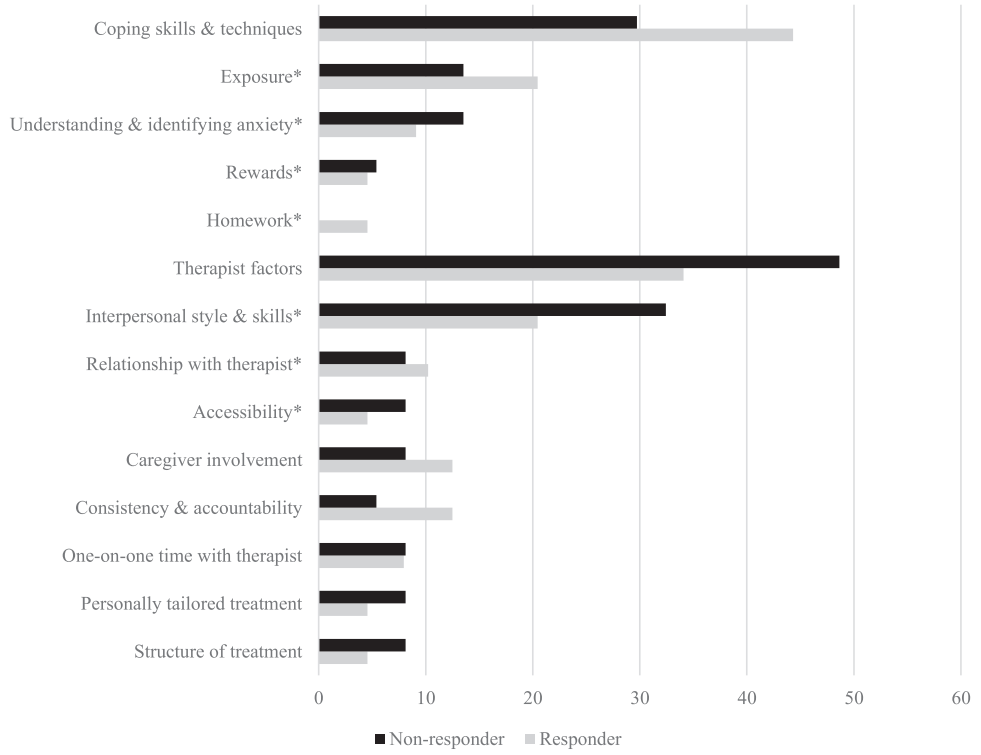


Fig. 1. Proportional Frequency (%) of Most Liked Treatment Feature Themes by Responder Status, Note. * indicates sub-code.

with payment and insurance coverage. In the sections below, the themes for most-liked and least-liked treatment features are reviewed in more detail. Code/sub-code definitions and representative quotes with identifying information redacted are presented in Tables 1 and 2.

3.3. Most liked treatment features

3.3.1. Coping skills and other treatment techniques

Caregivers often reported that their most preferred aspect of treatment was that their children learned coping skills and other strategies for addressing anxiety (e.g., "It taught my child skills to apply in stressful situations," participant [P] 46). Caregivers frequently referred to coping skills in aggregate (e.g., "coping strategies," P26), rather than identifying a single strategy or therapeutic technique that felt particularly helpful in addressing anxiety. When specific coping strategies or treatment techniques were described, these included exposure, psychoeducation, use of rewards, and homework. Caregivers often described the sense of pride or increased confidence their children experienced completing an exposure. For example, one caregiver stated, "I liked the exposure portion the best. My daughter was always so proud when she was able to overcome something" (P129). Caregivers also noted that it was helpful for their children to learn more about how anxiety works and how to recognize when they were feeling anxious, particularly in regard to thoughts and physiological sensations. Finally, caregivers liked learning how to use rewards effectively to motivate their child's engagement in difficult exposures and "having goals to work on between sessions" (P6) through weekly homework.

3.3.2. Therapist factors

Caregivers frequently identified their child's therapist as their most-liked part of treatment for a range of reasons. Often, caregivers described how the interpersonal skill of their child's therapist (e.g., having a therapist who was encouraging, thoughtful, kind, personable, friendly, patient) helped their child to feel more comfortable in session. Emphasis on the importance of interpersonal skill was not limited to the child's direct therapist, but was also referenced in regards to all individuals in the clinic who interacted with the child in some capacity. The therapist's ability and skill as a therapist were also discussed. For example, one caregiver said, "[My child] feels that [her therapist] has helped her more than any other mental health professional we have seen so far" (P121). Finally, caregivers felt that the relationship between their child and their child's therapist was "essential" (P13) in motivating their child to engage in treatment. This relationship was characterized by a sense of trust, comfort and connection, along with a feeling that their therapist was relatable to the child. More specific benefits associated with having a therapist who could work around family schedules and be contacted easily in between sessions as scheduling conflicts arose were also endorsed.

3.3.3. Caregiver involvement (but not too much)

Caregivers appreciated feeling that they were active participants in their child's treatment, noting that it was helpful to have a "true partnership" (P103) between them and their child's therapist. Caregivers liked having caregiver-only sessions and regular caregiver check-ins at the end of each session. During caregiver-only sessions and check-ins, they found it helpful to learn from the therapist how to help their child in stressful situations and how to communicate effectively with their child. As one caregiver stated, "I also really felt we as a family learned a lot about how to respond to him when he's upset. For example – not feeding into the bad behaviors or not unintentionally escalating an already tense situation" (P106). At the same time as caregiver involvement was emphasized, caregivers also noted that it was important for their children to have regular one-on-one sessions with their therapist without their caregivers present. Per caregivers, this allowed children to better "express [their] feelings" (P39) and to form an independent relationship with their therapist. For example, one caregiver wrote, "I liked that the therapist met with my child alone for the first several weeks. Previous therapists had us meet together. My child is 14 years old, so I felt like having him be with the therapist alone made him take ownership of the therapy" (P14).

3.3.4. Structured and consistent, but tailored

Caregivers referenced treatment structure as a well-liked treatment feature. Specifically, they appreciated that therapists had a plan for each session and that specific topics were discussed each week. Caregivers appreciated the consistency of their child meeting weekly with their clinician, as they felt that this consistency kept them on track and accountable to achieving their therapy goals. As one caregiver stated, "the pace is really important to ensure the work [child] had to do was consistent" (P57). At the same time, caregivers emphasized the need to balance structure and consistency with personally tailoring treatment. Caregivers liked that therapists worked to customize and tailor treatment directly to their child's needs. This increased the relevance of topics covered in therapy to their children. Per one caregiver, the "structure was a love/hate; [I] appreciated [the] therapist's ability to adjust as things didn't always line up specifically, yet kept us on track" (P37). Another caregiver "really liked the structure of the program but also the room for flexibility" (P136).

3.4. Least liked treatment features

3.4.1. Nothing

Many caregivers noted that they did not have any least-liked treatment feature, indicating that all aspects of the treatment were helpful for their child. For example, one caregiver said, "None, [e]very step was important to the end goal" (P3).

3.4.2. Questionnaires

Caregivers found the weekly questionnaires long, repetitive, and tedious. Although some indicated that they "understand it is necessary" (P9), many noted that the questions asked in the questionnaires seemed irrelevant to their child's concerns. As one caregiver stated, "survey questions were limiting and didn't seem to target our specific concerns/needs" (P132); another caregiver suggested open-ended questions may be preferred to Likert scales.

3.4.3. Cost and payment logistics

Some caregivers referenced the cost of sessions as their least-liked treatment feature. Related frustrations with insurance coverage were also described. Some caregivers referenced high co-pays for sessions while others described the lack of insurance accepted at the clinic as least-liked treatment features. Frustration with payment methods was also reported. Caregivers did not like the online payment portal system used in the clinic, although early participants in the study who were enrolled when the clinic only accepted cash or check cited the need for increased payment options.

3.4.4. Telehealth

Some caregivers did not like the transition to virtual sessions that followed the COVID-19 pandemic, although further details as to why this was the least-liked treatment feature were often not provided. One caregiver described "difficulty holding [child's] attention due to Zoom meetings" (P107) as a reason for selecting telehealth as the least-liked treatment feature. Otherwise, the majority of respondents provided responses such as "the virtual sessions" (P135) or "we were on Zoom out of necessity" (P125) without further elaboration.

3.4.5. Distance

Although caregivers seemed to prefer in-person sessions, there were aspects of in-person sessions that were not well-liked. Specifically, some caregivers found that the location of the clinic was not convenient for them, and they would have preferred to complete in-person sessions closer to home at a location that did not require lengthy drives.

3.5. More sessions

Some caregivers said that their least-liked treatment feature was that they would like more therapy sessions, with a particular emphasis on wanting more exposure sessions. For example, one caregiver reported wanting more sessions for "guidance through more difficult exposures" (P37), while another indicated that they wished "the length of the exposure 'period' was longer" (P13).

3.5.1. Other concerns not addressed

Caregivers noted that while treatment often helped them to identify other areas of growth for their child, treatment typically focused on anxiety. This left other co-occurring areas of concern less well addressed. For example, one caregiver reported, "We were only [able] to deal with one problem at a time when, in fact, it turned out my child has three distinct, inter-related problems - not just anxiety. This program did help identify that" (P61). Concerns that were not addressed in treatment included externalizing behaviors (e.g., "control and anger issues in the home," P24), school refusal, and environmental factors (e.g., "home stress," P102).

3.5.2. More caregiver involvement

Although a most-liked treatment feature was the amount of caregiver involvement, some caregivers wanted to be more involved in their child's treatment. Specifically, they felt that they needed more help to "apply therapy recommendations at home" (P10). Others felt that they did not know much about what their child was learning in session and wanted more education and direction earlier on in the therapy process than they received.

3.5.3. Aspects of exposures

Although infrequently endorsed, some caregivers described difficulties with exposures. Caregivers felt that it was sometimes difficult to create generalizable exposures. For example, one caregiver noted "there was limited opportunity for exposures with other kids to address social anxiety, just due to the nature of the circumstances [of the pandemic]" (P134). Other concerns described included the difficulty associated with doing exposures, both from witnessing their child's distress or from feeling "so tired from organic challenges that it's hard to want to do something else hard" (P74). A specific concern with a challenge where a child was asked to imagine their caregiver's death was also described by one caregiver (i.e., "I did not like the exercise having my [child] imagine what would happen/how he would feel if both his caregivers died and never came back." P54).

3.6. Mixed method analyses

Caregivers reported high overall satisfaction with treatment ($M = 29.18$, $SD = 3.30$; *range*: 16–32) and the majority of youth (67%) were classified as responders on the CGI-I at post-treatment ("very much improved" $n = 22$; "much improved" $n = 71$; "minimally improved" $n = 32$; "no change" $n = 8$; "slightly worse" $n = 1$; missing $n = 5$). Responders and non-responders did not differ by youth age [$t(160) = -0.91$, $p = 0.37$], race [$\chi^2(10) = 8.42$, $p = 0.59$], gender [$\chi^2(6) = 4.59$, $p = 0.60$], primary diagnosis [$\chi^2(16) = 13.45$, $p = 0.64$] or family income [$\chi^2(14) = 17.80$, $p = 0.22$].

Relative proportional frequencies of themes are presented in Figs. 1 and 2 separately for treatment responders (CGI ≤ 2) and non-responders (CGI > 2). With regards to most-liked treatment features, responders more frequently identified coping skills and other treatment techniques, particularly exposure and homework. Additionally, more responders cited caregiver involvement and consistency/accountability. Conversely, non-responders more frequently cited understanding and identifying anxiety. Non-responders also referenced therapist factors more frequently, particularly therapist interpersonal style and skills.

With regards to least-liked treatment features, responders indicated "none" more frequently. Non-responders more frequently endorsed questionnaires, cost and payment logistics, and the fact that other youth concerns were not addressed as least-liked treatment features.

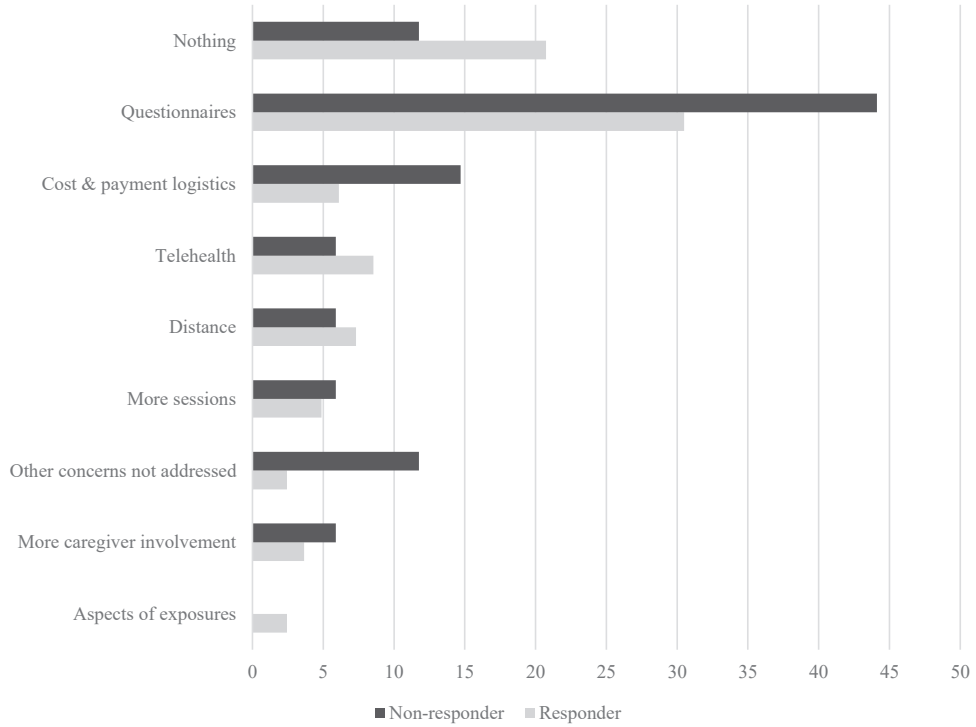


Fig. 2. Proportional Frequency (%) of Least Liked Treatment Feature Themes by Responder Status.

4. Discussion

Using an intervention mixed methods framework (Fetters et al., 2013), the current study clarified caregivers ($N = 139$) most- and least-liked components of a CBT youth anxiety protocol (*Coping Cat* protocol for children and the *C.A.T. Project* protocol for adolescents; Kendall et al., 2006, Kendall, 2002). Caregivers' high satisfaction with treatment emerged in both quantitative and qualitative assessments, in line with previous research (Olsson et al., 2020). Factors that caregivers cited as most-liked were broadly consistent with core components of efficacious youth anxiety treatments documented in previous studies (e.g., Peris et al., 2015), with some preferences specific to manualized CBT provided in a research clinic and others more general. Overall, caregivers appreciated that their children learned coping skills and other strategies for managing anxiety, often indicating that all treatment components, rather than particular modules, were beneficial. Although these skills and strategies were frequently referenced in aggregate, core treatment components for efficacious youth anxiety treatments (Ale, McCarthy, Rothschild, & Whiteside, 2015; Higa-McMillan et al., 2016; Kendall et al., 2005; Peris et al., 2015) were often cited, particularly exposure, psychoeducation, use of rewards and homework. Notably, relaxation or cognitive strategies were not frequently endorsed, consistent with prior work that neither are necessary for enhancing exposure efficacy (Ale et al., 2015) and that relaxation may be contraindicated for anxiety (Blakey & Abramowitz, 2016). In line with previous studies emphasizing the importance of the therapist and therapeutic alliance in youth therapy (Cummings et al., 2013; McLeod, 2011; Murphy & Hutton, 2018; Shirk & Karver, 2003), caregivers frequently cited the importance of a range of therapist factors, including interpersonal style, clinical skill and the relationship between the clinician and members of the family.

Overall, caregiver responses regarding most-liked treatment features were notable in the balance emphasized between contrasting concepts. For example, caregivers appreciated the chance to be involved in their child's treatment, while recognizing that it was important for their child to have a one-on-one relationship with their therapist. This is in line with treatment recommendations that encourage therapists to involve caregivers in treatment, while also providing individual therapy to the youth (Wei & Kendall, 2014). Caregivers also liked the structured approach to treatment and the consistency and accountability provided through the protocol, while recognizing the need for treatment to be personally tailored to their child's individual needs and flexibly administered. This balanced perspective is in line with a "flexibility within fidelity" approach to implementation and dissemination of evidence-based treatment protocols (Kendall, Gosch, Furr, & Sood, 2008; Kendall & Frank, 2018; Kendall, 2022) and previous findings that suggest dissemination efforts should highlight how evidence-based treatments can be flexibly tailored to individual patients (Becker, Spirito, & Vanmali, 2016). Clinician trainings that emphasize "flexibility within fidelity" may be augmented by inclusion of caregiver voices from this study that echo the concept. Caregiver responses indicating that exposure was a most-liked treatment feature also serve to challenge negative beliefs some clinicians might have about exposure (e.g., Deacon & Farrell, 2013; Olatunji, Deacon, & Abramowitz, 2009), while lack of caregiver emphasis on relaxation may be helpful to de-implement this frequently used approach (Chu et al., 2015).

Broadly speaking, the descriptions of the least-liked treatment feature lacked the nuance seen in the most-liked treatment feature descriptions. This difference may be a product of social desirability bias. Although therapists did not administer questionnaires to families, therapists did have access to CSQ-8 data, which may have led caregivers to respond in a more favorable manner. Results could also reflect high satisfaction with treatment overall. When suggestions were made, caregivers often suggested adding, rather than removing, components to the treatment protocol (i.e., more sessions, addressing comorbidities, more caregiver involvement). This finding is consistent with results from studies showing that community clinicians are more likely to augment, rather than reduce or reorder, evidence-based practices to fit local contexts (Lau et al., 2017). The remainder of the least-liked treatment features were not specific to the treatment itself, and focused more on logistical aspects of participation in the clinic. Questionnaires were a consistently least-liked treatment feature, which can be an important barrier to data collection for future intervention research. Furthermore, findings emphasize the need for use of brief measures in

measurement-based care (Scott & Lewis, 2015). Caregiver input indicated that open-ended questions with direct relevancy to child concerns were preferred, which is consistent with studies highlighting the potential utility of idiographic models in clinical practice (e.g., Frumkin, Piccirillo, Beck, Grossman, & Rodebaugh, 2021; van der Krieke et al., 2015) and measurement-based care more broadly. Despite a strong interest in continuing telehealth reported in other studies (Nicholas et al., 2021), some caregivers in this sample did not like the transition from in-person to virtual services, although notably data was collected in the unique context of an emerging pandemic. Details were typically not provided to explain this preference, although youth inattention online was referenced by one caregiver. It may be possible that therapies including exposure, which ideally involves creation of anxiety-provoking situations generalizable to real-world settings, may be particularly well-suited to in-person sessions. Caregiver dislike of telehealth services was also surprising in the context of caregiver endorsement of distance to the clinic as a least-liked treatment feature. Further, caregivers' dislike of the payment platform highlights the need for user-friendly technology in all aspects of the therapy experience. Various other logistical concerns were mentioned by caregivers, particularly around cost and payment, consistent with structural barriers to youth mental health treatments more broadly (Andrade et al., 2014) that will need to be tackled in implementation of precise interventions.

Quantitative analyses examined proportional frequencies of most- and least-liked treatment feature by treatment responder status. Consistent with studies suggesting that exposure and homework are key components of efficacious youth anxiety treatments (e.g., Ale et al., 2015; Higa-McMillan et al., 2016; Kendall et al., 2005; Peris et al., 2015; Whiteside et al., 2020), more treatment responders noted that exposure and homework were most-liked treatment features than non-responders. Contrary to therapist expectations that exposures may harm client rapport (Deacon & Farrell, 2013; Olatunji et al., 2009), this indicates that caregivers have favorable views of exposure therapy, a core treatment component. Conversely, non-responders were more likely to cite psychoeducation as a most-liked coping skill, which is included in most treatment protocols but is not considered a key mechanism of action in treatment. Interestingly, non-responders were more likely to cite therapist factors as most-liked treatment features. This may be because the current sample included only families who completed treatment; youth who did not experience symptom or functional improvement in treatment may have been motivated to continue treatment due to therapist interpersonal style and perceived skill. Consistent with previous studies showing that comorbidity may predict poorer outcome (Knight, McLellan, Jones, & Hudson, 2014), non-responders more frequently cited a lack of addressing other child concerns as a least-liked treatment feature; inconsistent with findings that socioeconomic status is not a consistent predictor of outcome (Knight et al., 2014), non-responders more frequently cited cost/payment logistics. Logistical barriers may have precluded maximal engagement with treatment and been a mechanism of non-response. Non-responders also more frequently endorsed questionnaires as a least-liked feature, which is an important concern, as questionnaire data from non-responders would be particularly valuable in understanding factors associated with non-response and in efforts to increase response rates.

Several limitations warrant consideration. This sample was drawn from a research clinic and included families who completed a 16-session structured treatment protocol in its entirety. Caregivers in this sample may differ from caregivers in a community clinic. It is also possible that families who withdrew from treatment before completing the 16 sessions may have offered more nuanced information regarding least-liked treatment features. In addition, given that the qualitative responses were gathered via a survey, there was not an opportunity to have participants expand on their responses (e.g., to clarify what they did not like about telehealth). Future studies should utilize in-depth interviews to generate richer data from caregivers. Further, families included in the sample were primarily White and Non-Hispanic. Most- and least-liked features may vary for families who identify from global majority racial and ethnic backgrounds, as studies have shown higher satisfaction with usual care psychotherapy among youth who self-identified as Caucasian (Garland, Haine, & Boxmeyer, 2007). Several potential areas of bias for coders were identified, including primarily White, Non-Hispanic identities, and the fact that therapeutic orientations beyond CBT were not represented. In addition, the majority of coders worked in the clinic that this study was conducted in. Although identifying information was removed, coders may have interacted directly with several of the participants. Differences in most- and least-liked features were also not examined across diagnostic or age groups, which should be examined in future studies. For example, caregivers of adolescents may be more likely to cite one-on-one time with a therapist as a well-liked feature of treatment than caregivers of children.

Overall, results from the current study indicate the utility of including mixed-methods approaches in treatment personalization efforts, and the importance of including caregivers as stakeholders in intervention development. Although exposure tasks are, by design, a challenge, they were "liked" and seen as valuable by caregivers. Results suggests that updates to treatment may include an extension of the exposure period. Other infrequently referenced treatment components, like relaxation or problem-solving, may not be essential. To help increase response rates among non-responders, treatment updates might target co-occurring behavioral concerns and broader contextual stressors. Given that psychoeducation was a preferred treatment feature among this group, but is not considered a key treatment ingredient, treatment updates may provide increased psychoeducation regarding the importance of exposure use specifically. Logistical concerns were frequently referenced across caregiver responses (i.e., accessing the clinic, cost), which is an aspect of treatment that often goes unaddressed in discussion of treatment personalization. Personalization of treatment delivery setting (i.e., school-based, home-based) might help ameliorate individual family burdens. Overall, caregivers provided nuanced responses about what they liked and did not like in a standardized CBT protocol for youth anxiety that were broadly in line with findings from the literature (e.g., the efficacy of exposure, the importance of cultivating the therapeutic alliance); caregivers themselves also pointed to the importance of treatment personalization, although when asked for suggested treatment updates, responses were limited. This further emphasizes the value of including caregiver perspectives in any discussion of treatment updates, although questions may need to be grounded more in direct experience of treatment. If the spirit of personalized treatment is a person-centered approach, it will be important to center caregiver and other key stakeholder insights as adaptations to treatment are developed.

Declaration of Competing Interest

Philip C. Kendall receives royalties, and his spouse has employment, related to publications associated with the treatment of anxiety in youth. Dr. Cervin discloses the following relationships: research support from the Swedish Research Council for Health, Working Life and Welfare, the Lindhaga Foundation, Stiftelsen Clas Grochinskys Minnesfond, the Crown Princess Lovisa's Association, Region Skåne, and Skåne University Hospital's Foundations and Donations; and financial compensation from Springer for editorial work outside of the present work. Other authors had no disclosures to report.

Data Availability

The data that has been used is confidential.

Appendix A. Supporting information

Supplementary data associated with this article can be found in the

online version at doi:10.1016/j.janxdis.2023.102742.

References

Acosta, M. J., Castillo-Sánchez, G., Garcia-Zapirain, B., De la Torre Diez, I., & Franco-Martín, M. (2021). Sentiment analysis techniques applied to raw-text data from a csq-8 questionnaire about mindfulness in times of COVID-19 to improve strategy generation. *International Journal of Environmental Research and Public Health, 18*(12), 6408.

Albano, A.M., & Silverman, W.K. (2016). The anxiety disorders interview schedule for DSM- 5-child and parent versions.

Ale, C. M., McCarthy, D. M., Rothschild, L. M., & Whiteside, S. P. (2015). Components of cognitive behavioral therapy related to outcome in childhood anxiety disorders. *Clinical Child and Family Psychology Review, 18*(3), 240–251.

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). ⟨https://doi.org/10.1176/appi.books.9780890425596⟩.

Andrade, L. H., Alonso, J., Mneimneh, Z., Wells, J. E., Al-Hamzawi, A., Borges, G., Bromet, E., Bruffaerts, R., Girolamo, G., de, Graaf, R., de, Florescu, S., Gureje, O., Hinkov, H. R., Hu, C., Huang, Y., Hwang, I., Jin, R., Karam, E. G., Kovess-Masfety, V., & Kessler, R. C. (2014). Barriers to mental health treatment: Results from the WHO world mental health surveys. *Psychological Medicine, 44*(6), 1303–1317.

Attkisson, C. C., & Zwick, R. (1982). The client satisfaction questionnaire: Psychometric properties and correlations with service utilization and psychotherapy outcome. *Evaluation and Program Planning, 5*(3), 233–237.

Attkisson, C. C., & Greenfield, T. K. (2004). The UCSF client satisfaction scales: I. The client satisfaction questionnaire-8. In M. E. Maruish (Ed.), *The use of psychological testing for treatment planning and outcomes assessment: Instruments for adults* (pp. 799–811). Lawrence Erlbaum Associates Publishers.

Bartholow, K., Milstein, B., McLellan-Lemal, E., & MacQueen, K.M. (2008). Team-based codebook development: Structure, process, and agreement. Handbook for team-based qualitative research. Lanham, MD: Rowman AltaMira, 119–135.

Becker, S. J. (2015). Direct-to-consumer marketing: A complementary approach to traditional dissemination and implementation efforts for mental health and substance abuse interventions. *Clinical Psychology: Science and Practice, 22*(1), 85–100.

Becker, S. J., Spirito, A., & Vanmali, R. (2016). Perceptions of 'evidence-based practice' among the consumers of adolescent substance use treatment. *Health Education Journal, 75*(3), 358–369.

Blakey, S. M., & Abramowitz, J. S. (2016). The effects of safety behaviors during exposure therapy for anxiety: Critical analysis from an inhibitory learning perspective. *Clinical Psychology Review, 49*, 1–15.

Braun, V., & Clarke, V. (2022). Conceptual and design thinking for thematic analysis. *Qualitative Psychology, 9*(1), 3.

Chorpita, B. F., Daleiden, E. L., Park, A. L., Ward, A. M., Levy, M. C., Cromley, T., & Krull, J. L. (2017). Child STEPs in California: A cluster randomized effectiveness trial comparing modular treatment with community implemented treatment for youth with anxiety, depression, conduct problems, or traumatic stress. *Journal of consulting and Clinical Psychology, 85*(1), 13.

Chu, B. C., Talbott Crocco, S., Arnold, C. C., Brown, R., Southam-Gerow, M. A., & Weisz, J. R. (2015). Sustained implementation of cognitive-behavioral therapy for youth anxiety and depression: Long-term effects of structured training and consultation on therapist practice in the field. *Professional Psychology: Research and Practice, 46*(1), 70.

Cohen, Z. D., & DeRubeis, R. J. (2018). Treatment selection in depression. *Annual Review of Clinical Psychology, 14*, 209–236.

Cohen, Z. D., Delgadillo, J., & DeRubeis, R. J. (2021). Personalized treatment approaches. In M. Barkham, W. Lutz, & L. G. Castonguay (Eds.), *Bergin and Garfield's handbook of psychotherapy and behavior change: 50th anniversary edition* (pp. 673–703). John Wiley & Sons, Inc.

Cummings, C. M., Caporino, N. E., Settipani, C. A., Read, K. L., Compton, S. N., March, J., & Kendall, P. C. (2013). The therapeutic relationship in cognitive-behavioral therapy and pharmacotherapy for anxious youth. *Journal of Consulting and Clinical Psychology, 81*(5), 859.

Damschroder, L. J., Reardon, C. M., Widerquist, M. A. O., & Lowery, J. (2022). The updated consolidated framework for implementation research based on user feedback. *Implementation Science, 17*(1), 75.

Deacon, B. J., & Farrell, N. R. (2013). Therapist barriers to the dissemination of exposure therapy. *Handbook of treating variants and complications in anxiety disorders* (pp. 363–373). New York, NY: Springer.

Edlund, M. J., Young, A. S., Kung, F. Y., Sherbourne, C. D., & Wells, K. B. (2003). Does satisfaction reflect the technical quality of mental health care? *Health Services Research, 38*(2), 631–645.

Fàbregues, S., Mumbardo-Adam, C., Escalante-Barrios, E. L., Hong, Q. N., Edelstein, D., Vanderboll, K., & Fetters, M. D. (2022). Mixed methods intervention studies in children and adolescents with emotional and behavioral disorders: A methodological review. *Research in Developmental Disabilities, 126*, Article 104239.

Fetters, M. D., Curry, L. A., & Creswell, J. W. (2013). Achieving integration in mixed methods designs—principles and practices. *Health Services Research, 48*(6pt2), 2134–2156.

Frumkin, M. R., Piccirillo, M. L., Beck, E. D., Grossman, J. T., & Rodebaugh, T. L. (2021). Feasibility and utility of idiographic models in the clinic: a pilot study. *Psychotherapy Research, 31*(4), 520–534.

Garland, A. F., Haine, R. A., & Boxmeyer, C. L. (2007). Determinates of youth and parent satisfaction in usual care psychotherapy. *Evaluation and Program Planning, 30*(1), 45–54.

Ghaderi, A. (2006). Does individualization matter? A randomized trial of standardized (focused) versus individualized (broad) cognitive behavior therapy for bulimia nervosa. *Behaviour Research and Therapy, 44*(2), 273–288.

Guest, G., MacQueen, K.M., & Namey, E.E. (2012). Applied thematic analysis. Thousand Oaks, CA: Sage Publications.

Guy, W. (1976). *EC-DEU Assessment Manual for Psychopharmacology, Revised CGI Clinical Global Impressions* (pp. 76–339). *US*: Department of Health.

Hamburg, M. A., & Collins, F. S. (2010). The path to personalized medicine. *New England Journal of Medicine, 363*(4), 301–304.

Harris, P. A., Taylor, R., Thielke, R., Payne, J., Gonzalez, N., & Conde, J. G. (2009). A metadata-driven methodology and workflow process for providing translational research informatics support. *Journal of Biomedical Informatics, 42*(2), 377–381.

Harris, P. A., Taylor, R., Minor, B. L., Elliott, V., Fernandez, M., O'Neal, L., & REDCap Consortium. (2019). The REDCap consortium: Building an international community of software platform partners. *Journal of Biomedical Informatics, 95*, Article 103208.

Higa-McMillan, C. K., Francis, S. E., Rith-Najarian, L., & Chorpita, B. F. (2016). Evidence base update: 50 years of research on treatment for child and adolescent anxiety. *Journal of Clinical Child & Adolescent Psychology, 45*(2), 91–113.

James, A. A. C. J., Soler, A., & Weatherall, R. (2005). Cognitive behavioural therapy for anxiety disorders in children and adolescents. *Cochrane Database of Systematic Reviews, 4*, 1–35.

James, A. C., Reardon, T., Soler, A., James, G., & Creswell, C. (2020). Cognitive behavioural therapy for anxiety disorders in children and adolescents. *Cochrane Database of Systematic Reviews*, (11).

Kagan, E. R., Frank, H. E., Palitz, S. A., & Kendall, P. C. (2023). Targeting Parental Accommodation in Anxiety: An Open Trial of the Coping Cat Accommodation Reduction Intervention. *Journal of Child and Family Studies, 32*(2), 398–408.

Kendall, P., Choudhury, M., Hudson, J., & Webb, A. (2002). The CAT project therapist manual. Ardmore, PA: Workbook.

Kendall, P.C. (2002). The CAT project workbook: For the cognitive behavioral treatment of anxious adolescents: Workbook Pub.

Kendall, P. C. (Ed.). (2022). *Flexibility within Fidelity: Breathing life into a psychological treatment manual*. NY: Oxford University Press.

Kendall, P. C., & Frank, H. E. (2018). Implementing evidence-based treatment protocols: Flexibility within fidelity. *Clinical Psychology: Science and Practice, 25*(4), 40.

Kendall, P. C., Gosch, E., Furr, J. M., & Sood, E. (2008). Flexibility within fidelity. *Journal of the American Academy of Child and Adolescent Psychiatry, 47*(9), 987–993.

Kendall, P. C., Robin, J. A., Hedtke, K. A., Suveg, C., Flannery-Schroeder, E., & Gosch, E. (2005). Considering CBT with anxious youth? Think exposures. *Cognitive and Behavioral Practice, 12*(1), 136–148.

Kessler, R., & Glasgow, R. E. (2011). A proposal to speed translation of healthcare research into practice: Dramatic change is needed. *American Journal of Preventive Medicine, 40*(6), 637–644.

Kidder, L. H., & Fine, M. (1987). Qualitative and quantitative methods: When stories converge. In M. M. Mark, & L. Shotland (Eds.), *New directions for program evaluation* (pp. 57–75). Jossey-Bass.

Knight, A., McLellan, L., Jones, M., & Hudson, J. (2014). Pre-treatment predictors of outcome in childhood anxiety disorders: A systematic review. *Psychopathology Review, 1*(1), 77–129.

Larsen, D. L., Attkisson, C. C., Hargreaves, W. A., & Nguyen, T. D. (1979). Assessment of client/patient satisfaction: Development of a general scale. *Evaluation and Program Planning, 2*(3), 197–207.

Lau, A., Barnett, M., Stadnick, N., Saifan, D., Regan, J., Wiltsey Stirman, S., & Brookman-Frazee, L. (2017). Therapist report of adaptations to delivery of evidence-based practices within a system-driven reform of publicly funded children's mental health services. *Journal of Consulting and Clinical Psychology, 85*(7), 664.

McLeod, B. D. (2011). Relation of the alliance with outcomes in youth psychotherapy: A meta-analysis. *Clinical Psychology Review, 31*(4), 603–616.

Morse, J.M. (2007). Sampling in grounded theory. The SAGE handbook of grounded theory, 229–244.

Murphy, R., & Hutton, P. (2018). Practitioner review: Therapist variability, patient-reported therapeutic alliance, and clinical outcomes in adolescents undergoing mental health treatment–A systematic review and meta-analysis. *Journal of Child Psychology and Psychiatry, 59*(1), 5–19.

Ng, M. Y., & Weisz, J. R. (2016). Annual research review: Building a science of personalized intervention for youth mental health. *Journal of Child Psychology and Psychiatry, 57*(3), 216–236.

Nicholas, J., Bell, I. H., Thompson, A., Valentine, L., Simsir, P., Sheppard, H., & Adams, S. (2021). Implementation lessons from the transition to telehealth during COVID-19: a survey of clinicians and young people from youth mental health services. *Psychiatry Research, 299*, Article 113848.

Olatunji, B. O., Deacon, B. J., & Abramowitz, J. S. (2009). The cruelest cure? Ethical issues in the implementation of exposure-based treatments. *Cognitive and Behavioral Practice, 16*, 172–180.

Olsson, N. C., Juth, P., Ragnarsson, E. H., Lundgren, T., Jansson-Fröjmark, M., & Parling, T. (2021). Treatment satisfaction with cognitive-behavioral therapy among children and adolescents with anxiety and depression: A systematic review and meta-synthesis. *Journal of Behavioral and Cognitive Therapy, 31*(2), 147–191.

Palinkas, L. A., Aarons, G. A., Horwitz, S., Chamberlain, P., Hurlburt, M., & Landsverk, J. (2010). Mixed method designs in implementation research. *Administration and Policy in Mental Health and Mental Health Services Research, 38*(1), 44–53.

Pedersen, H., Havnen, A., Brattmyr, M., Attkisson, C. C., & Lara-Cabrera, M. L. (2022). A digital Norwegian version of the client satisfaction questionnaire 8: Factor validity and internal reliability in outpatient mental health care. *BMC Psychiatry, 22*(1), 671.

Peris, T. S., Compton, S. N., Kendall, P. C., Birmaher, B., Sherrill, J., March, J., & Piacentini, J. (2015). Trajectories of change in youth anxiety during

cognitive—behavior therapy. *Journal of Consulting and Clinical Psychology, 83*(2), 239.
Rothwell, P. M. (2005). External validity of randomised controlled trials:"to whom do the results of this trial apply?". *The Lancet, 365*(9453), 82–93.
Ryan, G. W., & Bernard, H. R. (2003). Techniques to identify themes. *Field Methods, 15*(1), 85–109.
Scott, K., & Lewis, C. C. (2015). Using measurement-based care to enhance any treatment. *Cognitive and Behavioral Practice, 22*(1), 49–59.
Shirk, S. R., & Karver, M. (2003). Prediction of treatment outcome from relationship variables in child and adolescent therapy: A meta-analytic review. *Journal of consulting and Clinical Psychology, 71*(3), 452.
Silverman, W.K., Albano, A.M., & Barlow, D.H. (1996). Manual for the ADIS-IV-C/P. New York, NY: Psychological Corporation.
Silverman, W. K., Saavedra, L. M., & Pina, A. A. (2001). Test-retest reliability of anxiety symptoms and diagnoses with the anxiety disorders interview schedule for DSM-IV: Child and parent versions. *Journal of the American Academy of Child & Adolescent Psychiatry, 40*(8), 937–944.
Stirman, S. W., Gutner, C. A., Langdon, K., & Graham, J. R. (2016). Bridging the gap between research and practice in mental health service settings: An overview of developments in implementation theory and research. *Behavior Therapy, 47*(6), 920–936.
Strauss, A., & Corbin, J. (1998). Basics of qualitative research: Techniques and procedures for developing grounded theory (2nd ed.). Sage Publications, Inc.
Thorpe, K. E., Zwarenstein, M., Oxman, A. D., Treweek, S., Furberg, C. D., Altman, D. G., & Chalkidou, K. (2009). A pragmatic–explanatory continuum indicator summary (PRECIS): A tool to help trial designers. *Journal of Clinical Epidemiology, 62*(5), 464–475.
Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care, 19*(6), 349–357.
Tunis, S. R., Stryer, D. B., & Clancy, C. M. (2003). Practical clinical trials: increasing the value of clinical research for decision making in clinical and health policy. *JAMA, 290*(12), 1624–1632.
van der Krieke, L., Emerencia, A. C., Bos, E. H., Rosmalen, J. G., Riese, H., Aiello, M., & de Jonge, P. (2015). Ecological momentary assessments and automated time series analysis to promote tailored health care: A proof-of-principle study. *JMIR Research Protocols, 4*(3), Article e4000.
Walkup, J. T., Albano, A. M., Piacentini, J., Birmaher, B., Compton, S. N., Sherrill, J. T., & Kendall, P. C. (2008). Cognitive behavioral therapy, sertraline, or a combination in childhood anxiety. *New England Journal of Medicine, 359*(26), 2753–2766.
Wei, C., & Kendall, P. C. (2014). Parental involvement: Contribution to childhood anxiety and its treatment. *Clinical Child and Family Psychology Review, 17*(4), 319–339.
Weisz, J. R., Chorpita, B. F., Palinkas, L. A., Schoenwald, S. K., Miranda, J., Bearman, S. K., & Research Network on Youth Mental Health. (2012). Testing standard and modular designs for psychotherapy treating depression, anxiety, and conduct problems in youth: A randomized effectiveness trial. *Archives of General Psychiatry, 69*(3), 274–282.
Whiteside, S. P., Sim, L. A., Morrow, A. S., Farah, W. H., Hilliker, D. R., Murad, M. H., & Wang, Z. (2020). A meta-analysis to guide the enhancement of CBT for childhood anxiety: Exposure over anxiety management. *Clinical Child and Family Psychology Review, 23*(1), 102–121.
Wood, J. J., Piacentini, J. C., Bergman, R. L., McCracken, J., & Barrios, V. (2002). Concurrent validity of the anxiety disorders section of the anxiety disorders interview schedule for DSM-IV: Child and parent versions. *Journal of Clinical Child and Adolescent Psychology, 31*(3), 335–342.
Zaider, T. I., Heimberg, R. G., Fresco, D. M., Schneier, F. R., & Liebowitz, M. R. (2003). Evaluation of the clinical global impression scale among individuals with social anxiety disorder. *Psychological Medicine, 33*(4), 611–622.