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## Brief Transdiagnostic Intervention for Parents With Emotional Disorder Symptoms During the COVID-19 Pandemic: A Case Example

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*Concerns regarding parent mental health and well-being during the COVID-19 pandemic are justifiably on the rise. Although anxiety, depression, and traumatic stress levels have risen precipitously across all demographics during the pandemic, parents residing with their children are under particular and unique strain. Caregivers with children in the home are responsible not only for their own health, financial security, and safety during this time, but often full-time caregiving, household management and, in many cases, their children's schooling. In this case paper, we describe the development of the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders for Caregivers (UP-Caregiver) and provide a case example of its implementation. This 4-session indicated prevention for caregivers is a modification of existing versions of the Unified Protocols for adults and children, modified to maximize its responsiveness to issues faced by parents and caregivers living with youth (ages 6–13) during the current pandemic. UP-Caregiver was offered as part of a randomized, controlled trial via telehealth in a small group format to any parent with a child in the specified age range with mild or greater anxiety, depression or traumatic stress symptoms during an initial screening. The case example provided is of a White, Hispanic mother with a range of self-reported emotional disorder concerns at an initial assessment. Declines in anxiety, depression and traumatic stress symptoms were all noted, as well as improvements in parenting self-efficacy and distress tolerance 6-weeks after initiating UP-Caregiver. An ongoing randomized, controlled trial of UP-Caregiver will further evaluate the utility and feasibility of this approach to alleviate parental distress during COVID-19.*

COVID-19 was first identified in December 2019 and since expanded across the world (Lee et al., 2020). The spread of COVID-19 has caused a range of challenges to persons across the globe, including economic, psychological, and health difficulties (Gruber et al., 2020). The effects of COVID-19, including job loss, loss of social support, illness, death, and other traumatic experiences, have understandably led to psychological distress and decreased well-being in adults and youth (Gruber et al., 2020; Patrick et al., 2020). As such, the development and dissemination of effective mental health treatments during this time is paramount.

Parents and caregivers may be at particular risk during the COVID-19 pandemic given unique stressors and challenges associated with the pandemic for this

population (Sprang & Silman, 2013). Research on prior pandemics shows that quarantines may result in increased mental health concerns for caregivers, particularly posttraumatic stress (Brooks et al., 2020). Parents and caregivers in quarantine face additional stressors, such as balancing multiple roles (e.g., work, homeschooling, caregiving), that may vary in intensity within a given day or over time. Furthermore, caregivers and their partners who are health care or other essential workers, who have lost friends or family members to COVID-19, are young or single, have prior mental health concerns, or who are facing financial or food insecurities may be disproportionately impacted by COVID-19 stressors (CDC, 2020; Patrick et al., 2020). Parents and caregivers who are members of racial and ethnic minority groups in the United States—particularly Black parents—are also facing increased propensity to contract the virus and the ongoing stressors associated with systemic racism and violent oppression. Caregivers of children with autism spectrum disorder or other special needs may be particularly

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impacted by pandemic stressors, as well (Aishworiya & Kang, 2020; Colizzi et al., 2020). Business and school closures resulted in the loss or dramatic reduction in educational services and the movement to speech, behavioral, or other health care to telehealth/online delivery. Parents of children with special needs are thus facing an increased responsibility to facilitate or provide such services to their children, while managing other work, caregiving, home management, and financial demands. In addition to the psychological distress caused by prolonged periods of physical distancing and the management of multiple roles in the household, concern has also been raised for potentially increased rates of intimate partner violence, child abuse or neglect, and other harsh parenting behaviors due to this heightened caregiver stress (Humphreys et al., 2020). Since caregiver behaviors, especially during disasters and times of increased stress, may also play a key role in reinforcing feelings of safety and security, or anxiety and distress in youth (Carpenter et al., 2017), identification of effective preventative interventions for parents and caregivers is clearly warranted.

In a range of settings, brief, parent-focused interventions have been shown to reduce parental stress, anxiety, and depressive symptoms, increase parental confidence and self-efficacy, and reinforce positive parenting behaviors (Bloomfield & Kendall, 2012; Bodenmann et al., 2008; Warner et al., 2011; Zand et al., 2018). Such interventions include brief parent-directed cognitive behavior therapy (CBT) in pediatric oncology settings (e.g., Warner et al., 2011), group programs within a community-based setting (Bloomfield & Kendall, 2012), programs for caregivers of children newly diagnosed with autism spectrum disorder (Zand et al., 2018), and interventions to reinforce positive parenting behavior and improve overall family functioning (Bodenmann et al., 2008). Although these brief interventions were developed to mitigate parental distress, limitations include small sample and limited sizes, lack of follow-up assessments, and elevated rates of treatment dropout (Bloomfield & Kendall, 2012; Bodenmann et al., 2008; Warner et al., 2011; Zand et al., 2018).

Given the need for clinical services in light of the COVID-19 pandemic and the utility of brief parent-directed interventions, we are currently completing a randomized, controlled trial (RCT) of a novel adaptation of the Unified Protocols for Transdiagnostic Treatment of Emotional Disorders in adults (UP; Barlow, Farchione, Bullis, et al., 2017; Barlow, Farchione, Sauer-Zavala, et al., 2017) and Children and Adolescents (UP-C, UP-A; Ehrenreich-May, Kennedy, et al., 2017), called the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders

for Caregivers (UP-Caregiver), to address these needs. Parents in this RCT were randomized to receive the UP-Caregiver in English or Spanish immediately or after a 6-week delay. Those randomized to the delayed condition were provided with a low-intensity intervention using a psychoeducational handout regarding parent management of distress during COVID-19, then offered the UP-Caregiver after 6 weeks. Results will be observed at 6-weeks and 12-weeks post-randomization. The case example from this RCT is presented in this article to illustrate the application of UP-Caregiver for parents with elevated anxiety, depression, or traumatic stress issues during the pandemic.

The UP, UP-C, and UP-A are transdiagnostic, largely cognitive behavioral interventions meant to target distress in response to strong emotions. These protocols are, on the one hand, pragmatically derived (e.g., they are modular, use key treatment principles from existing cognitive behavioral and mindfulness-based treatments, etc.) and, at the same time, theoretically act upon a core dysfunction of neuroticism (i.e., the experience of frequent negative affect, poor distress tolerance in response, and subsequent experiential avoidance of triggers) in adults and youth (Sauer-Zavala, Bentley, et al., 2020). The UP-C and UP-A additionally target parenting behaviors that inadvertently reinforce youth emotional disorder symptoms (Ehrenreich-May, Kennedy, et al., 2017), including overprotection or accommodation behaviors, excessive criticism, inconsistent reinforcement of adaptive behaviors, and parental modeling of distress and avoidance.

Meta-analytic studies of the UP show that the UP is effective for adults with a range of psychopathology, although the vast majority of studies on this approach have primarily targeted adults with anxiety disorders (Sakiris & Berle, 2019). In a sample of 223 adults, the UP was found to be as efficacious as disorder-specific protocols in improving anxiety symptoms (Barlow, Farchione, Bullis, et al., 2017; Barlow, Farchione, Sauer-Zavala, et al., 2017). UP participants were less likely to drop out of treatment early compared with the disorder-specific protocols (Barlow, Farchione, Bullis, et al., 2017; Barlow, Farchione, Sauer-Zavala, et al., 2017). The UP has been applied to a number of other forms of psychopathology, including eating disorders, nonsuicidal self-injury, borderline personality disorder, and bipolar disorder, among others (Barlow, Farchione, Bullis, et al., 2017; Barlow, Farchione, Sauer-Zavala, et al., 2017; Ellard et al., 2012; Lopez et al., 2015; Sauer-Zavala et al., 2016; Thompson-Brenner et al., 2019). The UP-A and UP-C have also been shown to be efficacious in open-trial and randomized-controlled studies (Bilek &

Ehrenreich-May, 2012; Ehrenreich-May, Rosenfield, et al., 2017; Kennedy et al., 2019). A recent investigation using open trial data of the UP-C and UP-A found that, in addition to improvements in child emotional disorder symptoms, parents reported improvements in parenting behaviors (e.g., unsupportive parenting like minimization of responses), as well as improvements in parent psychopathology, distress tolerance, and cognitive reappraisal (Tonarely, Kennedy, et al., 2020). These results suggest that UP-C and UP-A content that prompts parents to apply treatment skills to their own lives before applying it to their children's emotional difficulties (e.g., cognitive appraisal examples) may be facilitating enhanced utility, understanding, and, possibly, parents' use of these techniques.

Brief and preventative versions of the UP protocols have been developed and are in the process of evaluation currently. Stepped-care and brief treatment adaptations of a transdiagnostic treatment like the UP allow for more efficient targeting of symptoms and may reduce financial and pragmatic barriers to care (Rapee et al., 2017; Salloum et al., 2016). For example, a brief, four-session, preventative version of the UP for college students was compared to a wait-list condition in a sample of 243 undergraduates (Sauer-Zavala, Tirpak, et al., 2020). Participants who were enrolled in this program were highly engaged and satisfied with the intervention (Sauer-Zavala, Tirpak, et al., 2020). Stepped-care and brief versions of the UP-C and UP-A have also been developed and tested. Preliminary results on these adaptations support their potential feasibility in targeting youth anxiety and depressive symptoms in a brief time course (Kennedy et al., 2020; Tonarely, Lanier, et al., 2020).

As stated, caregivers with symptoms of anxiety, depression, and traumatic stress are at higher risk of negative consequences due to COVID-19 and the quarantine (Brooks et al., 2020; Brown et al., 2020; Daks et al., 2020). The UP-Caregiver intervention was developed as a brief preventative intervention for the purposes of targeting caregiver distress during COVID-19 using a combination of transdiagnostic, cognitive-behavioral strategies from the UP and UP-C. It was developed to efficiently target caregiver distress in response to strong emotions (e.g., anger, guilt, shame, sadness), as well as provide strategies for caregivers to use to foster youth emotion regulation. The modules were tailored to briefly provide caregivers with strategies to address increased intolerance of uncertainty (e.g., mindfulness), increased isolation and decreased activation (e.g., engagement in wellness behaviors and value-directed actions), and increased worry and rumination (e.g., mindfulness, cognitive reappraisal, problem solving). Additionally, this intervention pro-

vided strategies for caregivers to aid in their children's emotion regulation, including increased positive attention for adaptive youth behaviors, modeling of adaptive emotion management, and encouragement of independent problem solving and coping.

## Case Background

"Angelina" (a pseudonym), who identified herself as White and Hispanic, was a 38-year-old woman whose data was obtained as part of the UP-Caregiver RCT and who consented to have her treatment course information and measures of parental psychopathology, distress tolerance, COVID-19-related fears, parenting strategies, and youth psychopathology included in the study and in this case example. All relevant identifying information has been altered to protect the confidentiality of this participant. The RCT aimed to recruit caregivers living in the state of Florida who were experiencing elevated symptoms of anxiety, depression, and/or traumatic stress. Approval was obtained from the University of Miami's Institutional Review Board (IRB) and the study was registered with ClinicalTrials.gov. Consent was obtained and documented before the start of any study procedures. Participants were recruited via social media, organization talks, listservs, and through university websites.

## Screening and Randomization

Angelina completed an initial screening on REDCap to confirm primary eligibility, which included living in Florida, having at least one child aged 6 to 13 years old, and either English or Spanish language fluency to complete study measures and interventions. Inclusion criteria also specified computer and internet access sufficient for delivery of the study assessments and intervention online. Due to a focus on a mild to moderate risk sample, exclusion criteria included having previously been diagnosed or treated for bipolar disorder, schizophrenia, psychosis, or substance use disorder or previous hospitalization for mental health concerns or a suicide attempt. At the time of the screen, Angelina lived with her two children, ages 6 and 12 years, and was partially furloughed at her full-time job due to COVID-19. She reported experiencing increased stress and frustration during the pandemic. She described a tendency to engage in controlling behaviors to manage her anxiety (e.g., strict house routines and schedules), guilt about her parenting behaviors, and a perception that she was not fully present during her interactions with her children. Regarding COVID-19-related stress, Angelina explained that she knew someone who had been diagnosed with COVID-19, she was unable to get needed medical care because

of COVID-19-related disruptions, experienced school and work cancellations, and experienced financial difficulties related to the pandemic.

Following the primary screen, Angelina completed three additional screening measures of self-reported anxiety, depression, and/or posttraumatic stress symptoms at pretreatment only, indicated by the Generalized Anxiety Disorder 7-item scale (GAD-7; Spitzer et al., 2006), Patient Health Questionnaire (PHQ-9; Kroenke et al., 2001), and Primary Care PTSD Screen for DSM-5 (PC-PTSD-5; Prins et al., 2016), respectively. Angelina reported moderate to severe levels of anxiety and depression on the GAD-7 and PHQ-9, respectively, and denied experiencing a Criterion A event on the PC-PTSD-5. She also endorsed suicidal ideation on the PHQ-9 and was further screened with the Columbia Suicide Severity Rating Scale (C-SSRS; Nilsson et al., 2013), which showed low to no risk for suicide. Following the screening measure, Angelina completed pretreatment questionnaires (Week 0) and completed a brief phone screen to confirm eligibility. The phone screen assessed for any involvement with local child welfare services or for arrests for child abuse or endangerment, which Angelina denied. Angelina did not report having any existent mental health diagnoses or that she was seeing another mental health provider; however, Angelina did report that she has always been an “anxious person.”

Upon completion of the phone screen and at least 50% of the Week 0 measures, Angelina was randomized to the immediate treatment condition, whereby she would receive the UP-Caregiver intervention (described below). See Figure 1 for an overview of assessment flow. Angelina was followed for 12 weeks and was administered questionnaires 2 weeks following the date of randomization (Week 2), and 2 weeks following the Week 2 date (Week 4) and 2 weeks after that (Week 6) via REDCap. Twelve-week data was not yet available at the time of manuscript preparation. See Table 1 for an overview of the assessment measures Angelina completed at Weeks 0, 2, 4 and 6 that are reported on in this manuscript.

## Intervention

Both the immediate treatment condition and the delayed treatment condition received UP-Caregiver in a group format. UP-Caregiver groups were generally administered via telehealth on a rolling basis, with caregivers joining Modules 2–4 in any order. All participants received Session 1 first, typically facilitated by a doctoral-level therapist. Groups were scheduled for 90 minutes, with 60 minutes of con-

tent related to caregiver emotion management and 30 minutes of application of caregiver content to parenting. Groups were composed of one to six participants and one to two therapists. Therapists for the subsequent modules were doctoral student or postdoctoral fellow therapists. One therapist was a staff psychologist. All therapists previously completed UP competency training and/or received UP workshop training. The PI provided weekly supervision for groups. Although participants were only offered four sessions of content per se, they were given the option to complete as many groups as desired until a maximum of 8 groups or study completion was achieved.

## Assessment

Angelina’s progress in the RCT and in sessions was measured using several reliable and valid measures of parental anxiety and depression, youth psychopathology, parenting self-efficacy, parenting satisfaction and satisfaction with the intervention itself. Clinical cut-off scores are provided for reference where available for a given measure below.

### *Treatment Satisfaction*

Following each session, caregivers were emailed two poll questions asking how satisfied they were with the session, from 1 (*not satisfied*) to 5 (*extremely satisfied*), and how helpful the session was, from 1 (*not at all helpful*) to 5 (*extremely helpful*).

*Overall Anxiety Severity and Impairment Scale* (OASIS; Norman et al., 2006) is a five-item self-report measure that evaluates anxiety severity and functional impairment. The OASIS has shown excellent reliability and validity in a range of anxiety disorders sample of adults (Norman et al., 2006). Previous research indicates eight as an appropriate cut-off score to determine the presence of an anxiety disorder (Campbell-Sills et al., 2009; Norman et al., 2006).

*Overall Depression Severity and Impairment Scale* (ODSIS; Bentley et al., 2014), a five-item, self-report measure, has also been well-validated as a brief screening measure for depression-related severity and functional impairment. A score of 11 or higher indicates clinical depressive symptoms (Ito et al., 2015).

*Parental Sense of Competence Scale* (PSOC; Gibaud-Wallston & Wandersman, 1978) is a 17-item measure assessing parenting self-efficacy and satisfaction with parenting styles. The PSOC has shown good psychometrics and is validated for use in measuring self-esteem in caregivers.

*PTSD Checklist for the DSM-5* (PCL-5; Bleivins et al., 2015) is a 20-item self-report measure of PTSD symp-

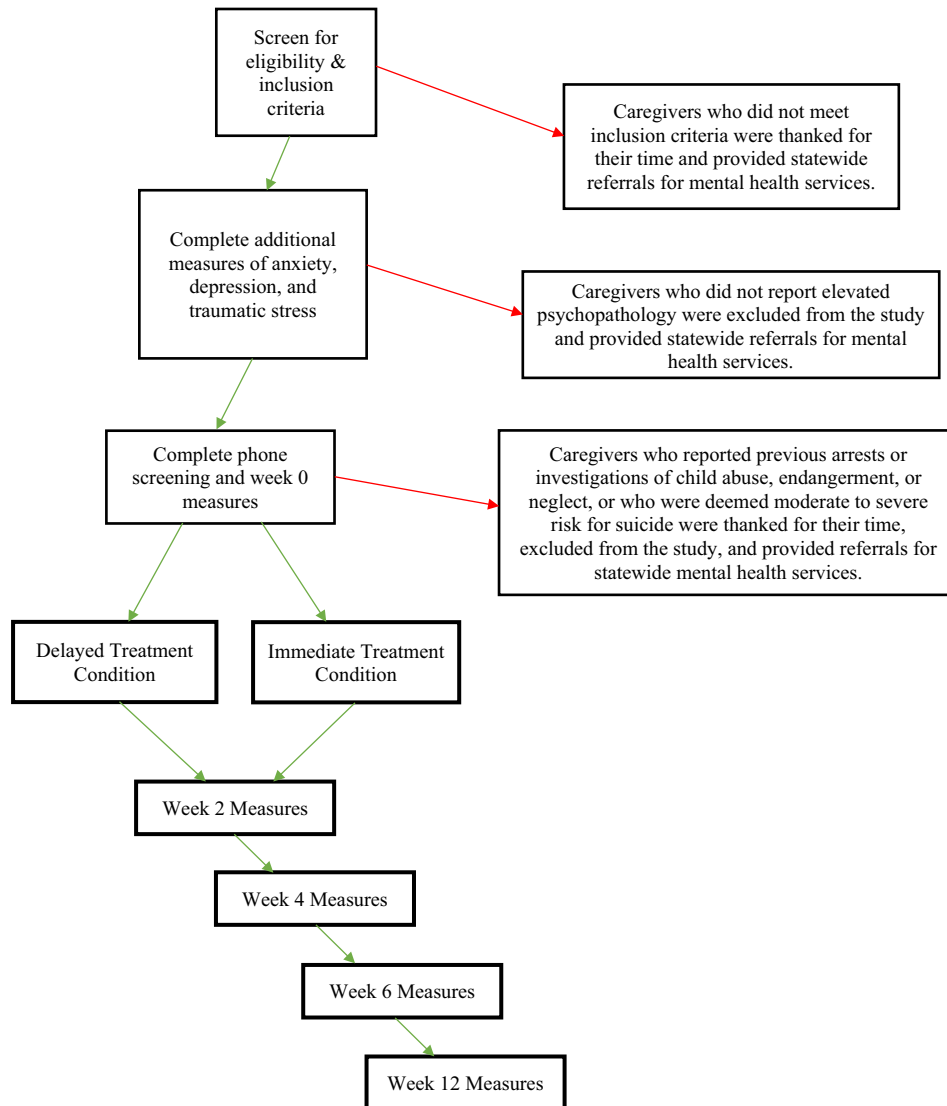


Figure 1. Overview of Assessment Flow.

toms. The PCL-5 has demonstrated strong reliability and validity (Blevins et al., 2015). Scores between 31–33 may indicate a PTSD diagnosis, and a change of at least five points indicates that an individual has responded to treatment (Weathers et al., 2013).

*Distress Tolerance Scale* (DTS; Simons & Gaher, 2005) is a 15-item self-report measure of perceived ability to tolerate negative emotions. The DTS has demonstrated good convergent and discriminant validity, and good internal consistency (Leyro et al., 2011).

*Youth Overall Anxiety Severity and Impairment Scale* (Y-OASIS; Comer et al., 2020), evaluates a caregiver's perceptions of their own child's anxiety, as well as the level of severity and impairment. The adult version of this measure has demonstrated excellent psychometric properties (Norman et al., 2006).

## UP-Caregiver Intervention

### Session 1: Dealing With Emotions and Parenting in a Crisis

This first session of the group intervention focused on psychoeducation about COVID-19 stressors, the structure and function of strong emotions, group introductions and establishment of rapport. The therapist spent time building rapport and getting to know Angelina and the concerns that brought her to the study. Following this, the therapist introduced and normalized increased COVID-19 stress and emotions. The therapist facilitated a discussion around current stressors for the group members and emphasized self-compassion throughout. Angelina noted increased feelings of guilt, anger, and anxiety, which the thera-

Table 1  
Selection of Angelina's Self-Report Measures

Measure	Citation	Screening	Week 0	Week 2	Week 4	Week 6
GAD-7	Spitzer et al., 2006	X				
PHQ-9	Kroenke et al., 2001	X				
PC-PTSD-5	Prins et al., 2016	X				
OASIS	Norman et al., 2006		X	X	X	X
ODSIS	Bentley et al., 2014		X	X	X	X
PCL-5	Blevins et al., 2015		X	X	X	X
DTS	Simons & Gaher, 2005		X	X	X	X
PSOC	Gibaud-Wallston & Wandersman, 1978		X	X	X	X
COVID Experiences			X			X
Y-OASIS	Comer et al., 2020		X	X	X	X

Note: GAD-7 = Generalized Anxiety Disorder-7 item scale; PHQ-9 = Patient Health Questionnaire; PC-PTSD-5 = Primary Care PTSD Screen for the DSM-5; OASIS = Overall Anxiety Severity and Impairment Scale; ODSIS = Overall Depression Severity and Impairment Scale; PCL-5 = PTSD Checklist for the DSM-5; DTS = Distress Tolerance Scale; PSOC = Parent Sense of Competence Scale; Y-OASIS = Youth Overall Anxiety Severity and Impairment Scale.

pist normalized. She reported feeling guilty that her children were not able to engage in typical activities due to COVID-19, and also feeling guilty about allowing her children to have increased time spent on screens. She shared that she also worried about her job stability. The therapist provided psychoeducation regarding the adaptive function of emotions, introduced the three parts of an emotional experience and the antecedent, response, and consequences (ARC) model (Barlow, Farchione, Bullis, et al., 2017; Barlow, Farchione, Sauer-Zavala, et al., 2017), and the concept of emotional behaviors. Angelina was able to break down a couple of her emotional experiences using the ARC model, including her guilt around increased screen time. Caregivers were then introduced to the Double Before/During/After form (Double B/D/A; Ehrenreich-May, Kennedy et al., 2017), which allows parents to track how their child's emotional responses illicit an emotional experience within themselves. During the parenting application portion of the session, the concepts of empathy and strategic attention were reviewed. Parents learned about expressing empathy for stressors and emotions experienced by their children during COVID and how to increase desired child behaviors by "catching their child" engaging in those behaviors and praising them for it. To reinforce the skills learned in session, parents were encouraged to practice identifying the parts of their own emotional experiences throughout the upcoming week using the ARC or Double B/D/A forms. Additionally, caregivers were tasked with using increased strategic attention to promote their children's positive behaviors. Angelina noted that she would catch her daughter using nice words and catch her son engaging in activities that were not on screens.

## Module 2: Valued Actions for You and Your Family in a Crisis

At the beginning of each session, the therapists reviewed the home-practice assignments from the previous week. Angelina shared that she practiced using empathy more and had practiced implementing strategic attention with her children since her first UP-Caregiver session, and that she had become more aware of her emotional experiences during the week. During the second UP-Caregiver module, the therapists and group members discussed the role of wellness behaviors (e.g., routines, sleep, eating, self-care) during COVID-19. Angelina identified the connection between valued activities and mood and acknowledged that personally meaningful activities (e.g., art) enhanced her mood. The therapists also introduced the concept of opposite action (i.e., doing something different from what one's strong emotion is encouraging) from the UP and the rationale for engaging in opposite actions to pandemic- and parenting-related emotional behaviors. Angelina described a number of emotional behaviors, including making many lists and trying to control her family's routines when feeling anxious. She also described yelling at her children or spouse when frustrated. During this module, the therapists also introduced the concept of value-directed actions (i.e., recognizing what one's emotion is resonated with the emphasis on value-driven opposite actions), as well as the emphasis on setting small and flexible goals. Caregivers were encouraged to select two valued opposite actions, self-care behaviors, or opposite parenting behaviors to try over the next week. In collaboration with the therapists, Angelina elected to practice pausing before reacting as an opposite

action for the controlling behaviors she demonstrated when anxious or frustrated. The therapists also encouraged Angelina to continue engaging in her preferred pleasurable activities. During the parenting application portion of the session, the caregivers were introduced to the concept of positive one-on-one time as one value-directed parenting action. This involves spending 5 to 10 minutes per day engaging with their children around something the child wants to do with a focus on using positive attention. Angelina committed to setting time for positive one-on-one time with each of her children for the week.

### **Module 3: Focusing on the Here and Now in the Midst of a Crisis**

Angelina shared that she had arranged a technology-free day over the past week to promote positive interactions with her children, and she described enjoying the opportunity to focus on her interactions with her family and play games with each of her children. Angelina shared how worries about her job, worries about her children, and feelings of guilt escalated her strong emotions over the past week. Additionally, she described having difficulty taking a pause when feeling anxious during her children's bedtime and the therapists connected these challenges with the UP-Caregiver Module 3 material. This module focuses on the role of thoughts, including worry and rumination, in leading to less helpful emotional behaviors related to the uncertainty associated with the pandemic and parenting during the pandemic. Therapists normalized worries regarding uncertainty about the future, especially given the uncontrollable nature of the pandemic and associated stressors. Angelina described how rumination negatively affected her interactions with her children and how her thoughts focused on negative future outcomes and was eager to use this skill. Mindful emotional awareness from the UP was introduced as a skill to help parents manage unhelpful thoughts. This is a mindfulness strategy whereby individuals identify a cue or anchor within their bodies (e.g., their breath, etc.) and use that cue to bring their attention to the present moment when experiencing a strong emotion. This skill was practiced in session using a mindfulness script, and caregivers identified ways they could use this skill at home. For homework, caregivers committed to engaging in a mindfulness activity at least once per day. Therapists emphasized flexible use of the skill to ease implementation. For example, parents could practice mindfulness using an app or script, exercise mindfully, or complete daily activities while anchoring in the present-moment (e.g., brushing teeth, showering,

cooking). This module's parenting application centered on a discussion about modeling of healthy emotion management. The role of modeling on youth emotion regulation is introduced and parents are taught a method of modeling adaptive emotion regulation (e.g., label the emotion they are experience, identify the urge to engage in an unhelpful response, and identify and complete the more helpful response). The therapists discussed how Angelina could model healthy emotion management when feeling overwhelmed in front of her children, which could help her children identify and use more adaptive responses to their own emotions. This skill could also provide Angelina with a moment's pause to slow down and engage in present-moment awareness.

### **Module 4: Thinking Flexibly in a Crisis and Planning for the Future**

When reviewing the previous session's homework, Angelina shared that she had been able to pause and allow her emotions to decrease when becoming overwhelmed during her children's bedtime. She noted that she was able to use her mindful emotional awareness skills to notice her thoughts and physical sensations while feeling anxious. After taking this pause, she was able to use an opposite action and elected to step back rather than try to overcontrol the situation as she would have in the past. The therapists praised Angelina's use of skills from the past sessions. In the fourth UP-Caregiver module, the content again focuses on caregiver's thoughts as they relate to the pandemic and parenting during the pandemic. The therapists facilitated a discussion about different worries parents are having about the future and how these thoughts influence their emotions and behaviors. The therapists introduced the concept of cognitive distortions (e.g., probability overestimation/catastrophizing), or automatic thoughts and interpretations of situations that lead to strong emotions. With Module 4's emphasis on cognitive flexibility, the therapists encouraged Angelina to identify her patterns of catastrophic and all-or-nothing thinking. The skill of cognitive reappraisal is introduced as a means for becoming more flexible in their thinking, whereby caregivers were taught to gather evidence to identify other potential interpretations for a given situation (e.g., what has happened before, what else could be true, do I know that for certain, etc.). Angelina was able to utilize cognitive reappraisal to develop more flexible thoughts about her parenting and her children's difficulties with online schooling and concerns about her job. Angelina also identified coping thoughts for if these worries were to come true (e.g., "we have savings and family

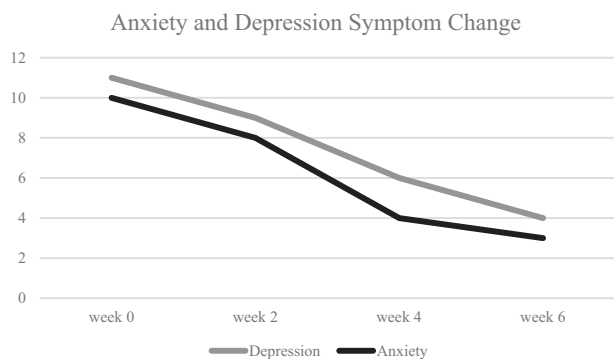


to rely on and I have valuable experience in my field if I were to lose my job”). Problem-solving was another strategy introduced during this module, especially as it related to planning for the upcoming school year and an uncertain future. The parenting application for this module focused on the concept of healthy independence granting, or allowing children to engage in age-appropriate coping behaviors, including practicing problem solving with their child or decreasing reassurance provision. The therapists guided Angelina in promoting healthy independence in her children’s management of their own strong emotions by scaffolding cognitive reappraisal and the use of child-generated coping thoughts, rather than providing reassurance. For homework, the therapists helped Angelina plan opportunities to use cognitive reappraisal and problem solving for herself and with her children. Worksheets to practice these skills were also provided, including a cognitive flexibility worksheet to prompt identification of a thinking trip, questions to ask to evaluate the thought, and alternative interpretations of the situation.

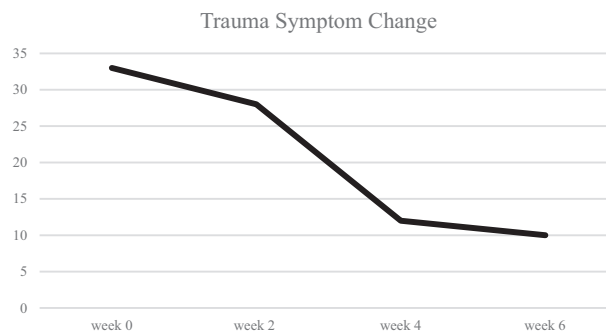
## Results

Overall, Angelina reported the intervention to be acceptable and helpful, and was satisfied with the outcomes. On treatment satisfaction, Angelina indicated an average score of 4.75 on satisfaction and on helpfulness for the four sessions.

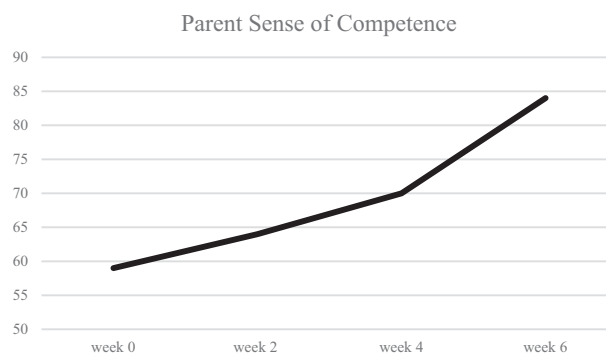
Changes in Angelina’s reported anxiety and depression symptoms are presented in Figure 2. Change in her trauma symptoms is presented in Figure 3. At pretreatment, Angelina noted clinically elevated depressive and anxiety symptoms, which decreased over the course of treatment, both falling within the average range by Week 6. Angelina exhibited reliable change



**Figure 2.** Self-reported change in anxiety and depression symptoms. Note. Depression symptoms were obtained via self-report on the ODSIS; anxiety symptoms obtained via self-report on the OASIS.



**Figure 3.** Self-reported change in trauma symptoms. Note. Trauma symptoms were obtained via self-report on the PCL-5.

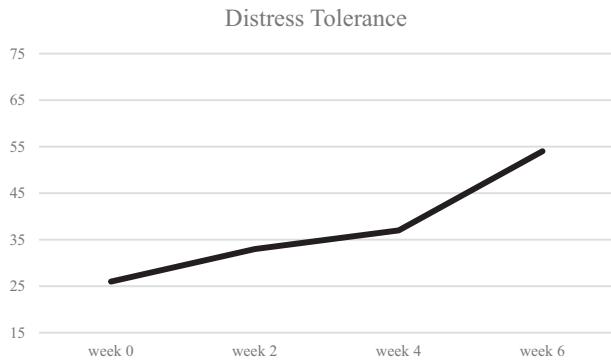


**Figure 4.** Self-reported change in parent sense of competence. Note. Parent’s sense of competence was obtained via self-report on the PSOC.

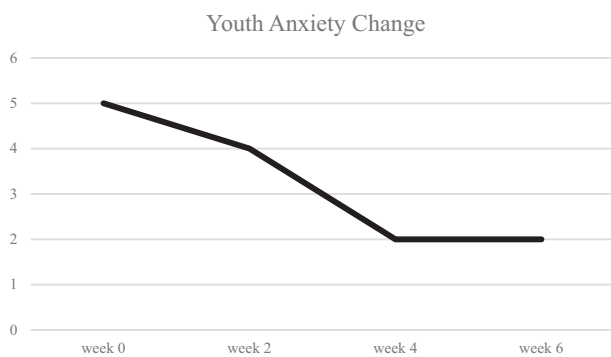
in her self-reported depressive symptoms (RCI = 3.46, effect size = 1.12) and anxiety symptoms (RCI = 4.46, effect size = 1.74). Angelina’s trauma symptoms were within the elevated range at pretreatment but decreased and fell within the average range by Week 6, indicating clinically significant and reliable change (RCI = 9.99, effect size = 1.56). Angelina self-reported improvements in her sense of parenting self-efficacy throughout treatment. Change in her perceived self-efficacy is presented in Figure 4. Angelina also noted improvements in her ability to tolerate distress and handle negative emotions from Week 0 to Week 6 (see Figure 5). According to Angelina, her child was experiencing moderate levels of anxiety at pretreatment. This decreased during treatment and fell within the average range by Week 6. Change in youth anxiety symptoms is presented in Figure 6.

## Discussion

UP-Caregiver was developed to help caregivers address the distress associated with strong emotions during the COVID-19 pandemic. Preliminary results suggest that UP-Caregiver is acceptable, helpful, and



**Figure 5.** Self-reported change in distress tolerance. Note. Distress tolerance is self-reported via the Distress Tolerance Scale.



**Figure 6.** Self-reported change in youth anxiety symptoms. Note. Youth anxiety symptoms were obtained via parent-report on the Y-OASIS.

leads to improved emotion management for this parent, who was experiencing elevated symptoms of emotional disorders during the COVID-19 pandemic. The case example demonstrated high client satisfaction, feasibility, and efficacy of the intervention for this case. Angelina found the intervention to be both enjoyable and helpful, and she and her child reported clinically meaningful and reliable improvement in symptoms. Angelina was receptive to all of the modules and was extremely compliant in applying the skills between sessions for home-learning.

Angelina utilized various skills from UP-Caregiver to address the emotion of guilt, in particular. She reportedly increased her use of opposite parenting behaviors, including increasing positive one-on-one time, healthy emotion modeling, and healthy independence granting. Angelina also particularly benefited from the mindfulness skills. Although she expressed that she previously had difficulty implementing mindfulness techniques, she felt that the anchoring in the present skill was helpful in allowing her to recognize her negative thoughts and shift her focus to the present. She also used mindfulness to slow down and notice her

emotion and urge to use unhelpful parenting behaviors as an effective way to integrate opposite actions and healthy emotion modeling in response to stress.

It should be noted that the circumstances around COVID-19 are changing rapidly and caregivers in this RCT reported highly varied experiences depending on their family, job, location, and the time they entered the study (e.g., May 2020 versus August 2020). Tailoring of the skills have changed over time, whether they were applied for experiences of being sheltered in place or for returning their children to school. Although this speaks positively to the flexibility of the intervention, these variations may confer different outcomes for different individuals and will need to be explored in subsequent RCT analyses. The inclusion criteria regarding internet access could be modified to provide a more inclusive treatment and address treatment access inequalities worsened by the pandemic. Caregivers in this sample often relied on phone use rather than a video app (i.e., Zoom); however, the clinicians found that this sometimes adversely impacted rapport and cohesion of the group, and participants were encouraged to keep their cameras on. In future deliveries of this intervention, how to best address the need to be more inclusive of families without sufficient internet should be considered. Last, the therapists in this study were already trained in the UP-C or UP-A and had existent experience with the model, easing training and adaption efforts for delivering this intervention.

Future work will examine the efficacy of the intervention to improve caregiver symptoms of anxiety, depression, and traumatic stress, possible transdiagnostic mechanisms of psychopathology, parenting beliefs and behaviors, and child internalizing and externalizing symptoms and behaviors. Future work will also include delivery of the intervention for caregivers of infants and children under 6 years old. This intervention may also have feasibility for other disasters or public health emergencies and have potential to be adapted for rapid dissemination in times of crisis.

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