

Short Research Article: Changes in Life Functioning in a Self-Help,
Online Program for Child & Adolescent Anxiety

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Abstract

Anxiety-related functional impairment, as reflected by life interference, is a lesser explored but highly relevant treatment outcome, and it is crucial that it is included and examined in the evaluation of treatment outcomes of internet-delivered Cognitive Behavioural Therapy (iCBT). This single group, pre-post study examined changes in life interference and anxiety symptoms in a sample of children ($n = 1198$; mean age 9.66 years) and adolescents ($n = 721$; mean age 13.66 years) participating in the BRAVE Self-Help program in Australia. Results demonstrated that both children and adolescents showed improvements in anxiety symptoms, with effect sizes ranging from $\eta_p^2 = .194 - .318$. Reductions in life interference were evident for children ($\eta_p^2 = .008 - .044$), particularly later in the program, but adolescents did not show such effects. Adolescents in the low completer group (completing 3-5 sessions) showed increases in at-home interference ($\eta_p^2 = .038$). Adolescents in particular may require more sessions before entrenched life interference, such as that resulting from avoidance behaviours, can be overcome.

Keywords: anxiety, child, adolescent, iCBT, life functioning

Key Practitioner Messages

1. Studies have shown significant reductions in anxiety symptoms following iCBT, but greater understanding of how this translates into reductions in anxiety-related functional impairment is required.
2. Children demonstrated reductions in life interference, however this was not evident until session 7. Adolescents failed to show significant changes in life interference throughout program participation.
3. Although anxiety symptoms improve early during iCBT, improvements in functioning appear to take longer (i.e. more iCBT sessions) for children. Adolescents may require even further intervention, or parental assistance to achieve noticeable improvements in life interference. Strategies aimed at improving program engagement are required for improvements in life interference to occur.

Introduction

Cognitive behaviour therapy (CBT) remains the gold standard treatment for youth anxiety, with significant empirical support and demonstrated effectiveness (Hill, Waite & Creswell., 2016; Ishikawa et al., 2007; Reynolds et al., 2012; Silk et al., 2018). However, there are a number of known barriers to help-seeking for childhood anxiety, including but not limited to: financial costs, lack of resources, geographic barriers, difficulties with diagnosis and poor recognition of anxiety symptoms in young people (Creswell, Waite & Hudson., 2020; Hill et al., 2016; Jolstedt et al., 2018). Interventions delivered online via the internet offer a significant opportunity to circumvent many of these barriers and to disseminate evidence-based treatment at a large scale and at little or no cost (Christensen, Griffiths & Farrer, 2009). Given its structured and systematic format, CBT is particularly amenable to translation into an online delivery format (Spence et al., 2006), and a growing body of evidence shows little to no variation in outcomes between internet-delivered cognitive-behaviour therapy (known as iCBT) and face-to-face therapy for anxious children and adolescents (Ebert et al., 2015; Podina et al., 2016; Vigerland et al., 2016). Online interventions can be delivered in a variety of ways, ranging from therapists using the programs in clinic with clients, to therapists using the programs as an adjunct to in-clinic sessions, to delivery whereby the young person completes the program independently without any therapist support (self-help).

BRAVE Self-Help is an open access, iCBT program for the treatment of child and adolescent anxiety that is freely available for all Australian young people and their families. It was originally delivered with therapist-assistance (Reyes-Portillo et al., 2014; Rooksby et al., 2015), and has more recently been converted into a self-directed program that has been accessed by over 64,500 registered users in Australia (March et al., 2022). The feasibility and

acceptability of BRAVE Self-Help has been demonstrated in two studies (March et al., 2021; March et al., 2018), showing significant reductions in anxiety symptoms for young people, with the greatest change evident within the first 6 sessions (March et al., 2021).

Although studies have demonstrated significant reductions in anxiety symptoms following iCBT (Christensen et al., 2009; Ishikawa et al., 2007; Jolstedt et al., 2018; Spence et al., 2006), more evidence is needed to comprehensively appraise the full benefits and limitations of this mode of delivery. Anxiety-related functional impairment generally refers to the way in which symptoms interfere with daily activities (Rapee et al., 2012) and is a highly relevant treatment outcome in practical terms (Creswell et al., 2021; Lyneham et al., 2013). The interference anxiety causes in a young person's day-to-day life can manifest in many ways, including decreased engagement at school, reduced participation in social activities, difficulties sleeping and family dysfunction (Rapee et al., 2012). Given that problems such as these are generally responsible for the debilitating nature of the anxiety disorder (Kreuze et al., 2018), it is crucial they are included and examined in the evaluation of treatment outcomes. A recent systematic review and meta-analysis found that psychotherapy led to significant improvements in global and social functioning, specifically supporting its efficacy in increasing both family functioning and school attendance. However, the impact of iCBT on life functioning has yet to be examined (Dickson et al., 2022).

This study examined changes in anxiety symptoms and life functioning in a sample of children and adolescents participating in the BRAVE Self-Help program. It was hypothesised that participants who completed the program would demonstrate significant reductions in anxiety symptoms and improvements in life interference (reductions in at-home and outside-home interference). It was also hypothesised that reductions in anxiety symptoms would be positively associated with reductions in life interference.

Methods

This study was conducted under ethics approval (H13REA264/H20REA298) from the governing university. A single group pre-post research design was adopted using data collected via a large community effectiveness trial of BRAVE Self-Help.

Participants and Procedure

Participants were 1919 Australian young people, including 1198 children (7-12 years, $M_{age} = 9.66$, $SD_{age} = 1.29$) and 721 adolescents (13-17 years, $M_{age} = 13.66$, $SD_{age} = 1.51$) aged 7–17 ($M_{age} = 11.15$, $SD_{age} = 2.37$), with elevated or clinical levels of anxiety symptoms. BRAVE Self-Help is available free of charge to young Australians and their families and can be accessed via self-referral or referral from a healthcare or education provider. Children under 16 years of age also require parental consent to register for the program. During registration, participants read a developmentally appropriate participant information sheet and provide informed consent to participate in research by agreeing to a series of confirmatory statements. Data were collected from 7th June, 2019 to July 18th, 2021. Almost half (49.7%) resided in major cities, with fewer living in inner regional (18.4%), outer regional (9.9%), and remote or very remote (2.5%) Australia; 59.7% were females ($n = 1146$), 37.9% males ($n = 728$). Of the participants, 2.4% ($n = 45$) identified as androgynous, genderqueer, transgender, or 'other', and 6.1% ($n = 118$) reported Aboriginal and/or Torres Strait Islander background. In total, 51.7% ($n = 993$) demonstrated elevated but not clinical levels of anxiety symptoms at baseline, while 48.3% ($n = 926$) demonstrated clinical levels of anxiety symptoms. Anxiety symptoms and life interference were assessed at baseline and at sessions 4, 7 and 10 of the program. To be included in the study, participants were required to have completed measures at baseline and session 4. Of the 1951 young people who registered for BRAVE Self-Help in the study period and presented with elevated or clinical levels of anxiety

symptoms at the time of registration, 1.64% ($n = 32$) had not progressed to complete the CALIS-C and CAS-8 measures at Session 4 and were subsequently excluded from this study.

Measures

Data relating to this study were collected online within the BRAVE Self-Help platform, and subsequently exported for analysis.

Anxiety Symptoms

Anxiety symptoms were assessed using the 8-item Child Anxiety Scale (CAS-8; Spence et al., 2008), a self-report measure completed by the young person, which has demonstrated good internal consistency in youth aged 7-17 (March et al., 2018; Spence et al., 2014). Total CAS-8 scores range from 0-24, with higher scores indicating greater anxiety. Scores ≥ 10 for males, ≥ 12 for females and ≥ 11 for other genders indicate elevated anxiety symptoms, while scores ≥ 13 , ≥ 16 and ≥ 14 indicate clinical levels for each gender respectively (March et al., 2018). Internal consistency in this study was $\alpha = .83$. Changes in anxiety symptoms were calculated as raw score differences from baseline to sessions 4, 7 and 10 respectively.

Life Interference

The 9-item Child Anxiety Life Interference Scale for Children (CALIS-C; Lyneham et al., 2013) is a child-rated measure of anxiety-related interference or impairment in young people aged 6-17 years. School, social, and home/family interference are assessed via two broad subscales: *At Home* (AH) and *Outside Home* (OH). AH scores relate to the young person's perspective regarding anxiety-related difficulties experienced in getting along with parents and siblings, daily activities such as getting ready for school, completing homework, playing and sleep and general feelings of upset or distress related to their anxiety. OH scores relate to perceived difficulties with friendships, schoolwork, sporting and other activities both in and outside of school. Scores for the OH and AH subscales range from 0-16, and from 0-20 respectively with higher scores reflecting greater interference. Given that standardised

norms are not available to assist with the interpretation of scores, raw score change was examined in this study. Internal consistency in this study was good for the OH subscale ($\alpha = .84$) and acceptable ($\alpha = .68$) for the AH subscale. Changes in life interference were calculated as raw score differences from baseline to sessions 4, 7 and 10 respectively.

Treatment Program and Session Completion

BRAVE Self Help is an interactive, 10-session iCBT program designed to provide treatment for child and adolescent anxiety (separation anxiety, generalised anxiety, specific phobia, social anxiety) and has been described elsewhere (March et al., 2021; March et al., 2018). There are child and adolescent versions of the program; children are encouraged to seek help from a parent if required and adolescents may complete the program independently (Spence et al., 2008). In this study, the program was completed by the child/adolescent and there were no parent-focused sessions. Sessions take between 30-60 minutes to complete, and content is presented in an interactive format including question and answer activities, quizzes and homework activities to increase engagement and skill rehearsal. Immediate corrective feedback is provided during quizzes via pop-up messages to reiterate key concepts and further aid retention (March, Spence & Donovan, 2009).

The first 4 sessions of the program focus on psychoeducation and knowledge acquisition around core CBT skills (e.g. identification and management of physiological and cognitive components of anxiety) before skills acquisition and application within a hierarchical exposure framework commences in session 5. A full list of activities covered in each of the sessions for both programs can be found in Appendix A. Users can progress through the program at their own pace (typically slower than one session per week), however sessions must be completed in sequential order.

Participants' progression through BRAVE Self-Help was automatically tracked within the BRAVE Self-Help platform. As CALIS-C was only measured at sessions 1, 4, 7 and 10, participants were grouped based on the final CALIS-C timepoint completed; being low (completing 3 to 5 sessions; 57.48%, $n = 1103$), moderate (completing 6 to 8 sessions; 20.95%, $n = 402$), or high session completers (completing 9 to 10 sessions; 21.57%, $n = 414$).

Analytic Strategy

Data were exported directly from the BRAVE Self-Help program and analysed using SPSS version 27. One-way ANOVA was utilised to determine whether there were any baseline differences between low, moderate, and high completer groups on age, gender, anxiety severity or interference scores. One-way repeated measures ANOVAs (including post-hoc contrasts with Bonferroni adjustments as appropriate) were conducted to determine whether there was a statistically significant change in CAS-8 and CALIS-C subscale scores across the available time points for participants categorised as low, moderate, and high session completers. For low completers, change from baseline to session 4 was examined, for moderate completers, change from baseline to session 4 and session 7 was examined, and for high completers, changes were examined across all time points. Analyses were conducted separately for child and adolescent samples. Subscales of the CALIS-C were analysed separately to compare changes in at-home and outside-home interference across the intervention. Effect sizes were calculated using the sum of squares within ANOVA analysis in SPSS, and were reported as small, medium or large as defined by Cohen (1988).

Results

Baseline Comparisons

Differences between completer groups of children and adolescents on baseline age, gender, anxiety symptom severity and life interference were examined. For adolescents, low completers ($M=13.85$, $SD=1.57$) were slightly older than moderate ($M=13.32$, $SD=1.38$) and

high completers ($M=13.47$, $SD=1.41$), and this difference was statistically significant, $p<.001$.

There were no other differences in baseline characteristics for completer groups of adolescents or children.

Changes in Anxiety Symptoms and Life Interference

A summary of changes in CAS-8 and CALIS-C (AH and OH) scores across timepoints for each of the completer groups for both children and adolescents is provided in Figure 1.

[INSERT FIGURE]

Figure 1. *Changes in Anxiety Symptoms and Life Interference Scores for Low, Moderate and High Session Completers*

Table 1 presents the results of the repeated measures ANOVAs for change in CAS-8 and CALIS-C for children and adolescents across each of the completer groups. Results demonstrated that children showed significant improvements in anxiety symptoms across all time points and all completer groups, with large effect sizes ($\eta_p^2=.281$; .318 and .308 for low, moderate and high completers respectively). Adolescents also showed significant improvements in anxiety symptoms from baseline to session 4 across all completer groups. Effect sizes for changes in anxiety symptoms for adolescents were also large, with $\eta_p^2=.273$ for low completers, $\eta_p^2=.194$ for moderate completers and $\eta_p^2=.282$ for high completers.

[INSERT TABLE]

In the low completer group, AH interference increased from registration to session 4 for both children ($p=.005$, $\eta_p^2=.012$) and adolescents ($p<.001$, $\eta_p^2=.038$) although this change was small (0.38 and 0.68 raw score points respectively) and the effect size was also very

small. Conversely, OH interference decreased for child low completers from registration to session 4 ($p=.021$, $\eta_p^2=.008$), and did not change significantly for adolescents ($p=.087$).

In the moderate completer group, there were significant reductions in AH interference from registration to session 7 for children with a very small effect size ($p=.018$, $\eta_p^2=.018$), between session 4 and session 7. Moderate completer children also showed significant reductions in OH interference, from registration to session 7 with a very small effect size ($p=.001$, $\eta_p^2=.031$). Adolescents showed no significant change in AH or OH interference ($p=.28$ and $.99$ respectively).

In the high completer group, children showed significant reductions in AH interference ($p<.001$), between registration and session 7, registration and session 10, session 4 and session 7, and session 4 and session 10. However, the effect size for this change was very small ($\eta_p^2=.044$). Children also showed significant reductions in OH interference with a very small effect size ($p<.001$, $\eta_p^2=.027$) between registration and session 7, session 4 and session 7, and session 4 and session 10. For adolescents, there were no changes in AH or OH interference ($p=.42$ and $.17$ respectively).

Relationship between changes in anxiety symptoms and changes in life interference

Reductions in anxiety symptoms from registration to the final session completed (i.e., session 4, 7 or 10) were positively associated with improvements in life interference at home and outside home for child low completers (AH: $r=.30$, $p<.001$; OH: $r=.24$, $p<.001$), moderate completers (AH: $r=.40$, $p<.001$; OH: $r=.28$, $p<.001$) and high completers (AH: $r=.25$, $p<.001$; OH: $r=.22$, $p<.001$); although these associations were relatively weak. Similar associations were evident for adolescent low completers (AH: $r=.29$, $p<.001$; OH: $r=.21$, $p<.001$), moderate completers (AH: $r=.22$, $p<.001$; OH: $r=.27$, $p<.001$) and high completers (AH: $r=.39$, $p<.001$; OH: $r=.39$, $p<.001$).

Discussion

This study examined changes in anxiety symptoms and life interference in a sample of young people participating in the BRAVE Self-Help iCBT intervention. To date, researchers have primarily focused on the assessment of anxiety symptoms when examining the efficacy of child and adolescent anxiety treatments such as iCBT (Dickson et al., 2022). This study provides further insight into the relationship between changes in anxiety symptoms and changes in life interferences, as it relates to both changes in anxiety symptoms and the level of program completion. As hypothesised, children and adolescents showed significant reductions in anxiety symptoms, with large effect sizes ranging from $\eta_p^2=.194$ to $\eta_p^2=.318$ across all completer groups. Similar to previous studies examining BRAVE Self-Help (March et al., 2021; March et al., 2018; Spence et al., 2006), improvements in symptoms occurred quickly, with significant reductions in anxiety symptoms evident even for those who completed only 3 or 4 sessions, and greater improvements for moderate and high completer children. Interestingly, adolescents showed significant improvements specifically in the first 3 or 4 sessions but did not statistically significantly improve after session 4. Further, the hypothesis that anxiety symptom improvements would be positively associated with overall reductions in life interference was supported for both AH and OH interference, a finding that aligns with Dickson et al. (2022), who found evidence that anxiety treatment improves daily functioning in young people. However, although anxiety symptoms were found to reduce immediately and continued or were maintained throughout program participation, this was not the case for life interference. In contrast to Dickson et al.'s (2022) findings, young people did not demonstrate significant changes in life interference in the early stages of program participation (from registration to session 4). In fact, both children and adolescents in the low completer group demonstrated an increase in AH interference, highlighting a potential

barrier to continued participation for some young people. It is possible that, for these participants, their awareness of their anxiety increased as they worked through the psychoeducational material, thus leading to greater awareness of its life impact, at least in the home context. Reductions in life interference for children generally occurred after session 4 of the program (for moderate and high completers, i.e. those who persisted), perhaps reflecting the need to consolidate anxiety symptom improvements and skill rehearsal prior to experiencing improvements in home life interference. The results were different for OH interference for children, which decreased throughout program participation (although effect sizes in all instances were small, ranging from $\eta_p^2=.008$ to $.044$). These differences in effects between AH and OH interference are interesting, potentially highlighting a relationship between completing the program within the home-setting and the AH context. It may be that engaging in the intervention at home resulted in increased stress in facing anxiety within that context.

Adolescents failed to show significant improvements in AH or OH life interference during the course of the program, despite demonstrating reductions in anxiety symptoms. It appears that, for adolescents in particular, despite improvements in anxiety symptoms, and the general association between improvements in anxiety symptoms and interference, significant improvements in interference were not an automatic consequence. This may suggest that, for adolescents, substantial reductions in life interference are unlikely to occur after 10 sessions of iCBT and may take longer to achieve through a sustained period of lower anxiety symptoms. It is possible that avoidance behaviours in adolescents may be more entrenched and may require more time and effort (more than 10 sessions) or additional support from a therapist in implementing skills to change. Further, while children may benefit from parental support in making behavioural changes to improve life interference,

adolescents are more likely to be participating in the program independently and this lack of external support may limit behavioural improvements. Certainly, greater improvements in anxiety severity and loss of diagnosis (which require clinical levels of functional impairment) have been found in therapist-supported versus self-help iCBT (Creswell et al., 2020; Richardson, Stallard & Velleman, 2010; Silk et al., 2018). Regardless, it is important to acknowledge that the demonstrated lack of improvement in life interference in the initial stages of program participation (which seems to be common even with children) may contribute to disengagement or discontinuation of the program, and potentially prevent young people from experiencing the optimal benefits from iCBT. Another potential consideration is the speed at which individuals complete the program. While it is recommended that young people complete sessions on a weekly basis, they are able to work through the program at their own pace. Thus, measures of anxiety symptoms and interference taken at session 4, for example, may not directly correspond to week 4 of participating in the program. It is plausible that those young people completing the program at a faster pace may not experience the same improvements in functioning or anxiety symptoms as those completing the program at a slower pace. Further, given the data collection period extended into the COVID-19 pandemic, it is possible that other stressors and impacts such as those associated with COVID-19 and the context of public health restrictions contributed to the lack of change in interference for adolescents (Sicouri et al., 2022).

Limitations

Being a real-world evaluation, this study has some design limitations, in that there was no control group and participants were not subjected to an initial interview to confirm anxiety and life interference severity. Further, it is acknowledged that multi-informant

measures (those of both parent and child) are often adopted in treatment evaluations for young people, and that the current study used child-report only. The inclusion of parent-reported measures may have provided further clarity on the patterns observed based on child-report. However, the study employed well-established and validated measures, which allow for the examination of the magnitude of change in terms of severity specifically from the young person's perspective. Further, given that the CALIS-C was only administered at sessions 1, 4, 7 and 10, this study was limited to those who had completed measures at a minimum of 2 of these timepoints, and corresponding analyses of CAS-8 scores were also only conducted at these timepoints. The average internal consistency of the AH subscale in this study was acceptable ($\alpha=.68$) but not high, which may mean that the results need to be interpreted with caution, though the reliability is consistent with that of the original validation study (Lyneham et al., 2013).

Future Directions

Given that reductions in life interference, especially for AH interference, appear to be somewhat delayed for children and were absent for adolescents, there is a need for research to more closely examine the trajectory of change in interference across iCBT, of both brief and extended durations, and at more regular intervals. This will also allow the examination of associations with changes in anxiety symptoms across all sessions, and difficulties with ongoing program engagement. It will be crucial for research to examine strategies for maintaining engagement with young people who do not see immediate improvements in life interference in order to obtain the benefits of iCBT and bring about changes in functioning which are likely to emerge later in the program. Further research is also required to understand the mitigating factors for why reductions in anxiety symptoms do not translate into improvements in life interference, specifically for adolescents, to ensure additional

strategies can be integrated to facilitate improvements or to ensure those who require additional support are redirected as appropriate.

Conclusion

Online, self-help iCBT can improve anxiety and life interference for many young people, however, results from this study show that reductions in anxiety symptoms do not necessarily coincide with similar and early incremental reductions in life interference. Improvements in functioning become evident for children after more treatment sessions are completed and entrenched avoidance behaviours can be overcome. Importantly, adolescents appear to require more than self-help iCBT to achieve significant improvements in anxiety interference.

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Table 1. Summary of One-Way ANOVAs Examining Changes in Anxiety and Life Interference (with post-hoc contrasts with Bonferroni adjustment)

Variable	F	df	p	partial η^2	Pairwise Comparisons							
					Comparison	Mean Difference	SE	p	95% Confidence Interval			
									Lower	Upper		
Low Completer Group (3 sessions)												
<i>Changes in CAS-8</i>												
Children (n=680)	264.666	1, 677	<.001	.281								
Adolescents (n=423)	15.284	1, 422	<.001	.273								
<i>Changes in CALIS-C (At Home)</i>												
Children (n=680)	7.912	1, 679	.005	.012								
Adolescents (n=423)	16.635	1, 422	<.001	.038								
<i>Changes in CALIS-C (Outside Home)</i>												
Children (n=680)	5.333	1, 679	.021	.008								
Adolescents (n=423)	2.940	1, 422	.087	.007								
Moderate Completer Group (6 sessions)												
<i>Changes in CAS-8</i>												
Children (n=221)	102.811	1.919, 424.093	<.001	.318	Session 1	Session 4	2.937	.306	<.001	2.200	3.674	
					Session 1	Session 7	4.712	.363	<.001	3.836	5.587	
					Session 4	Session 7	1.775	.325	<.001	.992	2.558	
Adolescents (n=181)	43.246	1.825, 328.555	<.001	.194	Session 1	Session 4	2.530	.321	<.001	1.754	3.307	
					Session 1	Session 7	3.017	.399	<.001	2.053	3.980	
					Session 4	Session 7	.486	.319	.389	-.285	1.258	
<i>Changes in CALIS-C (At Home)</i>												
Children (n=221)	4.125	1.929, 424.380	.018	.018	Session 1	Session 4	-.213	.251	1.000	-.819	.394	
					Session 1	Session 7	.502	.278	.216	-.168	1.172	
					Session 4	Session 7	.715	.236	.008	.145	1.284	
Adolescents (n=181)	1.282	1.982, 356.796	.279	.007								
<i>Changes in CALIS-C (Outside Home)</i>												
Children (n=221)	7.133	1.939, 426.620	.001	.031	Session 1	Session 4	.688	.358	.168	-.176	1.552	
					Session 1	Session 7	1.262	.337	<.001	.448	2.076	
					Session 4	Session 7	.575	.307	.187	-1.314	.165	
Adolescents (n=181)	.001	1.984, 357.202	.999	.000								
High Completer Group (9 sessions)												

Changes in CAS-8											
Children (n=297)	132.350	2.598, 771.711	<.001	.308	Session 1	Session 4	3.097	.295	<.001	2.315	3.880
					Session 1	Session 7	4.544	.345	<.001	3.627	5.460
					Session 1	Session 10	5.926	.360	<.001	4.971	6.882
					Session 4	Session 7	1.446	.294	<.001	.667	2.226
					Session 4	Session 10	2.829	.316	<.001	1.990	3.668
					Session 7	Session 10	1.383	.252	<.001	.714	2.051
Adolescents (n=117)	34.966	2.285, 265.028	<.001	.232	Session 1	Session 4	2.786	.364	<.001	1.809	3.763
					Session 1	Session 7	3.538	.466	<.001	2.288	4.789
					Session 1	Session 10	3.795	.519	<.001	2.402	5.187
					Session 4	Session 7	.752	.347	.194	-.180	1.684
					Session 4	Session 10	1.009	.436	.136	-.163	2.180
					Session 7	Session 10	.256	.331	1.000	-.632	1.145
Changes in CALIS-C (At Home)											
Children (n=297)	13.537	2.933, 868.206	<.001	.044	Session 1	Session 4	-.269	.204	1.000	-.810	.272
					Session 1	Session 7	.869	.214	<.001	.301	1.436
					Session 1	Session 10	.795	.236	.005	.168	1.421
					Session 4	Session 7	1.138	.212	<.001	.574	1.702
					Session 4	Session 10	1.064	.226	<.001	.463	1.665
					Session 7	Session 10	-.074	.0110	1.000	-.658	.510
Adolescents (n=117)	.923	2.473, 286.925	.415	.008							
Changes in CALIS-C (Outside Home)											
Children (n=297)	8.097	2.797, 827.868	<.001	.027	Session 1	Session 4	-.239	.267	1.000	-.948	.469
					Session 1	Session 7	1.084	.299	.002	.290	1.879
					Session 1	Session 10	.646	.337	.336	-.248	1.541
					Session 4	Session 7	1.323	.281	<.001	.578	2.068
					Session 4	Session 10	.886	.323	.039	.028	1.743
					Session 7	Session 10	-.438	.289	.785	-1.205	.330
Adolescents (n=117)	1.694	2.857, 331.444	.171	.014							