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An initial evaluation of a group school-based therapeutic intervention for low-level symptoms of anxiety in adolescents

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Declaration

I, Jillen Fatania, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Acknowledgements

Abstract

Anxiety is a common mental health difficulty in adolescence. The use of Cognitive Behavioural Therapy Approaches (CBTA) to treat anxiety has a broad evidence-base. This research aims to explore a new abbreviated CBTA-based group intervention for Key Stage 4 pupils (aged 14-16) that uses an ongoing training and supervision model delivered by Educational Psychologists (EPs) across four schools, which builds the capacity and skills of school staff to manage low-level anxiety in schools. A mixed methods study was employed to assess any changes in pupils' anxiety symptoms before and after the intervention, and also to understand pupils' and group facilitators' experiences of the intervention. The Revised Children's Anxiety and Depression Scale (RCADS) was used to measure any changes in anxiety symptoms before, immediately after, and two months after the intervention (n=16). Semi-structured interviews were used to understand pupils' (n=7) and group facilitators' (n=8) experiences of the intervention, with interview data analysed using thematic analysis.

Following the intervention, on average, pupils' anxiety levels decreased over time. Results varied across the schools, suggesting that findings may not be generalisable across all contexts. Pupils and facilitators mentioned key aspects of the intervention that supported pupils in alleviating anxiety (e.g. opportunities for containment, reframing negative thoughts to being more positive, reflecting on positive factors in their week, normalising anxiety). Pupils and facilitators also made valuable suggestions as to how to improve the intervention (e.g. greater flexibility to enable the intervention to be more person-centred, embedding a more systemic approach that compliments the complexity of different secondary school settings).

Impact Statement

This research evaluated a school-based therapeutic group intervention, (developed by an Educational Psychologist, EP) that aims to alleviate low-level symptoms of anxiety in adolescents (14- to 16-years-old; Key Stage 4). The intervention uses cognitive behavioural approaches (CBTA) alongside positive psychology to support pupils to manage anxiety. The findings demonstrated positive outcomes for the pupils (alleviated anxiety, peer support and developed knowledge and understanding of self-regulation skills) as well as insightful suggestions for improvement (more flexibility, embedding a whole-school approach and the importance of relationships).

Consideration was given to the implications of these findings for EPs, EP services and schools (e.g. in mental health policies). The table below gives a summary of the implications of this research in-line with the Process-Person-Context-Time model (PPCT; Bronfenbrenner, 2005).

Process	• Interactions regarding access to support need to be more dyadic between pupils and adults. • Sharing information between school staff, parents and professionals is highly important. • Senior leadership needs to be invested in the intervention to implement a whole-school MH approach and ensure successful implementation of the intervention. • Offering supervision allows staff the opportunity for containment (which is important, as staff wellbeing impacts pupils wellbeing). EPs are well placed to offer this.
Person	• Intervention groups should be organised with consideration to group dynamics that facilitate safe spaces and attuned relationships. • Adults should not over-encourage pupils to join the intervention groups. Positive outcomes are more likely for automatically motivated pupils. • Given the influence of social media, pupils may benefit from access to video blogs discussing coping strategies.
Context	• More clarity is needed in government initiatives promoting MH support in schools. • Individual circumstances need to be taken into consideration when including pupils in groups. Appropriate support for higher-level needs could be discussed with EPs.

	• Relationships need to be a high priority in schools (in school policies). Staff may benefit from training in attunement principles.
Time	• Interventions being implemented in secondary schools need to be manageable, sustainable and preventative. • Interventions would benefit from more flexibility to improve person-centred approaches and successful implementation of interventions in schools.

In light of the findings, and the strengths and limitations of the research, future research would benefit from considering the following (more suggestions can be found in Chapter 5.7):

- evaluating the intervention with a larger sample size including a control group;
- additional evaluations of interventions and the fidelity of their application in real-world settings, considering the funding difficulties and complexity of secondary schools; and
- evaluating the flexible use of interventions with the ongoing supervision of EPs.

The research provides initial evidence for the intervention, however larger scale and more tightly controlled experimental studies are needed. Thus, the findings cannot be generalised widely, due to the contextual nature of the research and its limited sample size. This does not affect the aim of the study, which was to provide an initial examination of the intervention and add to the growing evidence-base of what works for whom and why (Fonagy, 2015).

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Chapter 1: Introduction

The mental health (MH) of children and young people (CYP) is an increasing societal concern. In 2016, 17% of people aged 16 or over had a MH difficulty; a 0.8% increase from 2007 (Mental Health Foundation, 2016). More recently, the Department of Health (DoH; 2017) reported that one in eight children between the ages of 10-19 experience a MH difficulty, recognised by a clinical diagnosis.

Given the prevalence of CYP's MH difficulties in the UK, the government have targeted several initiatives aimed at improving CYP's MH in schools, such as:

- Targeted Mental Health in Schools Project (Department for Children, Schools and Families, 2008);
- Social and Emotional Aspects of Learning (SEAL; Humphrey, Lendrum, Wigelsworth, & School of Education, 2010);
- 'Improving Access to Psychological Therapies' (IAPT) for depression and anxiety disorders within the NHS (Clark, 2011);
- Future in Mind (DoH, 2015);
- Mental Health and Behaviour in Schools: Departmental Advice for School Staff (Department for Education (DfE), 2018);
- Transforming Children and Young People's Mental Health Provision: a Green Paper (DoH & DfE 2017).

The growing focus on MH in schools may be due to an increasing awareness and understanding of MH, leading to more frequent identification of needs among school-age CYP. This is likely to be beneficial as unmet MH difficulties limit people's opportunity to lead fulfilling lives (World Health Organisation (WHO), 2018). Suicide is known to be the third leading cause of death amongst 15- to 19-year-olds (WHO, 2018). Half of all MH conditions start by the time CYP are 14-years-old, and are frequently left undetected and untreated (Giedd, Keshavan, & Paus, 2008). However, some have challenged the perception of increases in MH difficulties and subsequent increases in access to social and emotional interventions (Humphrey, 2018). They argue that CYP's MH difficulties have been socially constructed through discourse of the

increasing emotional vulnerability of CYP and their need for therapeutic support (Furedi, 2004, 2018). Similarly, Ecclestone (2007, 2012, 2017) argues that the prevalence of CYP's MH difficulties is more commonly recognised and diagnosed as within-person vulnerabilities, whereas some of these CYPs responses may be better understood by their circumstances such as poverty or family breakdowns (and not simply the internalisation of social and economic difficulties). For example, CYP living in adverse conditions may face daily, challenging interactions due to prejudice and inequalities related to socio-economic status, ethnicity, gender, sexuality or other perceivable differences. Therefore, it could be argued that simply 'skilling up' the young person is not targeting the need. Despite this, further work and support is needed to create more understanding and provide more societal adaptations (e.g. striving for equality as well as more acceptance and support from the community). Ecclestone (2007, p. 466) argues that there is cultural discourse emerging that encourages the image of a 'diminished self' opposed to more widespread issues. Ergo, it is important that 'apocalyptic crisis discourses of mental health' (Ecclestone, 2017, p. 48) are heard with a critical ear, to ensure that an overtly within child model is not uncritically accepted (Humphrey, 2018). Future research would benefit from exploring why there is an increasing level of emotional difficulty amongst CYP, so that there is a better understanding of how best to respond to and support emotional and social needs. Additionally, alongside MH interventions such as CBT, having a more systemic approach to skill-up and train staff (beyond intervention facilitators) to recognise, support and adapt their practice to meet these young people's need may have wide reaching impact.

Nevertheless, it is vital that MH promotion and prevention are part of school's roles, in particular secondary schools (DfE & DoH, 2017). With a role outlined for schools to support CYP's MH (DfE & DoH, 2017), EPs are well positioned to support schools, as they have skills and knowledge in CYP development, learning and MH, as well as a close relationships with schools (Wagner, 2000).

1.1 Professional Context

1.1.1 Defining mental health.

MH can be understood as a part of a dual-continuum of wellbeing, and not simply the absence of mental illness (Dogra, Parkin, Warner-Gale, & Frake, 2017; Keyes, 2013; O'Hare, 2017; WHO, 2014). Keyes (2013) proposes that MH and mental illness are coexisting and independent, suggesting that a person with a mental illness can, nonetheless, have positive MH (Figure 1).

Good Mental Health

Severe Mental Illness   No Mental Illness
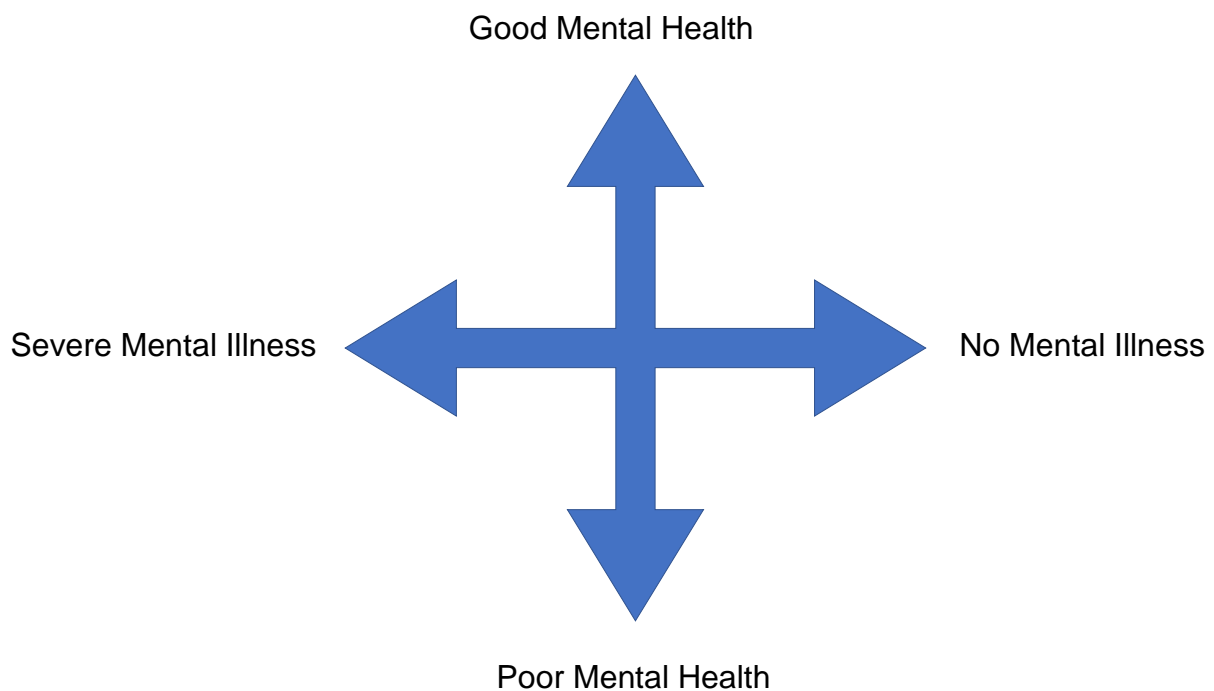
Poor Mental Health

Figure 1: Dual-Continuum of Mental Health

Westerhof and Keyes (2010) identify three key components of MH: emotional wellbeing (how feelings are recognised and expressed); psychological wellbeing (functionality and the ability to reach self-actualisation); and social wellbeing (relationships with others). It is important to recognise that the model does not consider risk and resilience to be factors that influence mental illness and MH (Galderisi, Heinz, Kastrup, Beezhold, & Sartorius, 2015). Therefore, whilst it could be argued that it is 'idealised and simplistic' (Dogra et al., 2017, p.8), the model is a considerable step towards supporting a broader understanding of a complex concept.

1.1.2 Mental health in the UK school context.

In 2017, one in eight 5- to 19-year olds, when assessed, were found to have a clinically diagnosable MH condition (NHS Digital, 2018). These were categorised into emotional, behavioural (or conduct), hyperactivity and other less common disorders. In this survey, 'emotional disorders', which include anxiety (7.2%), depressive (2.1%) and mania and bipolar affective disorders (0.7%), were most prevalent.

This research coincides with the release of the Green Paper (DfE & DoH, 2017), which aims to enable CYP to have access to MH support more quickly and easily, and sets out the government's plans to address the rising concern for CYP's MH, particularly within schools. The Green Paper outlines plans for £1.4 billion to be invested in CYP's MH services; highlighting schools' and colleges' responsibilities in identifying CYP's MH needs, providing preventative support and intervening early (see Appendix B for more information on the Green Paper).

Schools have been facing pressures to raise academic standards. Consequently, teacher training solely focuses on the national curriculum, as opposed to taking a more holistic view of CYP's development. The new Ofsted framework looks to include the MH of staff and pupils in its investigations, demonstrating the continuing recognition of the importance of MH (Ofsted, 2019). Nevertheless, it fails to demonstrate the support and training that teachers will receive to enable them to: prioritise the competing demands of the inspection; manage their own wellbeing; outline the training needed to identify MH needs; and implement effective support for low-level needs. Further, it does not provide information on how to access more specialised support for CYP's MH needs. Whilst the paper recognises the need for staff training in MH awareness; it does not identify who is most appropriate to deliver this. This needs further clarity to ensure a consistent quality of training across settings.

Although the Green Paper is a positive step towards supporting CYP's MH, additional consideration is required. For instance, it suggests the role of a

'designated lead' for MH; however, it lacks information about this person's level of training, the supervision they will need, and the time that should be protected for the role (in order for the person to be influential in promoting positive MH across the school). Additionally, it mentions the use of extra counsellors in schools to support CYP's MH; however, this promotes a more individual child approach. Further, the role of 'designated lead' may place much onus on one member of staff to manage all pupils' MH needs, despite literature advocating whole-school approaches (Weare, 2015).

WHO defines MH promotion as actions that create living conditions and environments for people that allow them to adopt and maintain healthy lifestyles (WHO, 2004). The Green Paper would benefit from a stronger emphasis on using a whole-school approach in MH promotion to target the wider school context and ensure that all CYP are supported to maintain healthy lifestyles. Nonetheless, in the current economic state and with the rising prevalence of CYP's MH difficulties, funding allocated to support MH may have a wider impact if it were split between developing whole-school approaches (a school-wide approach to supporting and developing CYP MH) and preventative measures (providing support for difficulties before they become more complex); as well as effective individualised and targeted interventions. This is particularly important since specialised targeted interventions can be more appropriate where the needs of the person are very complex (Weare, 2015).

1.2 Research context

CAMHS, in my current Local Authority (LA) placement, offers a range of services for CYP up until the age of 18 years, including consultation, one-to-one work, group work, signposting, and family therapy for *complex* MH needs. However, many of these services are offered in clinical settings as opposed to schools. Local General Practitioners and schools have raised concerns regarding CYP not meeting thresholds for specialist or early help services. This is despite them feeling that many CYP would benefit from support. The existing interventions provided by the LA were designed for pupils in Key Stages 1, 2 and 3 (6- to 14-years-old) and were predominantly used for groups of pupils

with Special Educational Needs and Disabilities (SEND). However, schools began to request interventions for Key Stage 4 (KS4; 14- to 16-years-old) pupils without SEND. Thus, an EP in the LA developed a self-referral intervention using CBTA and positive psychology for KS4 pupils with anxiety. The LA's EP service agreed that the intervention could be offered to schools out of core time (a free service, paid by the LA to schools, which is protected for preventative work).

Considering the national agenda promoting MH and the high proportion of EPs using CBTA, I felt that investigating the use of CBTA through a new intervention for KS4 pupils was in-line with my interests, the local context and the current national agenda. The intervention has the potential to build capacity within schools to support MH; therefore, it would be an interesting and informative piece of research of relevance to EP practice and schools. It may also inform more specific future government policies and legislation referring to MH prevention.

This research aimed to ascertain whether a group-based intervention using CBTA, designed to be implemented in a secondary school (for KS4 pupils), could reduce the perceived anxiety of adolescents who self-referred to take part in the intervention. Additionally, the aim was to elicit adolescents' and group facilitators' views, of the intervention (to determine whether it worked well and also identify areas to improve).

Chapter 2: Literature Review

Literature from the field of MH, anxiety and Cognitive Behavioural Therapy (CBT) was used to inform the ideas presented in the current research. Both systematic and non-systematic literature searches were adopted (see Appendix A for details with definitions of key terms).

2.1 Anxiety

2.1.1 What is anxiety?

NICE (2014) recognise anxiety as a common MH 'disorder' that includes generalised anxiety disorder, social anxiety disorder, post-traumatic stress disorder, panic disorder, obsessive-compulsive disorder and body dysmorphic disorder (see Appendix C). The symptoms associated with the 'disorders' described in the NICE guidelines reflect those identified in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5, American Psychiatric Association, 2013).

NICE (2014) offer national guidance on evidence-based recommendations for health and care in England. They posit that diagnosis can ensure that the most appropriate treatment is given and that those presenting with anxiety-like symptoms should receive an assessment that looks at specific anxiety disorders, the severity of the symptoms and the difficulties associated with the anxiety. They acknowledge that the recognition of anxiety disorders is poor and that few people receive the support needed to manage anxiety. However, the definitions proposed by them, and in DSM-5, are framed from a medical model (a within-child diagnostic approach) commonly referring to diagnosing and treating 'disorders', which contradicts the eco-systemic approach (Bronfenbrenner, 2005) favoured by many EPs (MacKay, 2007). Alternatively, Stallard defines anxiety as a:

> *"normative response designed to facilitate self-protection with the particular focus of the fear and worry varying according to the child's development and previous experiences." (Stallard, 2009, p.1)*

Stallard found that the difference between general anxiety and clinically diagnosed anxiety was not the *content* but the *intensity* of anxiety. He suggests that where intensity is high, anxiety can significantly impair day-to-day functioning and may lead to further difficulties in adolescence and adulthood (Stallard et al., 2014). When working with CYP, it is important to normalise anxiety and put in place preventative measures to reduce the risk of anxieties becoming more intense and, therefore, negatively impacting their daily functioning.

Anxiety is complex; it involves cognitive, physiological and behavioural components (Weems & Stickle, 2005). Cognitively, there is the appraisal and risk assessment of situations or events; physiologically, the body prepares for action (e.g. flight, fight or freeze); behaviourally, we anticipate and avoid future dangers (Stallard, 2009). Consequently, when supporting CYP with anxiety, it is important to acknowledge these different components and how they present for different individuals in line with a holistic approach; recognising the whole body experience and ecosystemic approach that incorporate wider systemic factors. This can be used to support the development of effective coping strategies beyond the within-person model, which may have wide reaching impact considering the high prevalence of anxiety in CYP.

2.1.2 The prevalence of anxiety.

Up to 33.7% of the population is affected by an anxiety disorder at some point during their lifetime (Bandelow & Michaelis, 2015). For CYP, anxiety is one of the most commonly experienced MH difficulties, occurring in 2.2% of 5- to 10-year-olds and 4.4% of 11- to 16-year-olds (Public Health England, 2016). Risk factors associated with anxiety include: life experiences, such as trauma and learned behaviours; societal factors, such as social media; and lifestyle factors, such as caffeine, relationships and work-related stress (Dabkowska & Dabkowska-Mika, 2015; Merikangas, 2005). However, it should be noted that these findings are primarily focused on anxiety in westernised cultures. Whilst beyond the scope of this thesis, further research is needed into the risk factors of anxiety associated with more diverse populations and various cultures. Understanding risk factors raises awareness of groups more vulnerable to

anxiety. This means people may be targeted for support with a preventative approach, opposed to a reactive approach. Whilst adolescents are recognised as a vulnerable group at risk of anxiety, more research into specific factors that attribute to their anxiety would be beneficial.

Stallard (2014) reports that anxiety is more prevalent in 'older children'. This may be due to their increased awareness of themselves and others, as well as adolescents being more aware of social comparisons and self-criticality (Weems & Stickle, 2005). Advocating early intervention could reduce the risk of CYP reaching crisis; therefore, needing more expensive, longer-term interventions in adulthood. Thus, not only reducing the risk of CYP developing complex MH needs, early intervention may provide long-term economic benefits. Considering the prevalence and risk factors highlighted above, any early intervention should aim to be further reaching than individual young people; also targeting the wider challenges faced by CYP, such as societal factors and work-related stress. Indeed, it is important to encourage more societal awareness of the impact anxiety can pose, opposed to solely focusing on individuals who recognise their experience of anxiety. Overall, it is important to support young people to develop their skills to manage anxiety, whilst larger movements within society are more gradually actioned.

2.1.3 What impact does anxiety pose?

Anxiety can have a significant (negative) impact on a person's life, including reduced employment, reduced social interaction and increases in medical utilisation, alcohol abuse and suicide (Rapee, 2002). Therefore, it is important to recognise symptoms and risk factors of anxiety as early as possible and implement interventions in the early stages of anxiety (prior to more negative coping strategies being embedded).

Whilst thoughts and feelings have a significant impact on anxiety, the physical impact of anxiety is also important to appreciate. The body is made up of several inter-related systems, of which six are involved in the production of anxious and fearful systems (including the nervous system, cardiovascular system, respiratory system, excretory system, digestive system and endocrine

system). Our bodies cannot distinguish between anxiety and perceived danger, so our body automatically prepares for a fight or flight response (Cherney, 2018).

Within the nervous system, the limbic system represents the emotion centre in the brain which encompasses the amygdala and the hippocampus (see Figure 2). The hippocampus is responsible for memory during anxious arousal, where we relate to previous experiences and memories that can initiate or heighten feelings of anxiety (Cardwell, Clark, & Meldrum, 2009). The amygdala leads to the hypothalamus, which controls the Automated Nervous System (ANS) and chemical messengers such as hormones and neurotransmitters. The ANS is made up of the sympathetic (SNS) and parasympathetic nervous system (PNS). The SNS is responsible for the fight or flight response, an all-or-nothing response that activates the adrenal glands to excrete adrenalin and nor adrenalin. The PNS is responsible for calmness and a relaxed state. When people recover from anxiety, the PNS is activated; however, during the gradual state of relaxation, some anxious and physical symptoms may take a while to completely go (such as dizziness, nausea and chest pain) (Steimer, 2002). Additionally, people may experience their heartbeat increase as their bodies attempt to get oxygen to muscles in preparation for fight or flight. This decreases the blood flow to the brain and other areas of the body, which may lead to difficulty concentrating. Our lungs pump extra oxygen to muscles, causing breathlessness and light-headedness (Davey, 2012). Increased heartrate and respiration can lead to perspiration. The digestive system can shut down, which can cause feelings of nausea, stomach pains and dry mouth (as we stop producing saliva). This demonstrates the intense physiological impact that anxiety can have. Therefore, during periods of anxious arousal, it is important that interventions look to target not only the challenging thought processes but appreciate the impact anxiety can have physically, and how the physical impact can influence cognitive ability.
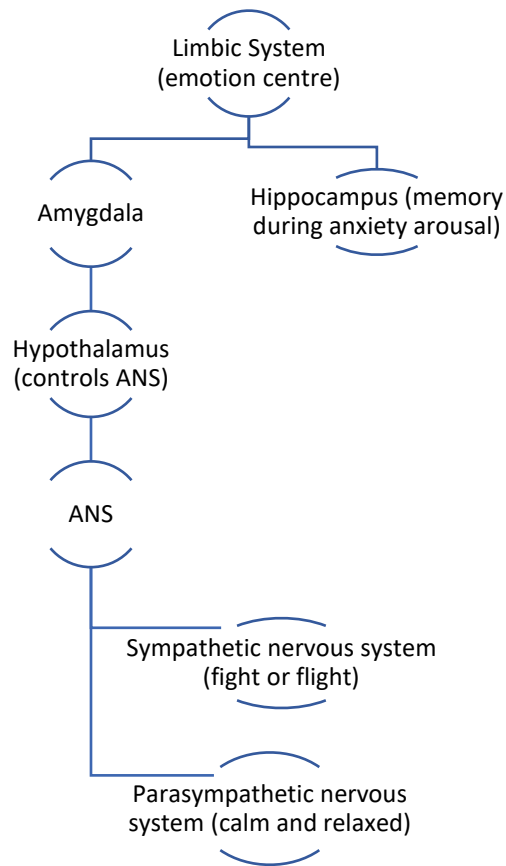
Figure 2: The nervous system

The assessment of anxiety disorders looks at the nature, duration and severity of the symptoms of anxiety. It also considers factors outlined that may have impacted the individual's development (NICE, 2014) such as:

> ➢ history of any MH disorder or chronic physical health problem;
> ➢ any past experience of, and response to, treatments;
> ➢ the quality of interpersonal relationships;
> ➢ living conditions and social isolation;
> ➢ family history of mental illness;
> ➢ history of domestic violence or sexual abuse; and
> ➢ employment and immigration status.

Much research on what works in supporting anxiety relies on participants with diagnosed anxiety disorders. Yet anxiety is often under-diagnosed (NICE, 2014).

Early life experiences play a significant role in development. However, this does not necessarily dictate our future. We continue to learn from new experiences, which impact on how we think and feel about ourselves, others and the world around us. For CYP with difficult early-life experiences, the need for systems around them to support and provide new experiences is especially important. EPs can have a positive impact on these CYP's futures, by facilitating the process of early intervention and positive change, by applying theories of learning and development, by identifying needs and by drawing on evidence-based support (Beaver, 2011).

Symptoms of specific anxiety difficulties coincide with stages of life, resulting in developmental challenges (Weems & Stickle, 2005), as shown in Figure 4:

Young Infant
- Infancy focuses on survival, thus loud noises, the unknown or unexpected and strangers may heighten anxiety. As infants develop attachments to their primary caregivers a fear of separation from their caregiver may develop but will commonly subside by age 1 or 2.

Age 6
- Children are now becoming slightly more independent and begin to acknowledge their vulnerabilities. This may result in worries about losing or separating from parents. Children may also begin to develop specific fears, such as a fear of animals or the dark.

Age 10 - 13
- Children in this age bracket are becoming more aware of their vulnerabilities and may become more anxious about personal injury, death, danger and natural disasters emerging.

Adolescence
- From adolescence fears are more focused on social comparisons. Commonly, adolescents have anxieties with regards to failure, criticism, and physical appearance.

Figure 3: Stages of development; developed from Weems and Stickle (2005, p.126)

Figure 3 demonstrates that anxieties are typical behaviours and, as highlighted by Stallard (2014), become more problematic when they continue to be persistent and limit CYP's everyday life and functioning. Further, Stallard (2014) suggests that the development of self-protective behaviours, such as 'stranger-danger' and personal injury awareness, demonstrate that some degree of anxiety can be useful and have a positive impact.

During these stages of life, we continue to develop our sense of self – influenced by our experiences, the environment and the people around us (Burr, 2003). This can impact upon personality traits, which Bachman (2015) suggests may influence vulnerability and resilience to emotional difficulties, such as anxiety and depression. Individual experiences may influence how these difficulties present in different people. For some people, these difficulties may be more apparent through externalising behaviours, such as shouting or crying; for others, these difficulties may be more internalised and less obvious for other people to notice.

Childhood anxiety is linked to school avoidance and absence (Public Health England, 2016; Van Ameringen, Mancini, & Farvolden, 2003). Adolescents are facing increasing pressures related to exams, decisions about further education and managing their self-identity (Garmy, Berg, & Clausson, 2015). Therefore, prevention, early identification and support for anxiety amongst CYP is of great importance. It is imperative to provide an accessible service for CYP, to support them to manage these pressures with healthy coping strategies. Van Ameringen, Mancini, and Farvolden (2003) used a variety of self-report questionnaires to measure the impact of anxiety on social functioning and premature school withdrawal in a sample of patients from an anxiety clinic in the United States, who provided retrospective accounts of their experiences. Their findings suggested that 48.8% of participants who had clinically diagnosed anxiety withdrew from school. Whilst the number of participants in this study was high (n=201), the retrospective self-report of their school experiences, across a wide age range of 18 – to 65-year-olds (33% male, 67% female) makes the results difficult to generalise. The study does

however, raise the concern that pupils with anxiety are more at risk of becoming emotionally-based school non-attenders; this in-turn impacts their academic development, as they miss parts or all of their educational input (West Sussex County Council EPS, 2004). This demonstrates that more school support is needed for CYP with anxiety, to enable them to continue attending school and engage academically. Interventions that support anxiety may reduce the number of CYP who are emotionally-based school non-attenders and go on to have clinically diagnosed MH conditions (Van Ameringen et al., 2003). Alongside this, it is important to continue to train staff to be able to support these young people. There is currently an array of support available for CYP with anxiety. However, access to this support can be challenging due to a lack of knowledge and understanding of the support available, as well as the necessary funding to provide accessible support.

2.1.4 What support is available for CYP with anxiety?

Support for CYP's MH is recommended through therapeutic interventions (DfE, 2018; Dunsmuir & Hardy, 2016). NICE (2014) suggests that current treatment tends to be medication-based, opposed to psychologically-based, despite their guidelines recommending evidence-based psychological interventions as a first-line of treatment. Interventions can be universal (interventions delivered to whole settings); targeted (small identified groups); or more specialised (one-to-one interventions) (Bercow, 2008; K Weare, 2015). Anxiety should firstly be supported with evidence-based therapeutic interventions, which may include self-help strategies and/or low/high intensity therapy (NICE 2014). This approach allows for effective intervention to be agreed and adapted in response to changes of need or responses to the intervention to meet individual need.

Educational settings are thought to be ideal for supporting CYP's MH as they are often the first point of contact for support, particularly in crisis situations (Anthony & McLean, 2015; Jones & Bouffard, 2012; Weare & Nind, 2011). In education settings, children with disruptive behaviours (that impact upon the rest of the learning environment) are easier to identify and, therefore, arguably receive more resources than CYP with internalised anxiety behaviours. CYP

with anxiety often exhibit less externalising (acting-out) behaviours, therefore anxiety can be under-recognised in these CYP in education settings (Fonagy, 2015). Seemingly, for quiet and compliant CYP, providing support is not an immediate priority in education settings (Vostanis, Svirydzenka, Dugard, Singh, & Dogra, 2013). As such, CYP experiencing anxiety often fail to receive targeted interventions. There is, therefore, a need for MH interventions that allow CYP to refer themselves for MH support, and that do not solely rely on adults to allocate CYP to interventions.

Vostanis et al (2013) examined MH support for CYP at school, using a survey of 599 primary-age and 137 secondary-age pupils. This revealed that interventions tend to be more reactive than preventative, that interventions often lack an evidence-base and that there are gaps in staff training and support. It is important to recognise that although the sample size is large, it focuses mainly on primary schools; therefore, it may not truly reflect secondary school settings. However, using universal targeted intervention with small groups or whole classes may assist schools in supporting CYP with both externalised and internalised anxiety, utilising a preventative approach (Stallard et al., 2014). Providing schools with interventions should also be accompanied with considerable training and support.

Bercow (2008, p.8) suggests that *"a continuum of universal, targeted and specialist services designed around the family is needed… Those services do not just happen. They have to be commissioned".* This raises the need for all encompassing support, whilst appreciating that for the support to be active, funding is needed. Fox (2011) suggests that EPs stretch beyond being scientists to being creative artists as well. Considering the current economic climate and staffing difficulties in schools (Lee & Woods, 2017), EPs need to work creatively to support schools to work flexibly with resources available, to accommodate the needs of the communities EPs work within. They can consider evidence-based and practise-based interventions that can support CYP, directly and indirectly. Parsons et al. (2013) reflect on the importance of everyday context and practitioner involvement and note that currently, many interventions lack flexibility. They suggest that intervention research must

consider the complexity of school settings. This sentiment was also echoed in a qualitative study of 50 trained CBT therapists by Ringle et al., (2015). Respecting and valuing practitioners' expertise is fundamental to successfully implementing interventions in the varied and complex settings of real-world classrooms. With schools playing a key role in early intervention of MH difficulties, there is growing focus on promoting interventions embedded in school systems, rather than clinic-based individual approaches (DoH, 2015; NICE, 2014).

Where appropriate, universal intervention may be more far reaching than one-to-one intervention, and should be used alongside targeted or specialised approaches (Weare & Nind, 2011). O'Reilly, Svirydzenka, Adams, and Dogra (2018) reviewed ten articles reporting on MH promotion in schools. They highlight four main issues in current research: lack of clarity in theoretical frameworks underpinning research; more support, training and supervision for staff implementing interventions; overcoming barriers to enable positive outcomes of interventions (e.g. challenges and confusion regarding implementation, poor communication and limited coordination of the whole-school approach); and sustainable and maintainable long-term impact. Additionally, only two out of ten of the studies in this review were conducted in the UK. O'Reilly et al. (2018) suggest that, for schools who have limited resources and funding with a high demand on teacher time (a challenge across many schools due to austerity measures), targeted interventions, opposed to universal whole-school interventions, are more manageable and sustainable.

There are many interventions that can be used to support anxiety, including medication and therapeutic interventions. Although medication can alleviate some symptoms of anxiety, the underlying cause of anxiety may remain unaddressed. Therefore, NICE (2014) recommend the first line of intervention offered should be therapeutic. CYP's anxiety can be supported with talking therapies such as counselling, mindfulness and Emotional Literacy Support Assistants (ELSA); however, the evidence-base for these interventions is not as robust, or extensive, as that of CBTA. For example, although mindfulness develops awareness of meta-cognition (e.g. being aware of inner processes

involved in thoughts and feelings), it does not support people to understand why they feel what they do and how their thoughts, feelings, sensations and behaviours are connected. Although mindfulness has been found to benefit the adult population, there is limited evidence to suggest its influence on the younger population (Weare, 2013).

It could be argued that although mindfulness has not been explored amongst CYP, strategies used in mindfulness are taught in many CBTA programmes (e.g. increasing awareness to sensations in the body). Reportedly, this supports people to feel 'anchored' and return their wandering minds when unwanted thoughts intrude, with this allowing them to explore thoughts more rationally (Weare, 2013). Other strategies include breathing exercises (controlled deep breaths), progressive muscle relaxation (tensing and relaxing muscles) and body scanning (focused attention on parts of the body). CBTA also includes psychoeducation, which supports CYP to build their understanding of the connection between thoughts, feelings, sensations and behaviours. Although it is not suggested that there is a causal relationship between CBTA and reduced anxiety, a correlation has been implied (Neil & Christensen, 2009).

Alternatively, counselling is a potential therapeutic intervention for CYP with anxiety. This opens discussions and allows people to explore how they are feeling and why. Counselling is less directive than CBT and hopes to help clients to better understand themselves and find their own solutions. In contrast, CBT is more collaborative in supporting people to understand and change thoughts and behaviour patterns. Counselling services are currently offered through schools and IAPT services; however, due to limited funding, schools are not able to offer counselling in school widely. Counselling tends to be delivered in a clinical setting, through IAPT, as opposed to schools.

Schools may also have ELSAs. ELSAs are trained by EPs to support CYP with a range of emotional needs. Whilst the evidence-base for ELSAs in primary schools is limited (but available e.g. Mann, 2014), the evidence-base for ELSA in secondary schools is not apparent (Grahamslaw, 2010). Much of the

research stems from theses, as opposed to peer reviewed articles. Therefore, it could be argued that with the wide-evidence available and the credible bodies such as NICE recommending it, CBTA are promising approaches to support CYP's anxiety, using psychoeducation as well as teaching and practising strategies.

The use of coping strategies enable changes in cognitive processes and behaviour so that external or internal demands can be better managed (Bachman, 2015). They support people to manage and reduce the negative qualities of stressful situations. However, Bachman, (2015, p.29) argues that these strategies could be considered as *'meta-motivational variables for coping with stress'*. Thus, they may be less effective for people who may not have as high a motivation to change than people who are self-actualised (Maslow, 1943). Bachman (2015) proposed two coping styles: emotion-focused, which aim to reduce the physiological and emotional reaction; and problem-focused, whereby there is an attempt to modify the problem situation to make it more manageable. Whilst the development of internalised coping strategies is important, it is equally important to develop understanding of why we behave the way we do as a result of situations we may find ourselves in. In line with Bachman (2015) and Bronfenbrenner (2005), the current intervention looks at enhancing the skills of staff, as well as teaching CYP effective strategies. As previously mentioned, many EPs use CBT; as a collaborative approach, it may reduce the onus placed on CYP, which may be overwhelming, thus reducing further anxiety. However, as recognised above, it is important there is a degree of motivation and readiness to change.

2.1.5 Readiness to change.

Weeks, Hill, and Owen (2017) found that pupils' (11- to 14-years-old) motivation to change was a key factor in ensuring the effectiveness of a CBT intervention. Whilst their study explored the effectiveness of a CBT intervention using a mixed method design (questionnaire data on anxiety levels, in addition to interview data on perceptions of the intervention), a small sample of CYP was included (n=19) and no statistically significant differences were found

between pre- and post-measures. Weeks and colleagues (2017) were, however, able to find that motivation to change was a key factor for the effectiveness of the intervention (as identified by staff involved in their study).

When making positive changes to our behaviour, such as increasing the use of coping strategies and developing more helpful cognitive processes, the transtheoretical model (Prochaska & DiClemente, 1983) suggests that there are six stages to change. The model highlights the critical need for motivational change to come from the individual themselves (see Figure 4; also Appendix D).

Termination **Precontamplative**

Maintenance **Contemplative**

Action **Preparing**
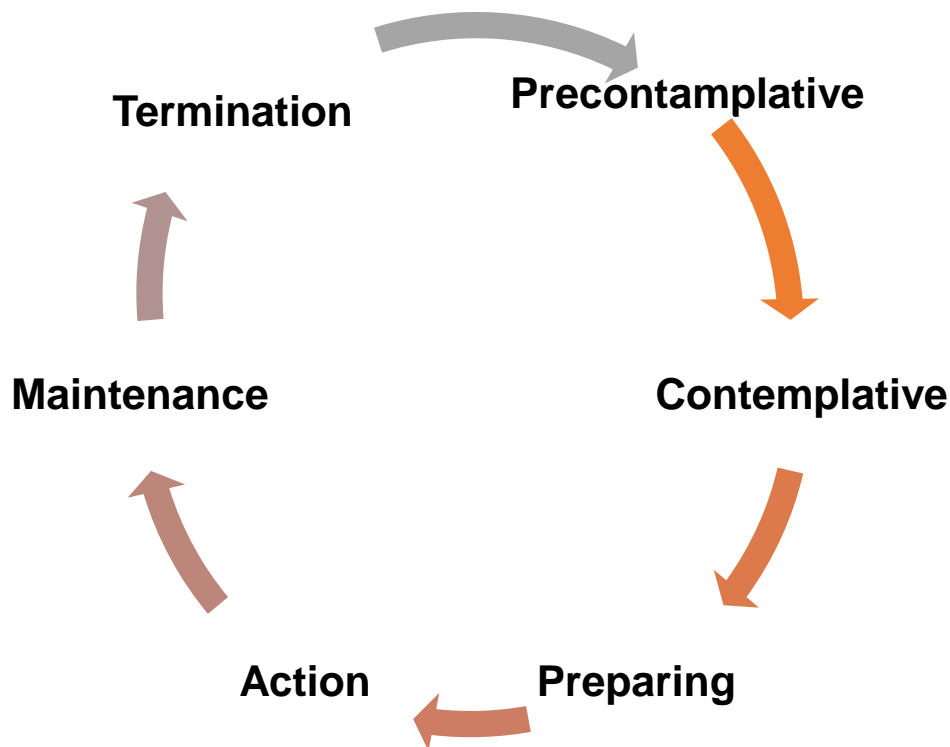
Figure 4: Stages of Change

The preparation stage is where people have acknowledged a difficulty that they have and would like to change it. Here, they are seeking out support to make behaviour changes and address unhelpful thoughts, feelings or behaviours. Prior to this stage, it appears that the motivation to change is not active. Therefore, it could be argued that CYP need to acknowledge their difficulties and be motivated to change in order to actively make changes.

Graham (2005) reports that for CBT to be successful, CYP must acknowledge their difficulties and want to change, yet often it is staff and parents who initiate the process of change, not CYP 'self-referring' (Graham, 2005; Stallard, 2009). CYP self-referring demonstrates their readiness and motivation to change, which facilitates more successful CBT interventions (Weeks et al., 2017).

The process of CBTA is collaborative and person-led; hence, engagement is fundamental. Graham (2005) and Stallard (2009) suggest motivational interviewing as a technique for assessment for CBT. However, the use of both CBTA and motivational interviewing techniques requires extensive training and support. Consequently, it may be more difficult to implement within school settings and ensure quality delivery by non-therapeutically trained professionals. Using a self-referral method for interventions may predetermine a degree of motivation to change, as the action is being taken by individuals themselves, as opposed to adults around them.

Self-Determination Theory (SDT; Deci & Ryan, 1985) is a broad framework for motivation, development and wellness. It suggests that autonomy, competence and relatedness are universally important for motivation. It proposes that the quality of motivation is more important than the quantity in predicting outcomes such as performance or MH. Whereas previous theories of motivation consider motivation a single entity, SDT differentiates different types of motivation. SDT considers both automatic motivation (intrinsic and extrinsic motivation that identify value in an activity and an integrated part of the sense of self) and controlled motivation (driven by external factors, e.g. reward/punishment). Autonomous motivation leads to more positive MH and maintained change (Deci & Ryan, 2008). Thus, it is important that CYP have autonomous motivation when taking part in an intervention and are not led or 'controlled' by external factors to improve the likelihood of sustained change. Whilst this theory focuses on the person's relationship with the activity, it is also important to consider the role of relationships within interventions.

Good relationships are key to successful work with young people (Beaver, 2011; Bombèr, 2007). Through consultation and therapeutic intervention,

practitioners can offer containment (Bion, 1962; Wagner, 2000). Containment refers to the energy and space between a consultant and the consultee by providing feelings of safety and being emotionally held. Within a therapeutic setting, considering the ecosystemic model (Bronfenbrenner, 2005), this process needs to be available for the intervention facilitator and the person receiving the intervention. For facilitators, this can be offered during supervision by trained professionals, which is a key structure enforced by psychologists' governing bodies (British Psychological Society, 2015; Health Care Professionals Council, 2015). When working with CYP, it is important to build attuned relationships by being aware and responding to them. Guiding principles of attunement include: being attentive, encouraging initiatives, receiving initiatives, developing attuned interactions, guiding and deepening discussion (Cubeddu & MacKay, 2017; for further information see Appendix E). Cubeddu and MacKay (2017) suggest that it is through this attunement that empathy is developed and thus becomes the foundation for future healthy relationships, emotional wellbeing and positive behavioural and academic achievement. It is essential that the space and relationship feels safe and child-centred (Rogers, 1995). Through these positive relationships, adults can offer CYP positive unconditional regard to develop a positive sense of self and self-worth ; not simply relying on CYP to manage difficulties independently, but receiving support from other adults too. This 'therapeutic alliance' has been defined as attachment and collaboration between therapists and their clients (Bordin, 1979; Youell & Canham, 2018). This, arguably, encourages autonomous motivation within CYP. Grencavage and Norcross's (1990) review of 50 studies on common therapeutic factors across various therapies, found that the largest commonality amongst a range of therapies was the therapeutic relationship between the therapist and client, which was cited in 56% of the studies. This suggests that the therapeutic relationship is an important factor across different therapies, such as CBTA.

2.2 Cognitive Behavioural Therapeutic Approaches (CBTA)

One approach that is particularly well researched and renowned for its use with people with anxiety is the CBT framework (Figure 6; Padesky & Greenberger, 1995). CBTA uses a collaborative approach to explore (with the person) the

connections between thoughts, feelings, behaviour and physical sensations; whilst managing the physical sensations, we are able to address other factors that impact anxiety. CBTA have wide reaching applicability (Fonagy, 2015) with a wealth of research supporting the efficacy and effectiveness of CBTA in supporting MH difficulties such as anxiety (Fonagy, 2010).

2.2.1 The development of Cognitive Behavioural Therapy.

From the 1920s to the 1950s, behaviourism was the dominant paradigm. Behaviourism is rooted in operant conditioning (Skinner, 1938), classical conditioning (Pavlov, 1927) and social learning theory (Bandura, 1977). In the 1950s, cognitivism and existential-humanistic therapy evolved from behaviourism. The approaches promoted positive, holistic change through developing supportive, genuine and empathic therapeutic relationships, which was a deviation from the psychodynamic therapy that previously dominated. Beck challenged the psychodynamic approach, which focuses on behaviour, emotion, feelings and early experiences, suggesting that "the way in which people perceived, interpreted and attributed meaning in their daily lives—a process known as cognition—was key to therapy" (Beck & Miller, 2012, p.6). At first, Beck's work was seen to conflict with the behaviourist approach; however, in the 1970s came the *"cognitive revolution"*. Beck was invited to share his work and behavioural modification techniques and cognitive therapy techniques were married together to form CBT.

The framework, known as the 'hot cross bun' (Figure 5), used in CBT was derived from Beck's (1970) cognitive therapy. Beck's framework described how individuals' perceptions of experiences (thoughts) influence behaviours, emotions and physiological reactions. He suggested that when people are distressed, these thoughts can become 'distorted or dysfunctional'. Beck proposed that identifying, evaluating and then correcting 'automatic thoughts' to more closely resemble reality can decrease distress, enable more functional behaviour and reduce physiological arousal. Beck further proposed that people's perceptions of experience are based upon their beliefs and their ways of interacting with experiences.

Thoughts

Physiological Reactions

Emotions

Behaviour
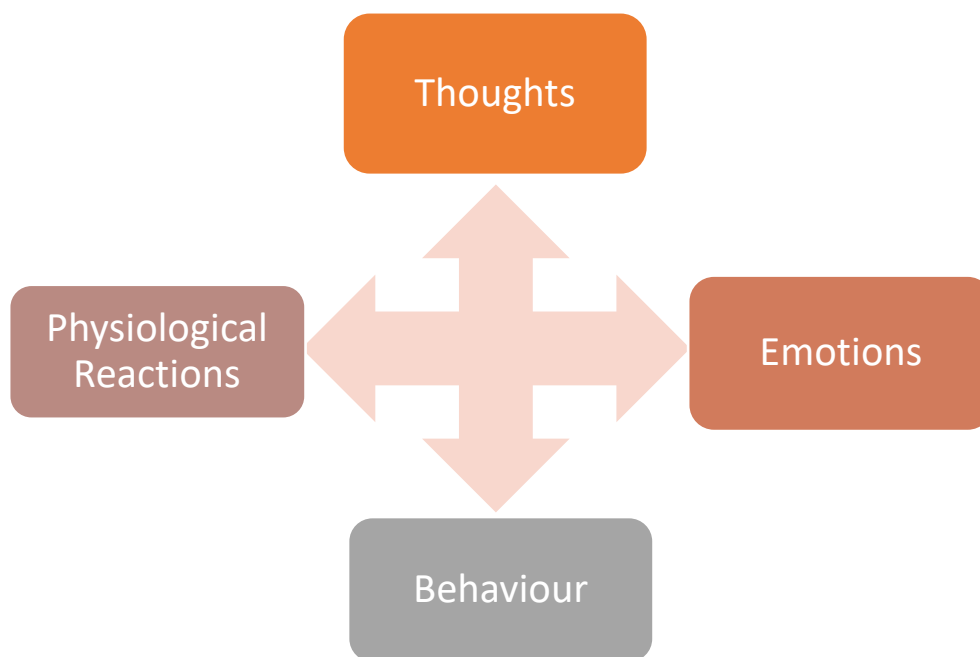
Figure 5: CBT framework - The Hot Cross Bun

CBT aims to identify and modify distorted/maladaptive beliefs associated with the internal working model (Bowlby, 1969) such as basic understanding of the self, the world and other people. Beck suggests that socratic questioning (probing questioning to encourage challenging thoughts) can help people evaluate themselves. CBT includes a range of talking therapy and teaching strategies to manage symptoms and support people in challenging and rationalising negative thoughts. This approach relies heavily on language and was originally developed for use with adults; however, it can provide beneficial insights for people with anxiety difficulties and has since been adapted to be more accessible to CYP. Nevertheless, this approach has a heavy focus on identifying deficits (Prasko et al., 2016) and therefore incorporating a more positive psychology approach alongside CBTA may strengthen the process and allow time and support to shift negative narratives to more positive narratives.

Positive Psychology (Seligman & Csikszentmihalyi, 2000) focuses on happiness, fulfilment and what makes life worth living. It explores optimal

experiences by encouraging people to be their best and do their best. Deficits and difficulties have been central in psychology for many years (Fredrickson, 2004). Positive psychology argues that human goodness and excellence are as valuable and authentic as disorder and distress. The broaden-and-build theory (Fredrickson, 2004) describes the form and function of positive emotions such as joy, interest, contentment and love. It proposed that positive emotions *broaden* people's thoughts and behaviours, for example: *'joy sparks the urge to play'*. This theory posits that positive emotions promote the discovery of a range of actions, ideas and social bonds, thus *building* a person's own resources to manage challenging situations.

Current research, albeit limited, suggests positive psychological interventions are theoretically-grounded instructions, activities, and recommendations designed to enhance well-being (Lomas, Hefferon, & Ivtzan, 2014). Waters (2011) reviewed 12 positive psychology interventions that had been systematically evaluated. They found that positive psychology interventions in schools improve well-being and academic performance. Whilst CBTA challenge negative factors, it is important to compliment these through building positive factors. Research suggests that self-compassion and kindness increase resilience to stress and anxiety (Poulin, Brown, Dillard, & Smith, 2013). This intervention draws on broaden-and-build theory, which suggests that positive emotions '(i) broaden people's attention and thinking; (ii) undo lingering negative emotional arousal; (iii) fuel psychological resilience; (iv) build consequential personal resources; (v) trigger upward spirals towards greater well-being in the future; and (vi) seed human flourishing' (Fredrickson, 2004, p.1375). Throughout the intervention, the young people are encouraged to identify strengths, gratitude and affirmations for themselves. Unlike CBTA, positive psychology has only come to the forefront of intervention for MH difficulties in recent years. There is a need for peer-reviewed empirical research in diverse populations (Bolier et al., 2013).

CBTA is an approach that uses principles outlined by CBT. CBTA are not homogenous; tools can vary and be developed according to individual needs

(Fonagy, 2015). Using CBTA facilitates the process of identifying people's thoughts and feelings of themselves, developing an approach to challenging maladaptive thoughts and beliefs, building self-esteem to support relapse and developing a bank of generalisable coping strategies (Clark & Beck, 2010; Stallard, 2009). In a systematic review of programmes available for anxiety, Neil and Christensen (2009) report that CBTA have been found to significantly reduce anxiety symptoms when delivered to CYP aged 7 to 16 years in school settings. However, they highlight that many therapists deliver CBT as it is the 'prevailing model', even though much of the time a 'loose CBT' is used, which has no fidelity with the model. Training and fidelity are critical issues for the dissemination of evidence-based practise such as CBT; therefore, further research is needed on the true fidelity of 'CBT' interventions, of which there are many (Neil & Christensen, 2009).

2.2.2 Summary of current group CBTA interventions.

CBTA-based interventions are recommended by WHO (2004) to support anxiety. Two such interventions are Skills for Academic and Social Success (Masai et al., 1999), a 12-week school-based group intervention for social anxiety disorder in adolescents, and Cool Kids (Lyneham, Abbott, Wignall, & Rapee, 2003), an eight-week CBT based intervention for 7-17 year olds, developed to target anxiety. However, the evidence-base to support their effectiveness for adolescents with anxiety is limited (Herzig-Anderson, Colognori, Fox, Stewart, & Warner, 2012). In contrast to this, the FRIENDS programme (Barrett, 2004), has received an extensive amount of research supporting its effectiveness (Barrett & Lock, 2005; Barrett, Farrell, Ollendick, & Dadds, 2006; Higgins & O'Sullivan, 2015). FRIENDS is a 10-week group-based intervention using CBTA, designed to alleviate anxiety and promote emotional resilience. However, FRIENDS was developed in Australia and the 10-week course can be challenging (pragmatically) in schools (considering the length of each half-term relative to the length of the programme). Thus, shorter term interventions using CBTA may enable schools to be able to deliver group-based early interventions within the current systemic and economic challenges.

The FRIENDS programme has been found to successfully reduce anxiety symptoms when delivered in the UK with CYP aged between 6- to 16-years-old (Neil & Christensen, 2009; Ruttledge et al., 2016; Stallard et al., 2014). It has received a wealth of research interest across the globe (Higgins & O'Sullivan, 2015). However, effect sizes (0.05–1.27) and replicability of studies seem to vary considerably. Also, the author of the intervention has extensively evaluated the programme; therefore, findings must be interpreted with caution and may represent a subjective bias (Barrett & Lock, 2005; Barrett, Farrell, Ollendick, & Dadds, 2006).

Historically, much CBT research has been drawn from quantitative measures. A recent study by Burke, Prendeville and Veale (2017) uses a mixed methodology study (combining data from the Beck Youth Anxiety Self-Report Inventory and parental semi-structured interviews) to explore the impact of FRIENDS in a sample of seven children with autism (10- to 11-years-old). Their findings suggest that FRIENDS can have a positive impact on autistic CYP. However, the findings demonstrate that significance cannot be captured on quantitative methods alone and qualitative data adds great value to research findings. Triangulation of data from the questionnaires and interviews enabled a holistic picture of the children's experiences of FRIENDS. Findings suggested that FRIENDS supports emotional expression, fosters a sense of belonging, increases confidence and positivity, reduces social isolation, supports developing friendships and enhances family communication regarding strategies to combat distress.

Yet, it should be acknowledged that the study had a small sample (n=7) so statistical analyses could not be carried out. Also, the study did not include a control group of CYP who did not receive FRIENDS, which means it is unclear whether the results were due to the intervention or maturation. Furthermore, no detail was given regarding the facilitators delivering the intervention (i.e. school staff, or other professionals), so, when trying to replicate the study accurately, it would be challenging to identify a person of the same level of relationship with the environment and professional knowledge. On the other hand, the parents' interviews provided a useful insight into the change parents

saw in the coping strategies used by their children, demonstrating the value of the programme on the development of coping strategies in autistic CYP; however, further research into the intervention's impact on typically developing CYP would be beneficial.

Green and Atkinson (2016) evaluated the impact of FRIENDS when implemented in a mainstream secondary school. Single case studies were run with five children (11- to 13-years-old). Contrary to Burke, Prendeville and Veale (2017), they used the Children Beck Youth Anxiety Self-report Inventory (Beck, 2005) and a children's questionnaire before and after the ten week intervention to evaluate the impact of the FRIENDS programme on seven CYP with an autism diagnosis (aged 10-11). The study found that the programme did not have the desired impact of reduced emotional stress and improved coping skills. However, due to the subjective nature of case study designs and the limited number of participants, the findings are difficult to generalise to pupils in mainstream secondary schools, or all pupils with an autism diagnosis more broadly. This demonstrates the need for further research into what works for whom and why.

Research suggests that CBTA interventions, such as FRIENDS (Barrett, 2004), can achieve successful results when delivered by trained school staff (O'Callaghan & Cunningham, 2015; Stallard et al., 2014). However, more research is needed to explore the effectiveness of therapeutic approaches, such as CBTA, delivered by school staff. Weeks, Hill, and Owen (2017) critique the 'good evidence' for the efficacy of CBT for anxiety, as previously many of the Randomised Control Trials (RCTs) were conducted in clinical settings. They state that the evidence for its effectiveness in 'real world' situations is only recently being examined. Additionally, Durlak, Weissberg, Dymnicki, Taylor, and Schellinger's (2011) meta-analysis of whole-school social and emotional (SEL) interventions suggested that, whilst SEL interventions have a positive impact on MH, the effect sizes at follow-up (at least six months after the intervention) were not maintained. This suggests that further examination of MH interventions and their effects over time is needed (Weeks et al., 2017). Thus, this current research aims to contribute to the growing body of

longitudinal research exploring 'real world' CBT applications (within a school and with school staff delivering the intervention).

2.3 Working with Schools

With the continuing development of government policies, which name schools as key stakeholders in CYP's MH, the professional development of staff is key (Groom, 2006). EPs are well placed to facilitate shared responsibility, training and the development of interventions. They are able to draw on their knowledge and understanding of evidence-based practices (empirically researched and evaluated), practice-based evidence (professional experiences) (Fox, 2011), schools, and child development; to enable school staff to develop their knowledge and understanding of effective ways to promote positive MH. EPs can also support those working in schools to utilise and develop effective interventions for school staff or specialists to deliver. However, some schools do not value formal training of staff (e.g. training in supporting SEN pupils), including teaching assistants, as a high priority (Blatchford, Bassett, Brown, & Webster, 2009). With more guidance promoting early intervention, staff training could be elevated in importance. EPs can therefore provide support and training for staff to effectively engage and support children with MH difficulties (Farrell et al., 2006).

Developing and promoting a whole-school approach and ethos to nurturing both MH and academic achievement is important to CYP's development. However, it is important to acknowledge that for some CYP, additional targeted intervention (for specific at-risk groups or individuals) may be required (Banerjee, 2010; Weare, 2015). Although school staff have been identified as skilled enough to deliver direct intervention, as they are able to engage CYP and differentiate tasks to meet their needs (Dunsmuir & Cobbald, 2017; Shute, 2012), good practice can be supported through supervision (e.g. the ELSA programme). More complex interventions such as CBT require direct support from psychologists. Blatchford et al. (2009) suggests that teaching assistants need more training and support to become more effective in supporting CYP, in line with a more ecosystemic approach (opposed to soley focusing on within-

person factors). Below is a discussion of how this research is informed by the literature explored above.

2.4 Identified Gaps in the Literature and a Critical View of the Key Models Underpinning the Intervention being Evaluated

In light of Government guidance (DfE, 2018; DfE & DoH, 2017; DoH, 2015) and the current challenges faced by specialist services (who are struggling to provide sufficient early intervention), it essential for EPs to work closely and creatively with schools to support CYP with anxiety and reduce the risk of them developing more complex MH problems. This research is aligned with current national agendas aiming to address the increasing prevalence of MH difficulties in CYP and provide early intervention, as it is targeted to low-level anxiety. The intervention examined in this research is an initiative from my current placement EP Service which was designed to build capacity in schools and enable staff to put in place early intervention for KS4 pupils with anxiety, within the realms of current funding difficulties.

A number of government reports on supporting MH highlight the use of early intervention and group-based cognitive interventions such as CBT (DfE, 2018; DoH, 2015; NICE, 2014; Public Health England, 2016). CBTA have an empirical evidence-base and are well recognised as an effective way of reducing anxiety-related symptoms for CYP experiencing anxiety (Fisak, Richard, & Mann, 2011; Stallard, 2009). EPs are trained in CBTA, which draws upon the principles of CBT (Rait, Monsen, & Squires, 2010). As EPs are already working within educational settings, they are well placed to support school staff in delivering CBTA to CYP in schools (Squires, 2010), as opposed to other practitioners based in clinical settings. Furthermore, the study aims to explore the longitudinal impact (two-months after the intervention) of such an intervention in 'real-life' settings (Weeks et al., 2017).

Vostanis et al., (2013) propose that many interventions are currently being used in a reactive, rather than preventative, manner. The newly developed intervention evaluated in this research aims to act as a preventative measure. Specifically, it is not being used in a reactive way (to target more complex MH

needs), but is made accessible to CYP who may not be identified or prioritised as needing support for their MH. As suggested by Graham (2005) and Stallard (2009), the intervention uses a self-referral system, which allows CYP to seek support when they are feeling ready, as well as providing a platform for pupils with more internalised behaviours to come forward and seek support. Arguably, this can lead to adolescents receiving the support they want or require before MH difficulties become more complex and challenging (as the programme focuses on within-school management of CYP's low-level anxiety). CBT is widely recommended for supporting anxiety in CYP, with much research supporting its effectiveness (Fonagy, 2014). Whilst CBT aims to improve children's ability to cope with emotions as they go about their day-to-day lives (Southam-Gerow & Kendall, 2002), Silk et al. (2018) argue that RCTs for child anxiety have focused on severity measures and little is known about the impact of CBT on daily emotional functioning. Therefore, as suggested by Weeks, Hill, and Owen (2017), qualitative research can be used to examine the impact these interventions can have on daily emotional functioning. Whilst quantitative data adds value to the body of research, as it allows investigation across large samples, qualitative data can add richness and deeper meaning to research findings. Therefore, as aforementioned, this research includes qualitative, in addition to quantitative, data.

Whilst CBTA were originally developed for use individually with adults, it has since been adapted for use with CYP and groups. With these adaptations comes more flexibility and potentially less rigor with regards to delivering CBT in its truest form. Therefore, the intervention being examined in this current research does not claim to use CBT in its truest form. Rather, it embeds principles of CBT in its use of CBTA. These adaptations allow for the further application and benefits of CBTA. Fonagy (2015) claims that group processes and peer support can facilitate better outcomes for CYP, which is supported by studies that have compared group and individual CBT interventions. However, these studies have not identified a substantial difference between the outcomes of group versus individual CBT (Liber et al., 2008; Manassis et al., 2002). Whilst the research base for CBT is vast, more research is needed examining the use of CBTA in the current climate (regarding which principles

of CBT are used, and the adaptations made is needed). Additionally, with schools playing a key role in early intervention MH support, there is growing focus on promoting interventions embedded in school systems, rather than clinic-based individual approaches (DoH, 2015; NICE, 2014).

Davidson and Scott (2009) argue that the outcomes of such interventions are influenced by the skills of the professionals delivering the intervention. Whilst respecting and valuing practitioners' expertise is fundamental to successfully implementing interventions in the varied and complex settings of real-world classrooms, it is imperative that those using CBTA are supervised by those well practised and trained in using CBTA, and that they do not claim to use CBT in its pureist form. The use of EPs to deliver therapeutic interventions (such as CBT) to support mental health needs (such as anxiety in school) is much debated (Silk et al., 2018). However, Mackay (2007) argues that EPs are well placed to deliver these interventions, given their training in delivering therapeutic interventions, close links with schools and other services, ecosystemic framing of difficulties and consideration of issues beyond the within-child medical model. Despite this, pragmatically, it can be difficult to offer due to the increasing demands on the EPS, leading to limits on EPs' time, as well as the current prevalence of MH problems (including anxiety) for CYP. Therefore, it could be argued that a more sustainable way forward is to build schools' capacities to support CYP's mental health. EPs can support schools in identifying anxiety difficulties in CYP, as well as embedding effective early intervention. With school staff highlighted as key stakeholders in CYPs' mental health, could train and support school staff to deliver such approaches; building schools' capacities to manage the increasing MH needs faced in school (e.g., anxiety).

CBTA has a heavy focus on identifying deficits (Prasko et al., 2016). Deficits have been central in psychology for many years (Fredrickson, 2004). Therefore, it could be argued that therapeutic approaches may benefit from incorporating approaches that include a strengths-based focus, such as positive psychology. Inclusion of such approaches may strengthen therapeutic

interventions, such as CBTA, to support CYP to shift negative narratives to more positive narratives.

Positive Psychology (Seligman & Csikszentmihalyi, 2000) focuses on happiness, fulfilment and what makes life worth living. It argues that human goodness and excellence are as valuable and authentic as disorder and distress. This theory posits that positive emotions promote the discovery of a range of actions, ideas and social bonds, thus building a person's own resources to manage challenging situations.

Positive Psychology has three core components (Seligman, 2002). The first is hedonic affect or positive emotion (e.g., joy, love, contentment, pleasure). The second is the state of flow and 'Engaged Life', which refers to losing self-consciousness, such as being at one with an activity (Csikszentmihalyi, 1990). Flow happens when one utilises their strengths to overcome a manageable degree of challenge within a task (Seligman, 2002). Seligman, Ernst, Gillham, Reivich and Linkins (2009) suggest that flow facilitates learning. The third component of positive psychology is 'the Meaningful Life' (Seligman et al., 2009, pp. 296) This relates to one's understanding of the meaning they give to their life pursuits.

It could be argued that the first two components (hedonic affect and flow), when isolated from the third component (meaningful life), may increase risk of self-centredness, as there is a degree of absorption in the self and a lack of recognition of others' needs (Seligman, et al, 2009). Flow and hedonic affect can be found in egocentric pursuits, but not in meaning of life. meaning of life can be developed through connections with others, or actions that transcend the self. Meaning, from a positive psychology perspective, is knowing your strengths, plus using them to belong and support beyond the self (Seligman, 2002). Therefore, the addition of Meaningful Life, could arguably add an element to positive psychology that thinks beyond the self, and therefore hopes to aid individuals to avoid self-centredness.

The positive psychology approach could be criticised for not expending enough time in acknowledging and exploring difficulties before shifting to a more positive narrative. Failing to acknowledge or explore difficulties may lead to ones' difficulties being supressed, and therefore being triggered in future events, for which they are not prepared. Using a combination of CBTA, which encourages acknowledgement of difficulties and exploration of triggers, and positive psychology, which includes more strengths focused ways of moving forward, could be a useful balance to establish positive wellbeing in CYP.

Seligman et al. (2009) have devoted 15 years to researching if well-being can be taught to CYP in schools. They examined two programmes, the Penn Resilience Program and the Strath Haven Positive Psychology Curriculum, and developed a curriculum for schools to embed positive psychology. The curriculum consists of discussions about CYP's strengths and skills, in class activities, activities for home to encourage CYP to apply positive psychology concepts at home, and a follow-up reflection journal. The curriculum was made up of approximately 20-25 sessions (80 minutes each) which was evaluated with 9th grade CYP (n=347). CYP, parents and staff completed 'standard questionnaires' (p. 300) to measure CYPs' strengths, social skills behavioural problems and enjoyment in school. These were completed by participants, pre, post and 2 years after the curriculum. The findings showed improvements in CYPs' engagement in learning, their enjoyment of school and achievements, as well as improved social skills. However, it did not improve CYPs self-report of their depression and anxiety. Never-the-less, the research demonstrates how positive psychology can make a positive difference for students and teachers in schools. Seligman and his colleagues have since trained staff in Geelong Grammar School in Australia to deliver the curriculum and are currently evaluating the impact of this curriculum at a whole school level. With an initial look at the findings, they reported positive difference to the students' and teachers' lives, demonstrating examples of pupils describing their experiences positively, such as happier home lives. Seligman and colleagues argue that the current education system focuses on wealth and accomplishment, whereas they urge more time and value to be placed on

wellbeing through the development of whole-school wellbeing curriculums with a positive psychology focus. Whilst there are significant strengths in Seligman et al.'s (2009) research (e.g., reports from teachers who did not deliver the positive psychology curriculum and were blind to whether students participated in the programme or the control classes), there was little clarity on what these 'reports' included, and how they were analysed. Furthermore, the research was conducted in America and Australia; therefore, generalisation to differing education systems cannot be fully accepted, such as that within England. Further research into such programmes in England are required. The current research study aims to examine the use of a CBTA programme that includes positive psychology (as suggested by.Bolier et al., (2013), thus not focussing solely on deficits, but aiming to shift narratives to be more positive) in secondary school settings, in a south east England LA.

The current study explores a self-referral intervention, rather than CYP being assigned to interventions by adults. Therefore, it could be argued that motivation and engagement in the intervention will be greater (Graham, 2005; Weeks et al., 2017). Additionally, the intervention aims to develop staff members' understanding of supporting CYP's MH; it could then be argued that the generalisability of skills from the intervention group to other contexts, such as the classroom, is increased. To limit and avoid subjective bias, in comparison to the evidence-based CBT interventions such as FRIENDS (Barrett, 2004), I did not develop the intervention, nor did I deliver the intervention. It also uses a mixed methodology (e.g. quantitative anxiety measure and interviews) to explore people's experiences of the intervention and inform future research and intervention implementation, adding insight into what works for whom and why.

This research examines a method of creating opportunities to foster positive MH in CYP (Hall, 2010) as well as highlighting the EP's role in promoting positive MH in schools and CYP. EPs can use their knowledge and understanding of the intervention and research findings to develop capacity in schools and broaden their opportunities for intervention. The intervention (see chapter 3.3 for further details) has potential to enable schools to support CYP

with anxiety difficulties before their needs become more complex, as it uses self-referral, so CYP can seek support when they feel that they need it. It is a group-based intervention that can support up to eight pupils per group. This research will extend the literature on CBTA interventions, as it evaluates a therapeutic intervention using CBTA for KS4 pupils experiencing low-level anxiety and, furthermore, the mixed method design incorporates the views of CYP as there is a need for CYP voice in evaluations of interventions (O'Reilly et al., 2018; Weeks et al., 2017). Considering the gaps in literature, the following research questions were developed:

2.5 Research questions

RQ1
- What are the outcomes of a therapeutic school-based group CBTA intervention on pupils immediately after the intervention and again two months later?

RQ2
- What are the pupils' experiences of the intervention, including strengths and challenges (as reported by the pupils themselves)?

RQ3
- What are the group facilitators' experiences of the intervention group, including strengths and challenges (as reported by the group facilitators themselves)?

Chapter 3: Methodology

3.1 Positionality and philosophical stance

Methodology is informed by ontology (theories about the nature of reality) and epistemology (the nature of knowledge) (Ramazanoglu & Holland, 2002). The epistemological and ontological perspective underpinning this study is contextualism. This has been outlined here to ensure the transparency, trustworthiness and reliability of the research. This research aims to examine the effectiveness of an anxiety intervention for 14- to 16-year-olds with low-level anxiety.

Braun and Clarke (2013, p.30) describe contextualism as '*a version of constructionism',* as it does not assume a single reality, but acknowledges individuals' constructions of their world: 'their truth' within different contexts. Contextualism argues that knowledge can be true in certain contexts; thus, knowledge is provisional and can change based on experience (Robson & McCartan, 2016). Whilst some argue that contextualism is *sceptical* of people's 'truths' (Dretske, 1991) – confining them to individual contexts – EPs work systemically adopting bio-ecological models inspired by the writings of Bronfenbrenner (2005) to consider individual contexts, and how they influence pupils and those supporting them. Therefore, more information is necessary on what interventions work for whom and why (Fonagy, 2015), which considers contexts. Throughout my research, I have acknowledged that whilst I aim to examine the effectiveness of the intervention, the findings are based on the experiences of the sample and their context. This study focuses on the context of a specific EP designed CBTA-based, anxiety, group intervention for KS4 pupils (aged 14-16) applied in four secondary schools in one local authority. It provides an in-depth analysis of the phenomenon studied in the LA.

Through the research, I have used quantitative measures to examine the effectiveness of the intervention. However, to provide further insight into the meaning of the quantitative data, qualitative measures have also been applied. My use of quantitative data to identify strengths, difficulties, and change in anxiety, accompanied by semi-structured interviews with pupils and group facilitators, provides a suitably flexible approach. Using mixed methods serves

to triangulate data and add depth and richness to quantitative information gathered.

Understanding the effectiveness of the intervention and looking at how it can be used more effectively in the future is central to this study. I believe that examining similarities and differences across the samples (facilitators and pupils) and schools (different contexts) included in the research adds value and develops a better understanding of what works for whom and why within the secondary school LA context for which this intervention was created. Furthermore, findings could be used to inform how the intervention can be improved in the future, as well as informing other contexts (e.g. different settings, different interventions), however, these will need further exploration. Therefore, a contextualist stance is felt most appropriate and applied throughout the study.

This is pertinent to the work of EPs, as they often engage in approaches that seek to uncover CYP's, school staff's and families' constructions of issues or world views that may impact on CYP's development (Beaver, 2011). This may be through consultations, supervisions or discussions, or in the context of research, through interviews with participants of study, analysed using thematic analysis (Braun & Clarke, 2013).

3.1.1 Role of the Educational Psychologist.

Bronfenbrenner's (2005) eco-systemic model highlights the many different social and cultural influences that can impact on CYP's development including family relationships, peers, the school environment and the cultural/historical context of the society in which they live. These are often referred to as the microsystem (immediate environment of CYP, e.g. family, peers, the school environment); the mesosystem (relationship between two or more settings, e.g. school and peers); the exosystem (an environment that does not directly involve the CYP but influences them, e.g. relationships between parents and their employment, local media, the community); the macrosystem (societal structures and values, e.g. social, cultural, religious, political); and the chronosystem (changes across time, e.g. puberty, marriage, divorce,

curriculum changes, legislative changes). Using this model, EPs can adopt a holistic approach to identify where support may be most effective.

Bronfenbrenner reviewed and developed his eco-systemic model over time. His focus shifted from how the person relates and connects with their environment (Bronfenbrenner, 1979) to proximal processes (reciprocal interactions between a person and their environment). The Process-Person-Context-Time model (PPCT; Figure 6; Bronfenbrenner, 2005) highlights the importance of the interactions between a person, their characteristics and the systems around them (Bronfenbrenner, 1994, 1995, 1999; Bronfenbrenner & Ceci, 1994; Bronfenbrenner & Morris, 1998).

Process
- Interactions in the immediate environment including form, power, content, and direction of proximal processes

Person
- Demand characteristic (biological/genetic make-up)
- Resources available to them (emotional, daily living, education)
- Force characteristics (temperament, motivation, persistence)

Context
- Context (microsystem, mesosystem, exosystem, macrosystem, chronosystem)

Time
- What is happening during the course of the specific activity being studied.

Figure 6: PPCT model

EPs guided by this framework must represent all four elements of the model. Where elements are not being adequately acknowledged or assessed in research, this should be transparent in order to uphold the integrity of the theory (Jaeger, 2016). Tudge, Mokrova, Hatfield, Rachana, and Karnik (2009) found that only four of 25 studies claiming to use Bronfenbrenner's theory used the PPCT model (as opposed to previous models), resulting in *'conceptual confusion and inadequate testing of the theory'* (p.1). The current study uses

the PPCT model through consideration of: the influence of CYP's wider environment (such as the national context); resources available and motivation; interactions between systems (such as school and EPS); and the time-context in which the study is being conducted.

Despite EPs having therapeutic skills and practicing therapeutic interventions (Beaver, 2011), 'therapy' is not always seen by schools and other professionals to be part of the EP's role. This is demonstrated through limited mention of EPs in government policies (e.g. EPs only having one mention in the aforementioned Green Paper, which referred to EPs as professionals that schools are encouraged to work closely with). Child and Adolescent Mental Health Service (CAMHS) are often considered more knowledgeable in therapeutic work than EPs (Wade, 2016). CAMHS are struggling to meet the demand for MH services and thresholds to access their services continue to rise. Further, EPs are well equipped to use, for example, Cognitive Behaviour Therapeutic Approaches (CBTA) with CYP experiencing anxiety (Squires, 2010).

Atkinson, Bragg, Squires, Wasilewski and Muscutt (2012) found that 92% of EPs use therapeutic interventions. These are used in a range of contexts, such as direct work with CYP, as part of assessments, in group work, and in systemic work (working beyond the needs of individual CYP). Atkinson and colleagues (2012) found that 63.4% of EPs reported using Cognitive Behavioural Therapy (CBT).

The current government's austerity measures, the national shortage of EPs (Islam, 2013) and the perception of EPs as '*gatekeepers*' for educational provision (Wagner, 2000), can act as barriers in enabling EPs to provide regular services, such as facilitating evidence-based therapeutic interventions for CYP with MH difficulties. The current context provides an opportunity for EPs to enhance understanding of their role in supporting CYP, families and schools to promote positive MH (Fallon, Woods, & Rooney, 2010; Farrell et al., 2006). EPs can use legislation and policy to reinforce the importance of early intervention with schools, and encourage more negotiation with regards to

preventative therapeutic work (Lee & Woods, 2017). EPs are not only able to draw upon the evidence-based research available but through their practise-based evidence (Fox, 2003); providing deeper understanding of what works and for whom (Fonagy, 2015).

3.2 Reflexivity

Reflexivity is a practice that encourages professionals 'to engage in both personal reflection and broader social critique' (Finlay, 2008, p.5). This can often be seen as the synthesis of reflection, self-awareness and critical thinking (Eby, 2000). Reflexivity is a dynamic process that involves continuous self-awareness (Finlay & Gough, 2003).

Having experienced anxiety during adolescence myself, I am passionate about providing better access to services for CYP. I believe that, had early interventions such as the one being examined in this thesis been available, it would have made a considerable difference to my MH at that time. The intervention has the potential to provide EPs with a tool to address the under-recognised anxiety in CYP. However, it is only through studying people's experiences of the intervention and examining its efficacy, that I will be able to confidently suggest the intervention to CYP I work with, where appropriate. I continue to acknowledge the critical impact of my background and experiences that may impact the interpretation of the findings. This has been addressed through peer supervision and supervision with tutors to ensure reflection, self-awareness and critical thinking throughout.

3.3 The Anxiety Intervention

My current placement uses a range of CBT interventions, including Worry Busters and Beat it with Boris, which were commissioned, developed and evaluated through the Targeted Mental Health in Schools project in 2008. This project was a government funded initiative that aimed to support pupils (5- to 13-years-old), who were experiencing, or at risk of experiencing, MH difficulties. Beat it with Boris was developed for reception to year 2 pupils (4- to 7-years-old), whilst Worry Busters was developed for year 4 to year 7 pupils (7- to 11-years-old). Year 3 pupils (7- to 8-years-old) could be offered either

intervention depending on their developmental levels. Although these interventions are yet to develop a strong public evidence-base, the practice-based evidence, in-house evaluations and theoretical underpinnings of the interventions render them promising, and they continue to be evaluated and used within schools in the local area. However, more targeted interventions for KS4 in the local area is needed. The intervention being evaluated in this thesis was developed by an EP in 2017, and was reviewed by EPs within the current LA in response to schools requesting support for KS4 pupils (14- to 16-year-olds), without SEND, who were struggling with anxiety. The intervention was developed to enable pupils to have access to support for anxiety and broaden the capacity of schools to support pupils with low-level anxiety (working within an early intervention model opposed to a reactive model). The EP who developed the intervention completed her doctoral research in 2016, entitled 'How does a group-based Autogenic Training intervention affect levels of anxiety in adolescents in mainstream schools?' (Atkins, 2016). The EP received training on CBT (whilst studying for their doctorate), as well as receiving supervision for delivering ten week CBT programmes. The EP reported that they had many years experiences in developing interventions for vulnerable groups.

This newly developed intervention draws on CBTA primarily, whilst incorporating aspects of positive psychology (such as positive affirmations and strengths finding). CBTA are extensively researched and highly recommended for supporting anxiety (Neil & Christensen, 2009; Stallard, Skryabina, et al., 2014). The intervention addresses the weaknesses of the interventions previously outlined by incorporating staff training and support (Vostanis et al., 2013) and by using self-referral, so pupils themselves opt into the intervention opposed to adults selecting pupils, demonstrating motivation to change from the pupil (Graham, 2005; Stallard, 2009). It aims to support pupils who perceive themselves as anxious and would like support. The intervention has been developed to be realistic and achievable for schools, recognising the current time and budget challenges that education services face. It is short (45-60 minutes weekly sessions for six weeks, with a two-month follow-up) and can be run in groups (six to eight pupils per group). The intervention also

appreciates that, when initially delivering CBTA, people can experience self-doubt (Squires, 2010). Thus, the intervention aims to support this through facilitator training and supervision when staff deliver the intervention for the first time (Wade, 2016).

The intervention comprises six sessions (45 minutes to an hour) and one review session two months after the final session (seven sessions in total). School staff get trained to deliver the intervention as each session is demonstrated by an EP or Assistant Psychologist. The Assistant Psychologists have completed an undergraduate Psychology degree, have experience of delivering group interventions and are supervised by the intervention developer. It was agreed that school staff would then deliver the session to their own group, within the same week. Each session has a brief introduction, a recap of previous sessions, a brief 'round robin' (to see how people's weeks have been), followed by psychoeducation and ending with the use of a strategy (see Appendix F for a summative overview of the intervention, including the outline of the intervention and an example page of the manualised programme). Throughout the psychoeducation aspect of the intervention, a range of resources, such as videos, tasks sheets and discussions are included. The use of psychoeducation and exercises aim to encourage pupils to reflect, recognise and self-manage their emotional states.

The intervention seeks to empower pupils by supporting them to understand and manage their anxiety, with psychoeducation alongside teaching and practising strategies (for more detail on the intervention and individual sessions see Appendix F). O'Reilly, Svirydzenka, Adams and Dogra (2018) suggest that skill development, such as teaching strategies, to promote wellbeing can have preventative effects. From working in this way, EPs can indirectly support many more students than they could through direct involvement. Furthermore, the strategies are based upon mindfulness techniques such as deep breathing and body scans, which have been found to support more rational thinking and feelings of being 'anchored' (Weare, 2013).

Weare and Nind (2011) suggest that programmes that are high-quality and successfully delivered should include: (1) a sound theoretical base with specific, well-defined goals that are communicated effectively; (2) a focus on desired outcomes; (3) explicit guidelines and thorough training, which is quality assured; and (4) have complete and accurate implementation. An explanation of how this intervention aims to meet these criteria is outlined below.

(1) *A sound theoretical base with specific, well defined goals that are communicated effectively*: The intervention uses CBTA, which is an evidence-based theoretical approach (Neil & Christensen, 2009). Furthermore, it incorporates evidence-based strategies such as mindfulness (Weare, 2013) and positive psychology approaches (Bolier et al., 2013). It aims to teach pupils strategies to support them to alleviate anxiety.

(2) *A focus on desired outcomes*: The outcomes of the intervention are outlined in the introduction and include: supporting pupils to understand their feelings of anxiety better; increase their resilience to challenging situations; and developing a range of coping strategies.

(3) *Explicit guidelines and thorough training, which is quality assured*: Each session is demonstrated by the EPS and observed by school staff. After this, the school staff deliver the intervention to their own group week by week. Before or after each EPS session, there is time for supervision and interim feedback for school facilitators. Joint problem-solving takes place, if necessary.

(4) *Have complete and accurate implementation:* Fidelity of implementation is monitored and supported through ongoing supervision and demonstration by the EPS.

3.4 Design and procedure

Ethical approval was obtained through the Department of Psychology and Human Development at UCL Institute of Education. Once ethical approval was obtained, the EPS contacted schools thought to potentially benefit from the intervention. When schools confirmed their interest, a meeting with the Special

Educational Needs Co-ordinator (SENCO), the senior EP and the author of the intervention was arranged to plan the intervention with the school. In this meeting, matters discussed included: the intervention itself, how to advertise the intervention, protected space for the intervention and intervention timings. Additionally, the senior EP and author of the intervention discussed this research and gauged schools' interest. This included discussing the use of a control group and how the school would potentially need to agree to deliver the intervention to the control group after the experimental groups' final session. Schools were then contacted by the researcher and information sheets and consent forms were distributed (see Appendix G).

Whilst the school advertised the intervention through posters (Appendix H) and discussions in tutor time, the assistant psychologists met with members of staff delivering the intervention, to talk through the intervention and the process of training and supervision, along with obtaining consent for research participation (Appendix I).

Once pupils signed up for the intervention and consent was obtained by parents via the school (see Appendix J), the pupils were split into three groups:

- a control group (to determine if any effects of the intervention were due to extraneous variable such as context and maturity, or whether they were directly related to the intervention);
- one of two experimental groups (the group ran by the EPS and the group ran by the staff member).

At this point, schools found agreeing to the use of control groups difficult. This was due to the timing of the research, which began in January 2018, leaving two school terms for recruitment and intervention delivery. Some of the pupils would also be leaving the school, as they were in KS4 (i.e. transitioning to post-16 provisions). Schools also raised concerns as to the long wait over the summer holidays and whether they could guarantee that the intervention would be available in the new academic year, due to staffing and pupil availability. Therefore, the control group was not obtained for the purpose of this research, leaving two experimental groups per school.

Groups were run by the EP who developed the intervention, as well as assistant psychologists who were trained and supervised by the EP to run the groups. Figure 7 depicts how the EP initially demonstrated the group to an assistant psychologist and a school group facilitator. The school group facilitator then ran the session with their own group. The assistant psychologist then demonstrated the group to a second assistant and a group facilitator from another school. The group facilitator then ran a parallel group, running the session demonstrated that week by the EPS. For example, session one was demonstrated by the EPS to a member of staff and, that same week, the school facilitator would run the same session. The following week, the EPS facilitator and school facilitator would meet and discuss sessions and any problems. The EPS facilitator then demonstrated session two, and so on, in a process that continued for the remainder of the sessions.
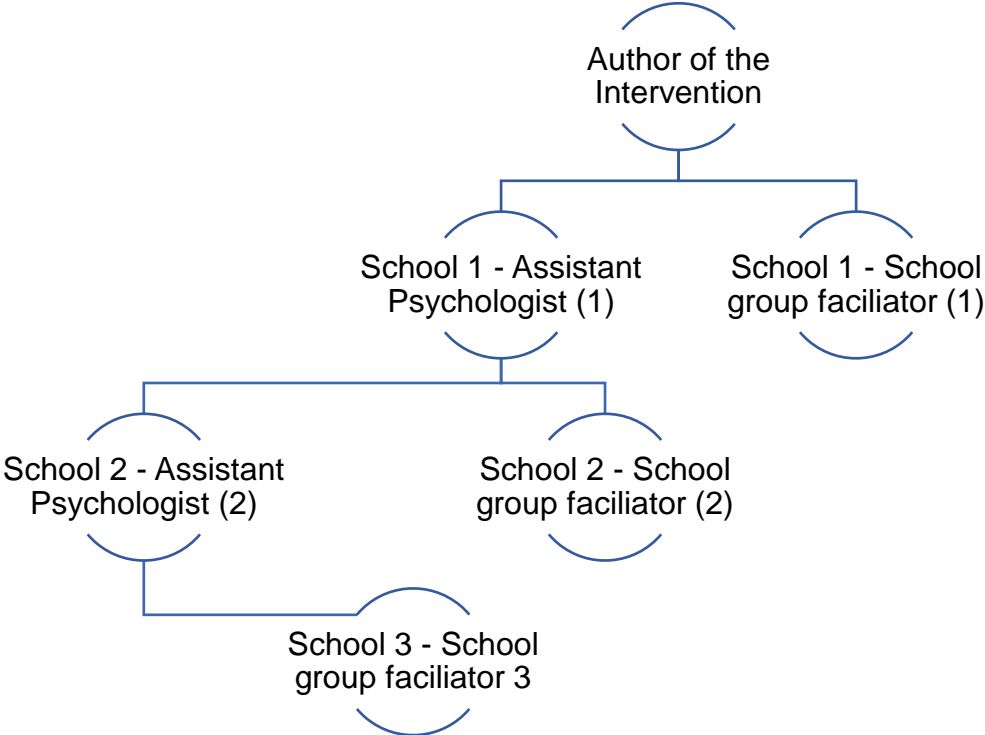
Figure 7: A representation of how staff were trained to deliver the intervention in this research

At the beginning of the groups, the group facilitator explained the research and then offered pupils the consent and information sheet (Appendix K).

As the Revised Children's Anxiety and Depression Scale (RCADS; Appendix L), described in detail below, was included to measure the impact of the intervention within the intervention guidelines, all pupils completed the RCADS before and after the intervention. However, only the pupils and parents who consented to take part in the research shared their RCADS scores with the researcher. The measures were also completed two months after the final session, to investigate any longer-term impact of the intervention. Semi-structured interviews (Appendix M; and described in detail below) were then conducted after the two-month review. A timeline for the research is included in Appendix N.

3.4.1 Research Design

A mixed methods design was used. Specifically, it was a two-phase, sequential project, with between-subjects measures and within-subject measures (see Figure 8). Specifically, there were both quantitative (numerical) and qualitative (non-numerical) measures, which were compared before and after the intervention (within subjects). Two groups of participants were involved: pupils and facilitators (between-subjects). The quantitative measures were collected first, followed by the qualitative measures. Creswell (2009) reports that research with people can be complex; therefore, using only quantitative or qualitative methods may not be adequate. Thus, using a mixed method design enabled an approach of inquiry that allowed me to improve the overall strength of my data and findings. Furthermore O'Reilly, Svirydzenka, Adams, and Dogra (2018) claim the 'crucial challenge' of universal and targeted interventions is to consistently and effectively engage CYP in the development and delivery of intervention. Therefore, interviews with pupils to explore their experiences of the intervention aimed to add additional value to the findings.

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                    │   Mixed Methods Design  │
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                   ┌───────────┴────────────┐
        ┌──────────────────┐      ┌──────────────────┐
        │                  │      │                  │
        │ Phase 1:         │      │ Phase 2:         │
        │ Quantitative     │      │ Qualitatative    │
        │ (RQ1)            │      │ (RQ2 & RQ3)      │
        └──────────────────┘      └──────────────────┘
             │                         │
        ┌──────────────────┐      ┌──────────────────┐
        │ Measure: Revised │      │ Measure: Semi-   │
        │ Childrens Anxiety│      │ structured       │
        │ and Depression   │      │ interviews with  │
        │ Scale (RCADS)    │      │ pupils and group │
        │                  │      │ facilitators.    │
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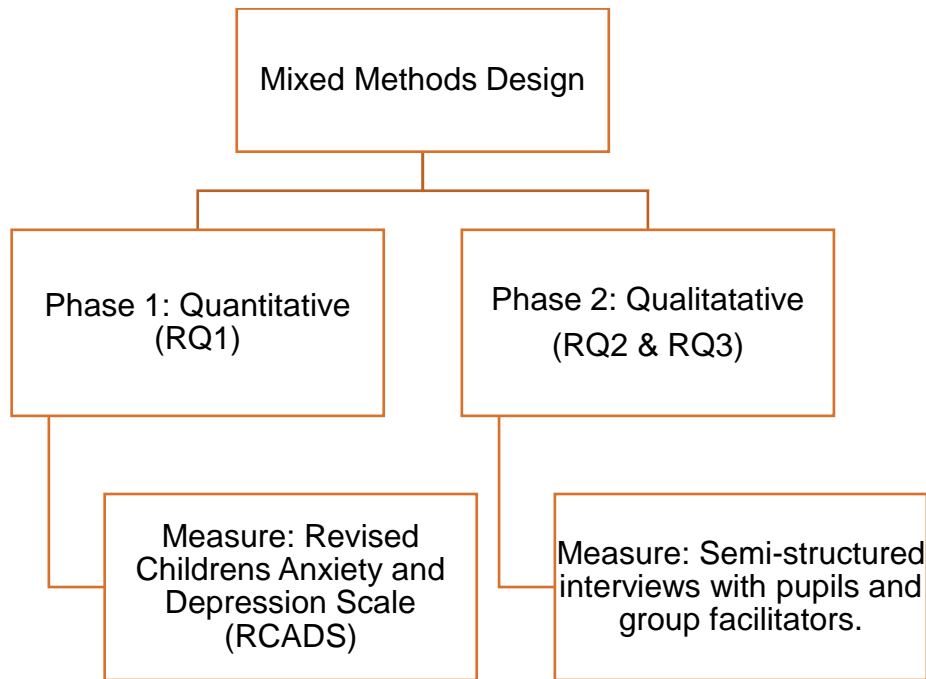
Figure 8: A diagram to show how the mixed methods design was employed in relation to the research questions

3.5 Participants

3.5.1 Recruitment.

An opportunistic sample (seeking those interested in the intervention and taking part in the research) was obtained. As the intervention has not previously been evaluated, a general overview of the effect of the intervention on anxiety and coping strategies was undertaken. Thus, the research sample included pupils who self-referred and subsequently experienced the intervention. To advertise the intervention, a poster was developed by the author of the intervention (Appendix H). The author also suggested that the group was advertised through tutor time, assemblies and discussions between tutors and pupils. Due to the range and extent of recruitment, it is not possible to determine a 'response rate' as such.

Initially, EPs put forward schools they felt would benefit from the intervention. Schools, parents and the pupils were then contacted (as mentioned in Chapter 3.4).

Whilst there were no significant difficulties in recruitment for the intervention reported by schools, obtaining consent for participation in the research was

challenging. I was unable to obtain consent for all pupils who signed up for the intervention, due to difficulties contacting staff who had left schools and the EPS after initially setting up the groups. Therefore, I cannot report if the sample size is representative of the total number of participants in the intervention.

3.5.2 Sample size.

Based on the original design, which included a control group, power analysis using G*Power recommended a sample of 44 participants to obtain a small effect size (0.25) and a power level of 80% for a 2 (group: pupils and facilitator) x 3 (time: pre-intervention, post-intervention and two months after the intervention) mixed design analysis of variance (ANOVA). Ishikawa, Okajima, Matsuoka, and Sakano, (2007) conducted a meta-analysis of 20 RCTs exploring the use of CBT with CYP between the ages of 6- to 17-years-old. They found that the effect size of a CBT intervention group, compared to a control group, was $d=0.61$. However, the average number of sessions for the interventions included in this meta-analysis was 13.5. Consequently, as the intervention being examined in the current study comprises just seven sessions, a small effect size was used to estimate sample size. In addition to this, Fernandez, Salem, Swift, and Ramtahal's (2015) meta-analysis of adult and adolescent attrition from CBT found, on average, 15.9% participant attrition pre-treatment and 26.2% during treatment. This indicates a 42.1% attrition rate. At a 42.1% attrition rate, the ideal sample size would equate to 63 participants. As I had a limited amount of time to conduct the study, I aimed to recruit 90 participants (to allow for any additional attrition). Additionally, I aimed to conduct 12 interviews, six with adolescents and six with intervention facilitators, to gain a broad understanding within the time limitations of the research.

As aforementioned, the control group was unobtainable in the timing of this research. Moreover, although six schools were originally due to take part (as agreed by the LA), due to the pragmatics of running the groups and training staff, only five schools finalised plans to host the intervention, one of which was unable to obtain any consent forms from parents. Furthermore, obtaining consent for pupils from parents across all schools became very challenging

(as discussed further in Chapter 5). Despite schools sending out numerous consent forms, calling parents, and forwarding an email containing a link to an electronic consent form, the overall sample size obtained for the purpose of the research was 16 pupils and eight group facilitators. Whilst below the target initially set, it still provides a fair sample size for an initial examination of the intervention.

3.5.3 Description of sample.

The school context

Aligned with my contextualist stance in this research, it is important to reflect on the context that the research took place in. Four schools took part in the research, including a mainstream boys' secondary school, an all-through free school, and two mixed mainstream secondary schools. Schools were all from a South East England Local Authority. This area is made up of both urban and rural areas. The socioeconomic status of the school areas varied from affluent to socially deprived. In mid-2017, the population was estimated at 66 million people with 86% of those being 'UK-born' (Office for National Statistics, 2019). A summary of the school demographics are reported in Table 1.

Table 1: School demographics

School	1	2	3	4
Grade 5 or above in English & maths GCSEs (2018)	27%	33%	50%	48%
Ofsted rating	Requires improvement - 2017	Good - 2017	Good - 2017	Good - 2018
Total number of pupils on roll (all ages)	Approximately 600	Approximately 850	Approximately 700	Approximately 1000
Pupils with a statement of special educational needs (SEN) or education, health and care (EHC) plan (national average = 4.4%)	Approximately 2%	Approximately 1%	Approximately 4%	Approximately 2%
Pupils with SEN support (national average (NA) = 10.4%)	Below NA	Below NA	Above NA	Below NA
Boys on roll	Approximately 100%	Approximately 51%	Approximately 56%	Approximately 49%
Girls on roll	Approximately 0%	4 Approximately 49%	Approximately 44%	Approximately 51%
Pupils whose first language is not English	Approximately 8%	Approximately 2%	Approximately 1%	Approximately 5%
Pupils eligible for free school meals at any time during the past 6 years (national average = 28.6%)	Approximately 39%	Approximately 13%	Approximately 19%	Approximately 13%

Participant sample

For phase one, 16 adolescents between the ages of 14 to 16 years (mean = 14 years) took part in the research. Although the intervention was designed for KS4 pupils, two pupils (who signed up and whose schools felt they would benefit from the intervention) were in year 9 (ages 13 to 14 years). However, both pupils were within the 14 to 16 years age range. In total, two pupils were in year 9, 12 were in year 10 and two were in year 11.

Data was collected from school-facilitated (n=6) and EPS-facilitated groups (n=10) to see if the outcomes of the intervention were affected in anyway. The sample comprised eight boys and eight girls. One of the pupils had a formal

diagnosis of an autism spectrum condition, however no other pupils reported a SEND. Table 2 outlines how this sample is represented across the four participating schools in terms of the number of pupils, which professional ran the group, the average age of pupils and their genders.

The school facilitators included a pupil premium lead, a SENCO, a MH first aider, teaching assistants and a pastoral support worker. Unfortunately, the facilitator from school two unexpectedly left the school, so I was unable to interview them. The EPS facilitators included the EP who wrote and ran the intervention and two assistant EPs who ran the groups.

Table 2: Pupil representation per school in the research

School	Number of pupils (EPS facilitated group)	Number of pupils (school facilitated group)	Average age	% of females	% of males
1	1	3	14.5	0	100
2	2	0	14	50	50
3	3	2	15.2	40	60
4	5	0	14.6	100	0
Overall	**11**	**5**	**15**	**50**	**50**

For phase two, interview data were collected from eight intervention facilitators (7 females and 1 male) and seven pupils (6 males and 1 female) across the

four participating schools (see Figure 9). Interviews explored their perceptions of the intervention.
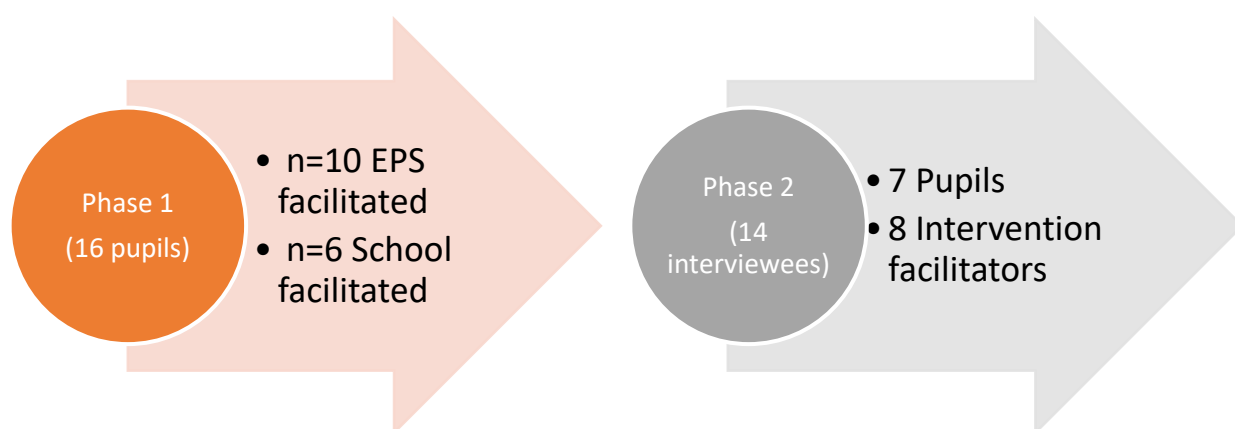
Figure 9: Numbers of participants in each phase of the study.

Originally, the selection process for adolescents' interviews was: two adolescents for whom the intervention led to the most change; two adolescents for whom the intervention led to moderate changes; and two adolescents for whom the intervention led to little/no change in anxiety levels, according to the RCADS. This would provide the representation of a broad range of experiences in the research: gaining a greater variety of responses to what the pupils found helpful, as well as any barriers to the intervention. However, due to the limited sample size and difficulties with obtaining consent, a more opportunistic sample was gathered.

3.6 Assessment tools

3.6.1 Phase 1 - Revised Children's Anxiety and Depression Scale (RCADS).

Current assessment of anxiety disorders relies on CYP being asked questions from a structured interview schedule, such as the Anxiety Disorders Interview Schedule for children and parents (Silverman & Albano, 1996), which follows DSM-5 criteria (American Psychiatric Association, 2013). The Revised Children's Anxiety and Depression Scale (RCADS; Chorpita, Yim, Moffitt, Umemoto, & Francis, 2000) and the Spence Children's Anxiety Scale (Spence,

1998) are quantitative measures that contain scales that broadly align with diagnostic DSM-5 categories .

Child Outcomes Research Consortium (CORC) is an organisation that evaluates CYP's care whilst assessing the effectiveness and efficacy of services to answer key research questions. CORC (2017) recommends the RCADS based on its reliability, test-retest reliability, concurrent validity and discriminant validity. Whilst the RCADS has been extensively used with adolescent samples, it could be argued that the RCADS (and other self-report measures) are 'language heavy', which may be challenging for CYP with speech and language difficulties. When examining the prevalence of MH difficulties such as anxiety, researchers could benefit from using semi-structured interviews flexibly with visuals and prompts, in addition to quantitative scales. This would allow researchers to engage people with different needs and explore any difficulties that may arise. Therefore, this research adopts a mixed method design.

The RCADS (Appendix L) is a 47 item self-report questionnaire, scored on a four-point Likert scale (0=never, 1=sometimes, 2=often, 3=always), used to measure various anxieties (including separation anxiety disorder, social phobia, generalised anxiety disorder, panic disorder, obsessive compulsive disorder and major depressive disorder). It can be used with CYP between the ages of 8-18 years. The RCADS can be scored using a spreadsheet available from the developer. The CYP's equivalent American school grade is inputted and scores are converted to t-scores (a type of standardised score, which allows comparison with similar groups e.g. pupils of the same age/gender). Alternatively, measures can be scored using the manual. A t-score of 65 means that the score is around the top 7% of scores of non-clinical populations of young people of the same age and gender (described as 'borderline clinical'). A t-score of 70 means that the score is around the top 2% of scores of non-clinical populations of young people of the same age and gender (described as 'clinical threshold'). The 'clinical thresholds' for the overall score were established using the anxiety disorders interview schedule for DSM-IV

(the DSM available at the time the measure was developed). The thresholds for sub-scales are set using normative data.

Mathyssek et al., (2013) explored the efficacy of using the RCADS to measure anxiety across adolescence (10 to 16 years) with a substantial sample (n=2226). Data were collected at three time points: 2001–2002 (age range 10–12); 2003–2004 (age range 12–15); and 2005–2007 (age range 14–18). Mathyssek et al. (2013) found the multiple factors encompassed in the RCADS (e.g. social phobia, generalised anxiety disorder) include the range of anxieties presented through adolescence and therefore suggested that the instrument is reliable and valid to assess anxiety levels across adolescence, within longitudinal research. Thus, the RCADS, which is the impact measure chosen by the EP who wrote the intervention and embedded it into the intervention, was felt appropriate to measure anxiety levels of the adolescents (before, after and at two months post-intervention).

In this research, the overall anxiety score was taken from the RCADS reports, as some schools submitted completed RCADS analyses with the anxiety and depression t-scores. Unfortunately, this meant that I was unable to breakdown the anxiety scores, as the subsections of the RCADS were not available. However, as the research is focusing on general anxiety and not specific anxiety difficulties, the available scores were effective in demonstrating any changes across general anxiety in the sample.

3.6.2 Phase 2 - Semi-structured interview schedule.

Semi-structured interviews allow for flexibility, in-depth information to be explored and interviewees' responses to be expanded (Rubin & Rubin, 2005). Semi-structured interviews are powerful as they provide an opportunity to elicit narrative data that can be investigated in detail and explore the 'negotiation and construction of meaning in a natural setting' (Kvale, 2003). It allows participants to use their own voices and language to express their thoughts and feelings to give a holistic picture of their experience. However, as interview data are rich, it can be very time-consuming to transcribe and analyse (Dörnyei, 2007). Therefore, for pragmatic reasons, the sample size selected

for interviews was limited to 15. Nevertheless, the interview data enabled a comprehensive picture with regards to the pupils' and facilitators' experiences of the intervention. Through careful diarising, this was found to be manageable.

Robson (2011) suggests that research should be piloted to test for difficulties which can be revised before formal data collection. The interview schedules (Appendix M) were piloted on staff in the LA and peers. They were adjusted accordingly to ensure the research questions were being addressed: revisions included reordering questions (where more introductory questions about participants involvement in the intervention were asked at the beginning and then exploring the outcome of the intervention), the addition of questions such as 'how did you become involved in the intervention?' and clarifying terms that were asked following the introductory questions.

The adaptations, in-line with interview structure (introductory questions, key questions, ending questions) suggested by Krueger (1997), allowed for interview flow, and more fruitful discussions. The interviews began with introductory questions to build rapport with the participants and allowed them to feel settled with the interviewing and audio recording process. This was followed by key questions, which included open-ended questions and scaled questions (e.g. on a scale of 1–10) to elicit participants' understanding of terms and their experiences of the intervention in a flexible manner. Questions were triangulated between EPS facilitators, school facilitators and pupils to explore the same areas, but allow for more appropriate questioning according to their roles (i.e. asking pupils how they felt the intervention supported them and asking facilitators how they felt the intervention supported pupils). The interviews ended with a question that allowed participants to share any additional thoughts.

3.7 Analysis

Data were analysed using quantitative descriptive analysis and qualitative thematic analysis (see Figure 10). Ideally, statistical analysis using a 2x3 mixed ANOVA would be used, but due to the limited sample size statistical analysis was not possible. Nevertheless, the quantitative data obtained from

the RCADS provided an initial understanding of the effects of the intervention on pupils and of any changes in their anxiety levels. Additionally, a box and whisker graph was used to visually display the distribution of scores across each time point. The RCADS score distributions are based on the lowest score, first quartile (middle number between the smallest and the median score), median (the middle value), third quartile (the middle score between the median and highest score) and highest score.
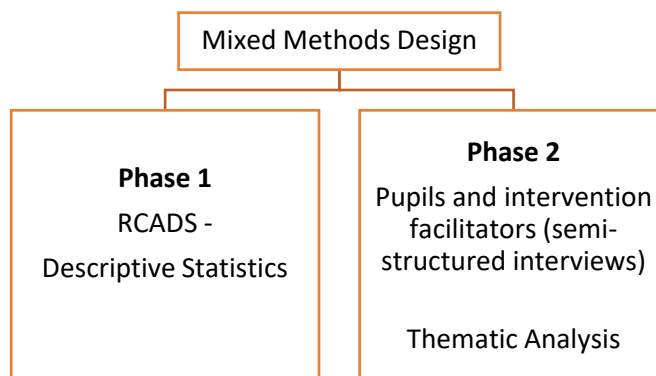
Figure 10: Analysis of data

The qualitative data obtained from the semi-structured interviews was analysed using Braun and Clarke's (2006; 2013) framework of thematic analysis. An overview of its application is detailed in Table 3, as suggested by Nowell, Norris, White, and Moules (2017) to ensure that the research is trustworthy.

Table 3: Braun and Clarke's seven stages of Thematic Analysis (Braun & Clarke, 2013, p.202–203) with an overview of its application within the current research.

Stages	Thematic Analysis	Description	Application in current research
1	Transcription	Turning audio into written text (or transcripts) by writing down what was said and how it was said, so the data could be systematically coded and analysed.	All transcripts were transcribed by the researcher.

2	Reading and Familiarisation	Reading and re-reading the data to become intimately familiar with the content (i.e., immersion); noticing things of interest that might be relevant to the research questions.	All transcripts were read a minimum of three times. Initial thoughts were noted and transcripts were checked for accuracy.
3	Coding (Selective and complete)	Identifying aspects of the data that relate to the research questions; can involve *selective coding* where only material of interest is coded or *complete coding* where the entire dataset is coded.	Complete coding was used to ensure a breadth of understanding. Codes were discussed with colleagues and peer reviewed (see Appendix M)
4	Searching for Themes	Identifying salient features that capture something important about the data in relation to the research questions; may represent some level of patterned response or meaning within the dataset.	Themes were identified by capturing patterns of responses and the most salient points. Diagrams were created to make sense of connections
5	Reviewing themes	Determining whether candidate themes fit well with the coded data; themes should tell a story (not necessarily *the story)* that "rings true" with the data, essentially represents quality control in relation to the analysis.	Transcripts were peer reviewed by a colleague experienced in using thematic analysis. Codes elicited from the peer review matched that of my own. Themes were also reviewed in supervision with experienced researchers.
6	Defining and naming themes	Defining themes by stating what is unique and specific about each one; useful because it forces researchers to define the focus and boundaries of the themes by distilling to a few short	A table of themes with definitions was produced (Appendix T and U). These were reviewed by supervisors and peers to fine tune the meaning and focus of each theme.

		sentences what each theme is about.	
7	Writing the report	Writing the report by selecting compelling, vivid examples of data extracts, and relating them back to the research question and literature.	Themes were written up, including quotes from interviewees to demonstrate the patterns elicited from interviews. Throughout this process I referred to the context of quotes to ensure accurate meaning was elicited.

The interviews were audio recorded and transcribed by the researcher. When analysing data, a deductive approach allows one to explore pre-determined theories (accepting or rejecting existing theories). However, this limits creativity and exploration of information. An inductive approach allows one to form meaning from data, moving from specific observations to broader categories. Nonetheless, this does not follow pre-determined theories, so it could be argued that this approach leaves the findings vulnerable to researcher bias. Both approaches play an important role in research and work well in combination alongside this mixed methods design. Therefore, an inductive approach was used to structure the analysis, ensuring breadth in the knowledge obtained from interviews and ensure all voices were heard, regardless of the amount of people who shared an opinion. I do, however, acknowledge that my research questions guided the questions in my interview schedule. Therefore, a flexible approach, using both inductive and deductive approaches was applied. I looked through all data and selected all codes, before generating themes, using NVivo as suggested by Creswell and Plano Clark (2018). All themes were recorded in a thematic map. One transcript was shared with a colleague to peer-review codes (Appendix O). Much of the codes were agreed, however differences were discussed and mutually agreed upon. Following the peer-reviewed coding, codes were made more descriptive and specific (e.g. 'coping strategies helped' changed to 'coping strategies help to identify feelings'). Themes were also reviewed with peers and supervisors, again adding more specificity and clarity to themes (e.g. 'developing

knowledge and application of self-regulation skills' changed to 'Pupils developing knowledge and effective application of self-regulation skills'). Examples of the themes, codes and quotes are also included (see Appendix P & Q).

Although I strived to remain neutral, as highlighted by Burr (2003), researchers are unable to view the world entirely objectively as they will be influenced by their own experiences. Although the thematic analysis model shows transparency in the process of interpreting data, the results continue to be vulnerable to my subjective view and researcher bias. Data analysis is subject to my interaction with the data collected and may influence the knowledge identified within the research process. To provide more transparency in my experiences and views, my philosophical stance and reflexivity were shared in Chapter 3.1. I also used supervision to continually reflect on the research process and ensure a good degree of objectivity. To limit subjectivity, codes and themes were checked by peers (Appendix O). An example of codes and quotes for each theme is in Appendix N.

3.8 Trustworthiness

Creswell (2014) suggests that a mixed method approach can be used to: collect and rigorously analyse quantitative and qualitative data in response to research questions; integrate the forms of data and results; organise the procedures into logical research designs; and frame the procedures within theory and philosophy. The reliability of quantitative research refers to the study's replicability, with regards to precision and accuracy (Creswell, 2014). Quantitative validity (also known as construct validity) ensures there are meaningful indicators of the construct being measured, so data are consistent and stable over time (Creswell & Plano Clark, 2018). To establish reliability and validity, researchers must reduce threats of internal validity (the extent to which cause and effect claims can be made) and external validity (generalisability) (Creswell & Plano Clark, 2018).

In contrast, qualitative research rejects the notion of validity and reliability in favour of trustworthiness and transparency; in which the process of analysis

and interpretation are outlined explicitly (Creswell & Plano Clark, 2018; Robson, 2011; Robson & McCartan, 2016).

According to Creswell and Plano Clark (2018), validity in mixed methods research is defined by the employment of strategies to overcome any threats to the accurate interpretation and analysis of data. Yardley (2000, 2017) proposes four criteria to demonstrate quality in qualitative research: sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance.

Creswell and Plano Clark (2018) recommend that mixed method research uses at least three of the following strategies: member checking; triangulation of data (demonstrating construct validity); disconfirming evidence (including more than solely positive information) and asking others to examine the data. In the current research, triangulation of data, disconfirming evidence and peer review were undertaken. However, member checking, which involves checking interpretations with participants after the analysis, was not carried out. This was because I had no control over extraneous variables, such as changes in school context over time, so I could not be certain of the reasons for any changes or shifts in their narratives.

Whilst strategies suggested by Creswell and Plano Clark (2018) can be found in Appendix R, strategies adopted to ensure trustworthiness and reliability, as well as actions taken to reduce threats to validity, are detailed below:

Table 4: Trustworthiness, reliability and validity of research

Actions to address trustworthiness of research	Details
External review	• External review and feedback during interim research exam. • Approval from UCL Data Protection Team and the UCL IOE Department of Psychology and Human Development ethics process.
Acknowledging limitations	• Limitations of research have been acknowledged, such as difficulties with recruitment.
Internal review	• Data analyses were reviewed by supervisors, including both quantitative and qualitative data.

Sensitivity to context	• Articles from the literature review reported relevant socio-cultural factors and theory.
Commitment and rigor	• I was deeply engaged with the topic as highlighted in the reflexivity, and aimed to give depth to understanding through critical analysis.
Impact and importance	• The research uses a mixed method design to enrich understanding of the intervention and its future use.
Transparency and coherence	• Methodology, data and analysis was reported clearly with visuals. • Clear reporting of philosophical stance and reflexivity was included in the thesis.
Clarity of participant recruitment	• Information was provided regarding selection criteria and the recruitment process in this thesis. • Salient information about participants involved and their representation of the target population.
Peer review	• Codes and themes were peer-reviewed with colleagues from the DEdPsy and supervisors experienced with research.
Supervision sessions	• Regular supervision was used to reflect on the process and to discuss alternative approaches and relevant theory as well as exploration of potential researcher bias. • Regular supervision with peer working groups was employed throughout the research.
Disconfirming evidence	• Results were interpreted critically to avoid over generalisation and aimed to explore what works for whom and why, with the inclusion of disconfirming evidence.
Evidence using quotes	• Quotes and examples used to evidence interpretations from data are included in Appendix P and Q.
Actions to address validity of research	**Details**
Transparency around researcher's philosophical stance and reflexivity.	• Information was provided about the researcher's own beliefs, values, experiences and motivations for carrying out the research (see chapters 3.1 and 3.2).
Rigour in developing the interview schedules	• Supervision was used to develop the initial interview schedule. • The initial interview schedule was piloted and necessary amendments were made (see chapter 3.6.2).
Triangulation of information	• Multiple sources of information were collected including interviews with a range of facilitators and pupils, as well as quantitative measures from pupils.
Immersion in data	• Researcher was fully immersed in the raw data through multiple exposures to audio files and reading the transcripts multiple times.

	• Data was revisited on a number of occasions to ensure a good understanding of the context of quotes.
Using a systematic process of data analysis and providing explicit detail regarding this	• Details have been provided regarding the thematic analysis applied, with attention given to steps taken to ensure trustworthiness and rigor (see Table 4).
Complete coding	• All information was coded, regardless of whether or not it supported a positive representation of the intervention.
Consistency in transcription	• All data was transcribed by myself, ensuring a consistent approach.
Evidence-based quantitative measures	• The RCADS were critically evaluated in the methodology.
Participant Bias	• I did not facilitate groups, or train staff, to ensure distance from the programme before conducting interviews.

3.9 Ethical considerations

The British Psychological Society (BPS, 2014) and Health Care Professional Council's (HCPC, 2015) guidance on research standards and ethics were followed. Data protection registration and ethical approval were granted in accordance with the General Data Protection Regulations (GDPR) by the Department of Psychology and Human Development at UCL Institute of Education. Due care and consideration were given to ethical implications of this research, and a brief overview of these are provided below (more detail can be found in Appendix S):

➤ *Data Barring Service (DBS):* I have a recent, clear DBS, which allows me to work with vulnerable children and adults.

➤ *Managing* adolescents' *anxiety:* School staff were guided to contact their EP should any concerns arise in relation to pupils' anxiety increasing, or having reached 'clinical' levels. This was agreed with the LA, as the EPS had a joint interest in piloting and evaluating the intervention.

➤ *Intervention participation:* Information and consent forms highlighted that not taking part in the research would not influence the adolescents' opportunity to take part in the intervention group.

- > *The control group:* Omitted from the research due to uncertainties that the intervention could be run after the experimental groups, due to the timing in the year and students and staff availability in the following academic year.

- > *Informed consent:* Full informed consent was gained from all participants (Appendix H, J, K & L). The information sheet highlighted participants' rights to withdraw at any time and reassured participants that all information would be held securely and be pseudonymised.

- > *Reporting, confidentiality and anonymity:* Pupils' schools and names were replaced with letter/number codes (i.e. 1a), to preserve confidentiality.

- > *Data storage:* Data will be securely stored for a minimum of ten years.

- > *Dissemination and use of findings:* The research will be used to examine the effectiveness of the intervention and potentially begin to build an evidence-base for the intervention. All participants were debriefed about the research. EPs could use the intervention within schools to build schools' capacity to support adolescents with anxiety with consideration to the findings.

The mixed methodology approach enabled a comprehensive examination of the therapeutic school-based group CBTA intervention. The outcomes included: changes in anxiety symptoms of adolescents from before the intervention to immediately after the intervention and at two months' follow-up (RQ1); adolescents' self-reported experiences of the intervention group, including both strengths and challenges (RQ2); and the group facilitators' self-reported experiences of the intervention, including strengths and challenges (RQ3). This chapter will report the findings from these analyses, and further discussion and triangulation of findings will be presented in Chapter 5.

4.1 Phase 1 (RQ1) – Quantitative Data Analysis – Descriptive Statistics

Due to the small sample size (n=16), statistical power would be too low to detect statistically significant differences in RCADS scores before and after the CBTA intervention (Cohen, 1977). Therefore, to address RQ1, I present descriptive statistics for illustrative purposes only and the Reliable Change Index (RCI).

Table 5: Individual participant RCADS scores at pre- and post-intervention and a two-month follow-up

Pupil	School	Gender	Age	Pre-intervention RCADS score	Post-intervention RCADS score	2 Month follow-up RCADS score
1a	1	M	15	80	44	39
1b	1	M	14	45	43	39
1c	1	M	15	59	54	37
1d	1	M	14	78	60	65
2a	2	F	14	64	68	64
2b	2	M	14	80	80	79
3a	3	F	14	74	73	80
3b	3	F	16	71	88	92
3c	3	M	16	56	58	56

3d	3	M	15	97	98	105
3e	3	M	15	32	26	24
4a	4	F	14	65	55	52
4b	4	F	15	79	66	48
4c	4	F	14	80	80	80
4d	4	F	15	49	43	38
4e	4	F	15	73	80	61

Notes. A "t-score" of 65 = 'borderline clinical'; a score of 70 = clinical threshold (thresholds for sub-scales set using normative data); RCADS = Revised Children's Anxiety and Depression Scale
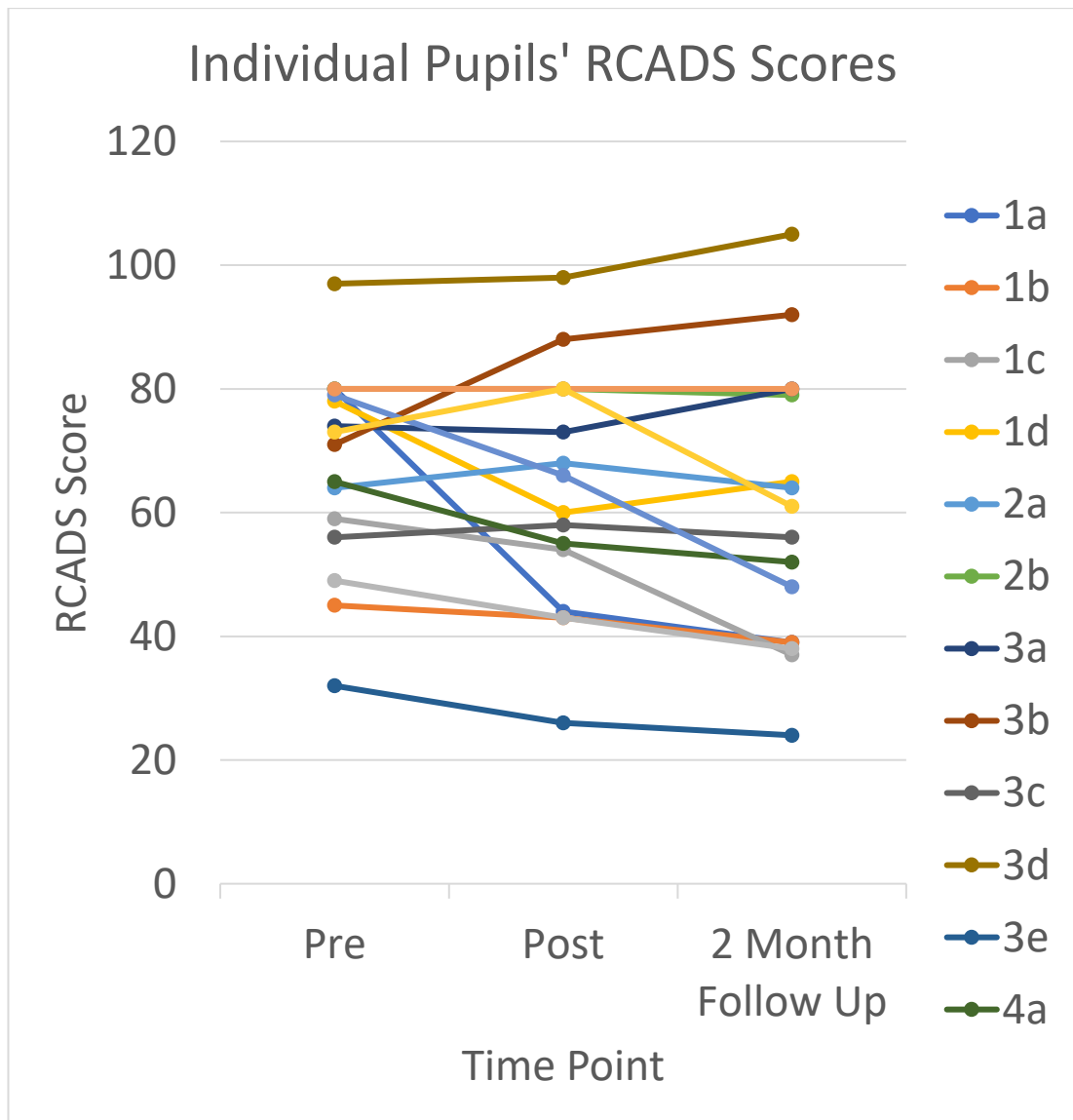
Figure 11: Pupils' RCADS scores across each time point.

Table 5 and figure 11 show the RCADS t-scores for each participant at pre-and-post-intervention and at the two-month follow-up. Ten participants' scores decreased from pre to two-month follow-up. Pupils from School 3 (3a, 3b, and 3d) had RCADS scores increase over time; for pupils 2a and 3c, RCADS scores increased before returning to their pre-score (showing no positive benefit from the intervention). Pupil 4c showed no change.

Table 6: Descriptive statistics of RCADS t-scores* throughout the research study

	Mean	Median	Standard Deviation (SD)	Mode	Range
Year Group	10.00	10.00	0.516	10.00	9–11 (3)
Age	14.69	15.00	0.704	15.00	14–16 (2)
Pre-intervention RCADS score	67.63	72.00	16.325	80.00	32–97 (65)
Post-intervention RCADS score	63.50	63.00	19.246	80.00	26–98 (72)
Follow-up RCADS score	59.94	58.50	22.608	39.00	24–105 (81)

Notes. A "t-score" of 65 = 'borderline clinical'; a score of 70 = clinical threshold (thresholds for sub-scales set using normative data)

Table 6 demonstrates that, on average, RCADS scores reduced 4.13 points from pre- to post-intervention and then reduced a further 3.56 points from post-intervention to the two-month follow-up. The total average reduction in score from pre-intervention to the two-month follow-up was 7.69.
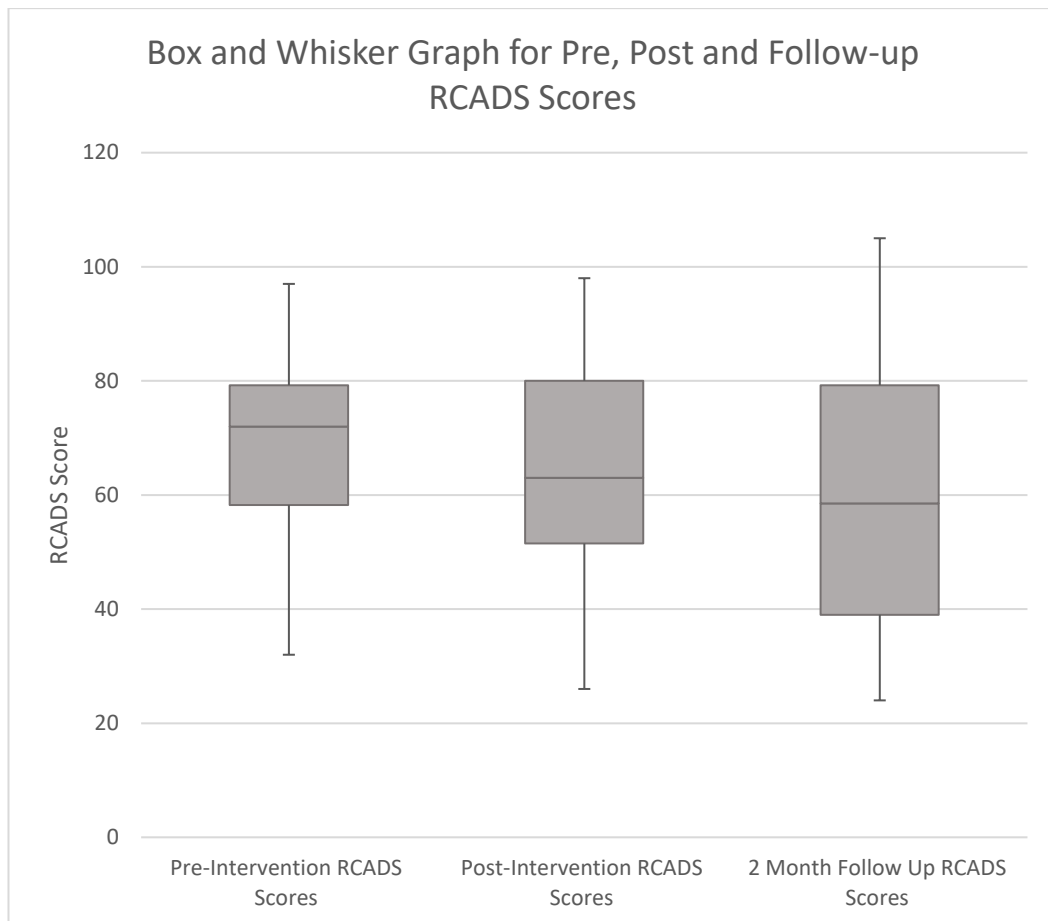
Figure 12: A box and whisker plot to show descriptive statistics of RCADS scores

In line with Table 6, Figure 12 suggests that, on average, the anxiety levels of the pupils who took part in the intervention reduced. Figure 12 demonstrates that the variance in change across the RCADS scores increased over time (with the most variation in scores seen at the two-month follow-up), whilst the modal scores decreased over time. The median RCADS scores decreased across the time points. This implies, on average, fewer anxiety symptoms over time in the pupils.

The Reliable Change Index (RCI) was introduced by Jacobson and colleagues in 1984, to determine whether the magnitude of change for individual participants is statistically significant (Jacobson & Truax, 1991). Zahra and Hedge (2010) report that, where there is a limited sample size and other statistical analyses are not appropriate, the RCI can be useful for tracking individual change across time. The RCI scale was used in the current research

to determine whether individual pupils' scores significantly changed. To complete the RCI, the co-efficient alpha and standard deviation from a 'normative sample' for the RCADS was needed. RCI scores also needed to be above 1.96 for reliable change to have occurred (Jacobson & Traux, 1991) .

Piqueras, Martín-Vivar, Sandin, San Luis and Pineda's (2017) conducted a meta-analysis of 146 studies examining the mean reliability of the RCADS, providing the standard deviations and co-efficient alphas for the studies included within their paper. From these studies, seven were appropriate for RCI analysis for the current study, as they reported the total RCADS score co-efficient alphas and standard deviations, used the English version of the RCADS for children (47 item measure), and included pupils within the 14 -16 age range. Of these seven studies, four were conducted in the United States (Brown et al., 2013; Kaat & Lecavalier, 2015; Levin, Henderson, & Ehrenreich-May, 2012; Ung, 2016), one in Denmark (Esbjørn, Sømhovd, Turnstedt, & Reinholdt-Dunne, 2012) and two in the Netherlands (Hogendoorn et al., 2010; van Tuijl, de Jong, Sportel, de Hullu, & Nauta, 2014). To generate the co-efficient alpha and standard deviation for the RCI, an overall mean for these studies was calculated, producing an average alpha coefficient of 0.95, a mean of 0.72 and a standard deviation of 0.38. These figures where then used to calculate the standard error for the RCI (which was 1.05). The RCI was then computed for each pupil in the current study, using (1) their pre to post scores, and (2) their pre to follow up scores. The difference between the RCADS scores were divided by the RCI standard error of difference. See Table 7 for the individual RCI scores generated.

Table 7: Reliable Change Index for each participant.

Pupil	Pre - Post	Reliable Change (RC)/Not Reliable Change (NRC)	Pre - Follow up	Reliable Change (RC)/Not Reliable Change (NRC)
1a	299.58	RC	341.19	RC
1b	16.64	RC	49.93	RC
1c	41.61	RC	183.08	RC

1d	149.79	RC	108.18	RC
2a	-33.29	RC	0	NRC
2b	0	NRC	8.32	RC
3a	8.32	RC	-49.93	RC
3b	-141.47	RC	-174.76	RC
3c	-16.64	RC	0	NRC
3d	-8.32	RC	-66.57	RC
3e	49.93	RC	66.57	RC
4a	83.22	RC	108.18	RC
4b	108.18	RC	257.98	RC
4c	0	NRC	0	NRC
4d	49.93	RC	91.54	RC
4e	-58.25	RC	99.86	RC

Using the RCI approach, 88% (n=14) of the pupils achieved reliable change at pre to post intervention and 81% (n=13) of pupils achieved reliable change from pre to follow up. These findings broadly corroborate the descriptive data indicate that, overall, a high percentage of the changes over time were reliable.

Findings demonstrated that, on average, anxiety levels decreased over time. For four pupils, their 'borderline clinical' anxiety scores decreased to below 'borderline clinical'. Whilst the RCI demonstrates a high percentage of reliable change, due to the varied results between schools, findings should not be generalised across all contexts. The range in scores highlights that this study's qualitative interview data, exploring what works for who and why, has the potential to add value to the above findings in this research. The findings will be triangulated with the quantitative findings in Chapter 5.

4.2 Phase 2 (RQ2) – Qualitative Data Analysis – Thematic Analysis

I identified three overarching themes from the pupils' interviews: theme one– pupils developing knowledge and effective application of self-regulation skills; theme two – facilitative factors that influence positive engagement with the intervention; and theme three – providing containment and the importance of attuned relationships. I also identified three overarching themes from facilitator

interviews: theme one – pupils developing knowledge and effective application of self-regulation skills; theme two – providing containment and the importance of attuned relationships with pupils; and theme three – facilitative and systemic factors to quality assure the intervention and embed it at a whole-school level (see Figure 13 and 17 for illustrations of the themes and associated sub-themes). Initial reflections on these data suggested that there was heterogeneity across the facilitators' and pupils' experiences. Both facilitators and pupils enjoyed the intervention and made valuable reflections on: the influence they felt the intervention had on the pupils' anxiety; what worked well; and what could be improved. As aforementioned, my own philosophical stance (contextualism) has been acknowledged, as it will likely influence how I interpret these data. However, I strove to be objective and took a flexible inductive-deductive approach to analyse the data. This allowed me to examine the breadth of these data whilst acknowledging the research questions I aimed to answer. This approach also enabled me to acknowledge patterns in these data that may not directly relate to the research questions.

In line with the established practise of qualitative methodology, the aim of the research was to examine people's *experiences* of the intervention (Polit & Beck, 2010). This gives richness to people's experiences, opposed to quantitative methods (Burnard, Gill, Stewart, Treasure, & Chadwick, 2008). This is particularly important within thematic analysis, opposed to other methods such as content analysis (Wilkinson, 2000). Whilst some may use more descriptor language to report the prevalence of themes such as 'majority' (Meehan, Vermeer, & Windsor, 2000, p.372), 'a number of participants' (Braun, Gavey, & McPhillips, 2003, p.249) or 'many' (Taylor & Ussher, 2001, p.298), the value of this is debated; potentially as they are vague concepts that may not be reported truthfully (Braun & Clarke, 2006). As per Braun and Clarke (2006, p.10), I believe more instances of a theme "do not *necessarily* mean the theme itself is more crucial". I have chosen not to present the prevalence of the themes for each group separately with figures or descriptors but rather have maintained the overall approach, which seeks to set out the participants' experiences as thoroughly and accurately as possible, through prose description and illustrative quotes.

4.2.1 Pupils' perspectives.

Figure 13 shows the three key themes (and associated sub-themes) identified in the pupils' data: theme one – pupils developing knowledge and effective application of self-regulation skills; theme two – facilitative factors that influence positive engagement with the intervention; and theme three – providing containment and the importance of attuned relationships. Further description can be found in Appendix T.


```
Theme one – Pupils              Positive thinking and reframing; applying
developing knowledge            CBTA
and effective application
of self-regulation skills       Pupils developing understanding of anxiety
                                from a holistic perspective.

                                Physical and emotional impact of applying
                                self-regulation strategies.

                                Applying a range of self-regulation strategies.


Theme two – Facilitative        The benefits of a person-centred approach.
factors that influence
positive engagement             Improving the frequency and structure of the
with the intervention           sessions.

                                Valuing a systemic approach.


Theme three – Providing         Creating a safe space
containment and the
importance of attuned           Improving access to support
relationships
                                Valuing the experience
```

Figure 13: Pupils' thematic map

4.2.1.1 Theme one: Pupils developing knowledge and effective application of self-regulation skills.

Pupils spoke of their developed knowledge and application of self-regulation skills. Within this overarching theme, I interpreted four subthemes: positive

thinking and reframing; applying CBTA; pupils developing understanding of anxiety from a holistic perspective; physical and emotional impact of applying self-regulation strategies: and applying a range of self-regulation strategies (Figure 14).
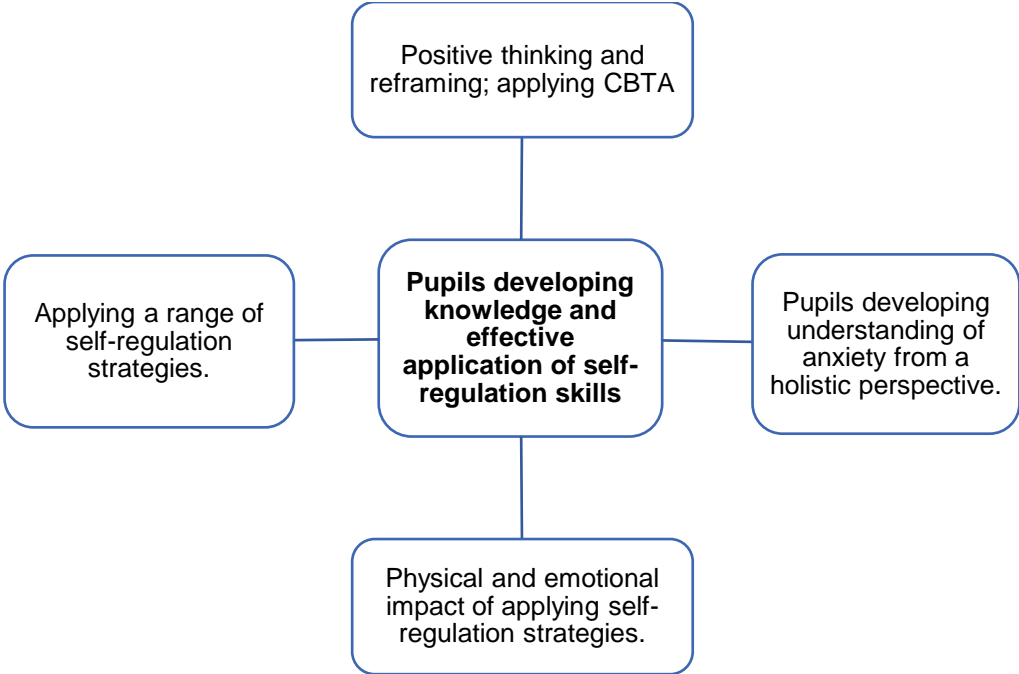
Figure 14: Pupils developing knowledge and effective application of self-regulation and themes.

Subtheme 1.1: Positive thinking and reframing; applying CBTA.

Pupils reported using methods of positive thinking and reframing – a key factor encouraged in CBTA. Pupils found it useful to reflect on their week and focus on positive things that had happened:

> *"…focusing on good things that have happened,…we did…three good things in the past week [in which the pupils were asked to think about things that went well in the past week as part of the intervention] …thinking about that …realises that I've actually got a lot of good things…" (2b).*

Pupils also recognised a shift in their thinking from how they felt before the sessions, acknowledging a change within themselves:

"When you finish [the sessions], you reflect on it and that kind of made my mind go exploding, because I found out what my other point of view was…how much has changed." (1d)

They shared a range of strategies they used to reframe their thinking; challenging negative automatic thoughts when they felt anxious. They reported that this enabled them to take on difficult tasks:

"…it made me feel calmer because I know I wasn't going to do amazing on them [exams] but I knew I can try my hardest and that's all I can do and that got me through it." (3e).

Pupils began to normalise anxiety and recognise it within themselves and others. This enabled them to think about anxiety more positively, as opposed to holding onto negative thinking:

"anxiety to me is something that a lot of people deal with and I've dealt with myself. It's not always fun but you can overcome it…." (2b).

Reference was also made to the benefits of the intervention in preventing their symptoms of anxiety from developing further:

"…just showing that I'm not the only one who has these feelings and that there are ways to…help prevent these things from getting too serious." (1a).

Subtheme 1.2: Pupils' understanding of anxiety from a holistic perspective.

Pupils made a range of references to the consideration of external factors that may influence anxiety. Pupils recognised that anxiety had a negative impact on their quality of life:

"[anxiety is] something that holds me back from doing normal things in my life" (4c)

"Anxiety means…where I don't feel safe about myself being around new people or even friends..." (1d).

Pupils recognised that anxiety was felt by others and that they did have supportive people available to them:

"…we're not the only ones who have these emotions…" (1a)

"I think everyone has it [anxiety], everyone…copes…made me…appreciate…the people around me…and think people are there to help you..." (3e).

References were also made to the physical and cognitive impact of anxiety; demonstrating recognition of the connection between anxiety and various physical symptoms:

"yeah it like shuts down and like my butterflies in your stomach." (1b)

"…sleep was a good one because it just lets your body rest and let it kind of recharge…" (1c).

Subtheme 1.3: Applying a range of self-regulation strategies.

Pupils explained that, through the intervention, they learnt strategies to manage their anxiety. They were able to apply these hypothetically and across different contexts (e.g. home and school):

"…lay down in her bed or like breathe…or like focus on one body parts and start moving it." (1d)

They also described strategies they had used when feeling anxious during school:

"…gave an assembly yesterday to like my whole year group so that was…terrifying but…I used techniques the intervention taught me and I kind of got through it." (4c)

Some pupils were fond of visualisation strategies, focusing on physical sensations and progressive muscle relaxation to alleviate symptoms:

"…tense up different parts of your body like your feet and just like let it all go…sort of the same as the spotlight…just makes

you feel like a lot more relaxed and puts your mind at ease..."
(2b)

References were also made to the use of breathing exercises that supported them to think differently and bring themselves out of a state of anxiety:

"…my brothers didn't come home till late, and I was worried so…I sat down and I did the breathing technique and then I did the muscle stress reliver and it helped a lot." (1a)

"…breathing lets me think…and let me plan what I'm going to do." (1c).

Subtheme 1.4: Physical and emotional impact of applying self-regulation strategies.

Pupils began to recognise that applying the strategies to support their emotional regulation had a positive impact physically:

"…exercising like it makes you feel free and clears your mind" (1d)

"before I started doing it [breathing exercises] I was paralysed…I just couldn't move and I'm shaking and…whilst I was doing it, my body kind of came a bit looser and I could move around a little bit more..." (4c)

Pupils also recognised the positive impact that applying strategies had on enabling them to feel that they could manage their emotions:

"…[the intervention] helped me a lot to control my personal emotions." (1a)

"it's given me techniques to try and calm myself down if I'm in stressful situations…" (1a)

Pupils recognised that, by applying the strategies, they were able to become calmer and more positively engage in challenging tasks:

"The thinking techniques…helped my anxiety a bit, because now I know how to focus on other stuff other than the thing that's panicking me, so I have been able to go forward and do more..." (4c)

4.2.1.2 Theme two: Facilitative factors that influence positive engagement with the intervention.

The second theme identified from the pupils' data was facilitative factors that pupils felt supported them to positively engage with the intervention. They spoke of a variety of opportunities that the intervention opened up for them and explained what encouraged them to invest in the intervention. This was organised into three subthemes: the benefits of a person-centred approach; improving the frequency and structure of the sessions; and valuing a systemic approach (see Figure 15).
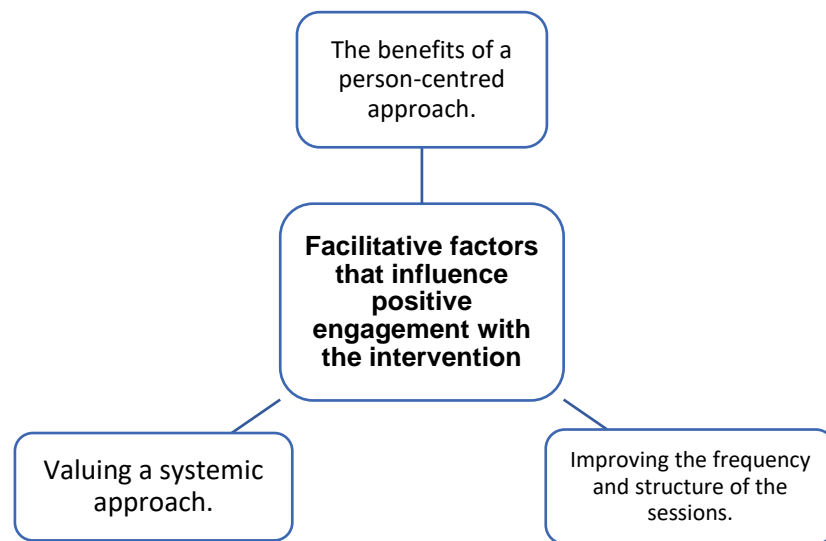
Figure 15: Facilitative factors that influence positive engagement with the intervention: theme and subthemes.

Subtheme 2.1: The benefits of a person-centred approach.

Pupils reported that they signed up to the intervention after hearing about it in tutor times, feeling that they would benefit from the support:

"…I got told about it…it was at tutor time and…was like oh ok I'll go and have a look at it…was like yeah this can help me, so I signed up for it and…I'm really enjoying it…" (1c)

"I tried it, because I wanted to be better with my life and like make the best out of it" (1d)

Pupils reported that they were encouraged to attend by staff, but were given the option to attend sessions or not:

"…Miss took me out of the lesson one day and asked if I wanted to do it and I said sure…" (3e)

"…I mean the teachers did say that I didn't have to go…but after the first one I kind of enjoyed going and it…helped a lot, so I …chose to go after that point." (1a)

They also commented on parental encouragement to attend sessions:

"…my parents thought I would need this because I've talked to my mum before about me feeling very stressed and anxious about a lot of things…" (1a)

On the other hand, some pupils reported that they did not feel like they had much choice to attend, but felt it would be helpful nonetheless:

"I was actually recommended to sign up for it…I didn't really get that much of a choice in it but I didn't really mind because…I kinda [thought] that would be like helpful cause my anxieties got quite bad…" (4c)

Despite this, there was the sense that, whilst some pupils found the sessions fun, they did not feel they needed to be there:

"…it was fun to be there, I got out of lesson for a while and that was quite fun and I get to talk to people which was quite fun, but I didn't 100 percent feel like I needed to be there..." (3e)

Subtheme 2.2: Improving the frequency and structure of the sessions.

Pupils commented on the frequency of sessions, reporting that regular weekly sessions were helpful in supporting their application of newly learnt skills. This was because it enabled them to practice their skills and consolidate their new learning:

> *"…I think having it weekly was something that let us sort of go through it and give us chance to do it at home and then come back…we weren't sort of losing anything that we learnt…" (1c)*

However, pupils also suggested that the intervention might be better if there was more than one session a week, as gaps in sessions could lead to them forgetting what was learnt and the strategies they were taught. They were particularly concerned about longer gaps between sessions, which sometimes arose due to cancelations and/or school holidays:

> *"…obviously a week in-between that's quite a long time, but that's alright but…we had half-terms and…there was one where it was snowing…we had to cancel a few…2 sessions in a week…I think that would probably help to…remember all of it…" (2b)*

> *"…more sessions I guess in that month instead of just doing once a week..." (1d)*

Learning new material and having time to consolidate the new learning was highlighted as important. Yet pupils also commented on the repetition inherent in the sessions. They suggested that regular sessions required more novel activities (as opposed to recapping previously learnt information):

> *"Just trying to introduce different kind of mechanisms…we had a lot of breathing exercises and I just felt that the one-hour time period wasn't used effectively. I felt like we spent too much time with stuff we've done before…" (1c)*

Pupils suggested a number of ways to improve the sessions, including: a greater variety of activities; a range of ages within the groups; the use of personal sessions (to accompany the group sessions); and each member having the chance to share their thoughts and feelings at the beginning of the sessions:

> *"…more activities would be fun." (3e)*

> *"…I think we should have more of a range like maybe year 8 to year 10...." (3e)*

> *"…instead of being in…a group…a personal…session with just one person and a teacher." (1d)*

> *"... if we all had like 10 minutes to say like everything, like get everything out..." (2b)*

> *Subtheme 2.3: Valuing a systemic approach.*

Pupils suggested more discussion about how their community and school could support them and how they could apply strategies within school:

> *"…helping with…the school and stuff we think…having time out of classrooms if we feel a bit anxious and I think we could talk…more about that,…our own…community after schools and stuff like that..." (2b)*

> *"probably more ways to deal with like lower level anxiety…like how to deal with the anxiety of just walking into a classroom. How to deal with the anxiety of like where to go at lunch..." (4c)*

Pupils also valued support from parents in implementing the strategies learnt in the sessions:

> *"…getting other people to read out stuff to you is something that I use quite a lot…my parents are quite supportive of it so they always…ready to help..." (1c)*

4.2.1.3 Theme Three: Providing containment and the importance of attuned relationships.

The third theme I identified was containing experiences and relationships. This comprised three subthemes: creating a safe space; improving access to support; and valuing the experience (Figure 16). I found that opportunities to share their experiences (which they previously kept private) with trusted people were of great value. I identified that their relationships with peers and staff were paramount to the success of the intervention.

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                    ┌─────────────────┐
                    │  Creating a safe │
                    │      space       │
                    └─────────────────┘
                            │
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                    │   Providing      │
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                    │ the importance of│
                    │    attuned       │
                    │  relationships   │
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        ┌─────────────────┐    ┌─────────────────┐
        │  Valuing the    │    │ Improving access to│
        │   experience    │    │     support      │
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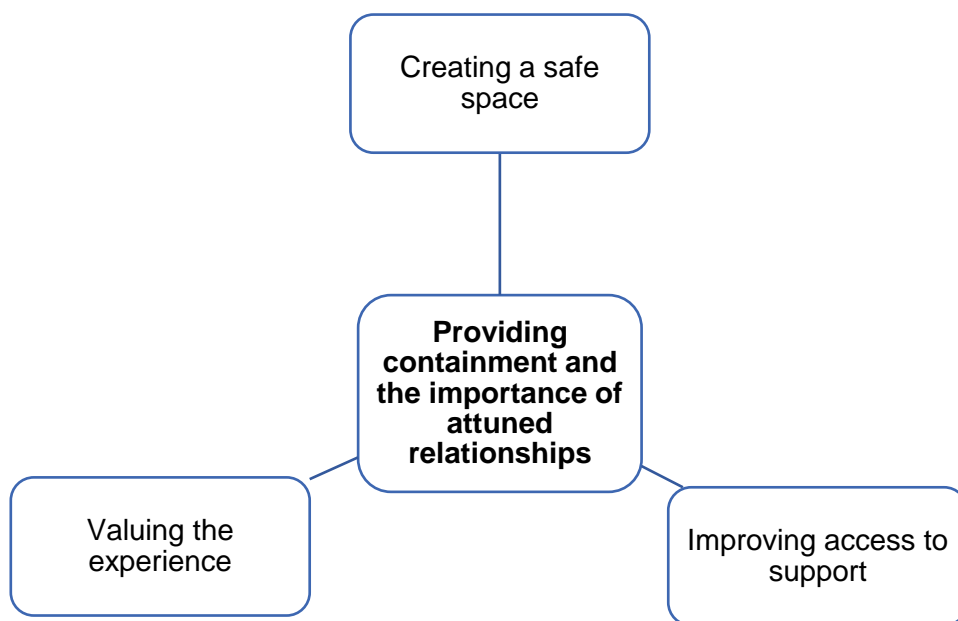
Figure 16: Providing containment and the importance of attuned relationships.

Subtheme 3.1: Creating a safe space.

Pupils referred to the importance of attuned relationships between peers and their facilitators. They reported this was fundamental to enabling them to open up within the group and share their thoughts and feelings:

> *"…in a group with people that I'm like ok with opening up around…" (4c)*

"I didn't mind…saying anything and they were…interested in what I had to say, like I had a piano exam…I was really nervous for it and they were…telling me like I'd be fine..." (2b)

Pupils extended this to suggest that a space that was free of judgement gave them confidence to share their worries:

"…I felt like no one would judge us or like no one would judge me either…I didn't feel like they would judge me for whatever I said..." (2b)

It was also mentioned that group dynamics that varied from their norm made them feel distant from the rest of the group. Pupils added that dissonance in personality types led to feelings of segregation within the group:

"… I think its cause…I'm a very loud, jumpy person and most of them are quite quiet, shy people so it wasn't…my kind of people…that's probably why I felt a bit out cause they're all quiet and shy..." (3e)

Pupils reported wanting to be in groups with peers they felt comfortable opening up with. When this did not happen, they felt uncomfortable and it impacted on their feelings of safety within the group, making them reluctant to share their thoughts and feelings:

"there was some people there that I didn't really want to open up to and I tell about my insecurities and stuff so maybe be put in a group with people that I'm like ok with opening up around would probably be a bit better…I did kind of want to share some stuff in the groups which I wasn't really comfortable doing around certain people in the group..." (4c)

Knowing that 'what was said in the groups was confidential' seemed to help pupils to share their thoughts and feelings:

"…we said at the beginning like no one would talk about it outside of the room…" (2b)

Subtheme 3.2: Improving access to support.

Pupils reported that they had not experienced an intervention like this before and they valued the opportunity to access support:

> *"I've never really done anything like it…they don't have anything…in school like that…nothing to help you…they help you with exams obviously but not like fear of it and stuff like that and not just exams everything in general...." (2b)*

> *"…I feel like with it being there, it was something I would have never of tried before…it was something that without I wouldn't have done as well...." (1c)*

Pupils recognised that there is not much teaching on anxiety and having some input to understand more about anxiety was highly valued:

> *"…there's…nothing in school that…teaches us about that [anxiety]…it's…really helpful…I knew more about it and that helped me to know how to…combat it and how to…stop it being such a problem." (2b)*

Subtheme 3.3: Valuing the experience.

Pupils reported enjoying the intervention, giving overwhelmingly positive comments:

> *"…they always try and involve like fun activities into it…like we'd learnt breathing activities and stuff which I find quite fun…" (1b)*

> *"It couldn't really improve. It's perfectly fine as it is. It helps a lot." (1a)*

Pupils also commented on how the intervention had enabled them to manage their anxiety. They reported feeling more relaxed and able to think about situations from an alternative perspective (allowing them to access more activities):

"It just kind of relaxes me and my mind…just let me think and that was something that was really quite vital in situations…it was really quite needed sometimes and it being there was really quite useful." (1c)

"…it [thinking techniques] has helped my anxiety a bit, because now I know how to focus on other stuff other than the thing that's panicking me, so I have been able to go forward and do more stuff." (4c)

Pupils also reported that they looked forward to the intervention, as it was some time in their week to be calm, when their academic week could be quite stressful (e.g. the pressure of exams):

"It was really helpful with what I was going through at the time and it was something I knew I could look forward to in the week." (1c)

"…mostly because I was going into exams, quite a stressful time, I thought it would be something that I could have in the week that would let me calm down a bit…it was…quite interesting…" (1a)

Summary of the pupils' perspective.

Pupils' views were overwhelmingly positive about the intervention, with a range of benefits (access to support, sharing experiences with others and developing a bank of tools to support their anxiety and enable them to access a wider range of activities) noted. They did, however, provide some useful observations on how the sessions could be improved in the future (e.g. in terms of the content and frequency). Pupils also shared some barriers to accessing and benefitting from the intervention (e.g. in terms of peer relationships and various personality types, and the need for other school staff to support them in managing anxiety).

4.2.2 The facilitators' perspective.

I identified three key themes from the facilitators' data: theme one – developing pupils' knowledge and effective application of self-regulation skills; theme two – providing containment and the importance of attuned relationships, and theme three – facilitative and systemic factors to quality assure the intervention and embed it at a whole-school level. These themes and associated subthemes are shown in Figure 17 (further description can be found in Appendix U). Additionally, responses from the scaling questions, which were used as a basis for discussion, can be found in Appendix V.

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Theme one –                    Pupils applying strategies learnt in the
Developing pupils'             intervention to alleviate anxiety
knowledge and
effective application          Positive impact on pupils
of self-regulation
skills                         The benefits of pupils developing psychological
                               understanding of the connection between
                               thoughts, feelings and behaviours.

                               Pupils understanding of anxiety developed


Theme two –                    The benefits of a person-centred approach
Providing
containment and the            Building attuned relationships within the groups
importance of                  between facilitators and peers; and between
attuned                        peers.
relationships


Theme three –                  The need for a flexible        The importance of a
Facilitative and               therapeutic approach           whole-school approach
systemic factors to
quality assure the             Reducing barriers to           Training the facilitators;
intervention and               successful                     a cascading affect to
embed it at a whole-           implementation                 develop positive
school level                                                  mental health across
                               Building resilience in the     the school.
                               system
                                                              Developing long-term
                                                              support to ensure
                                                              lasting effects


                                                              Supervision –
                                                              providing facilitators
                                                              with containment
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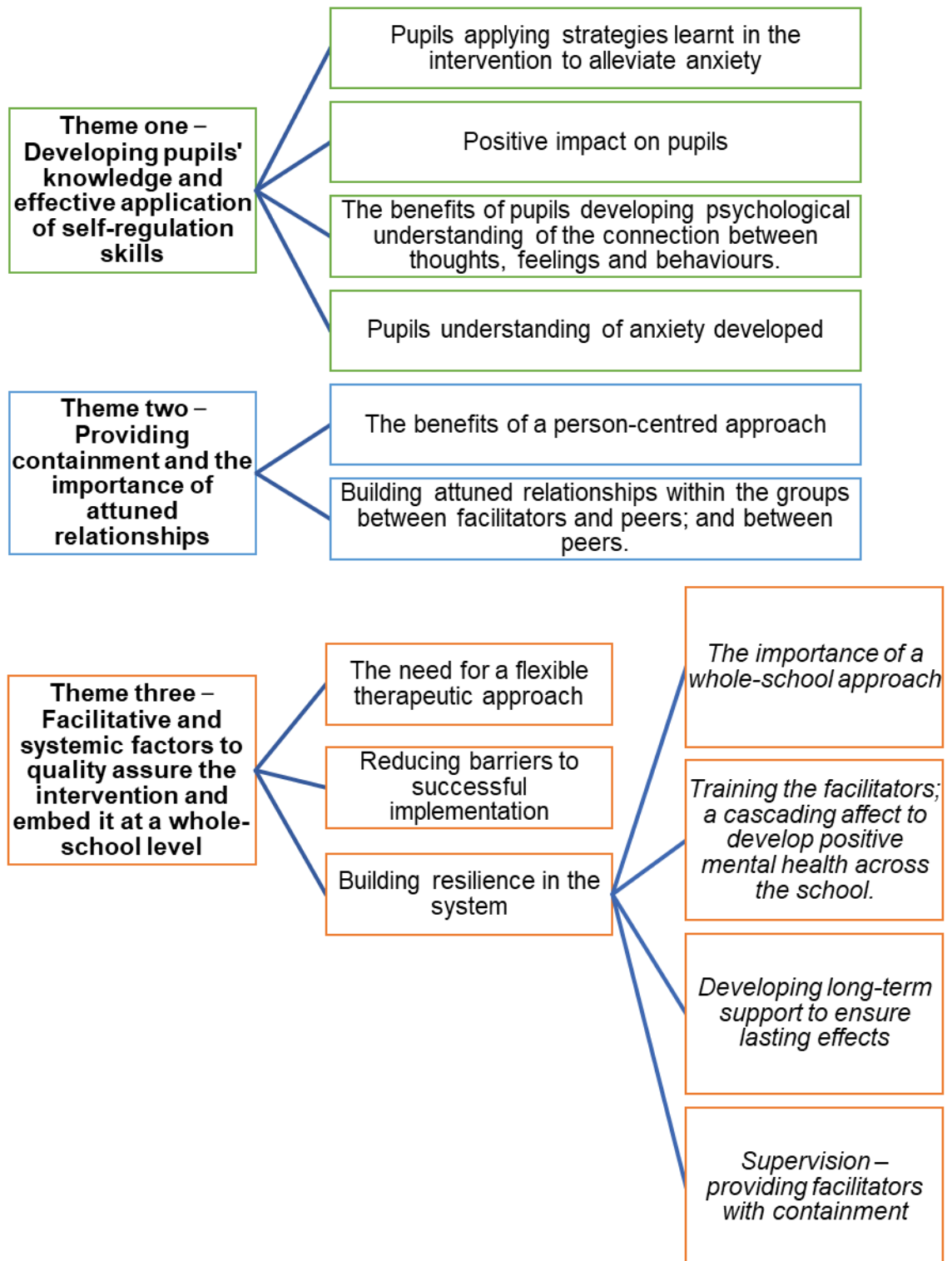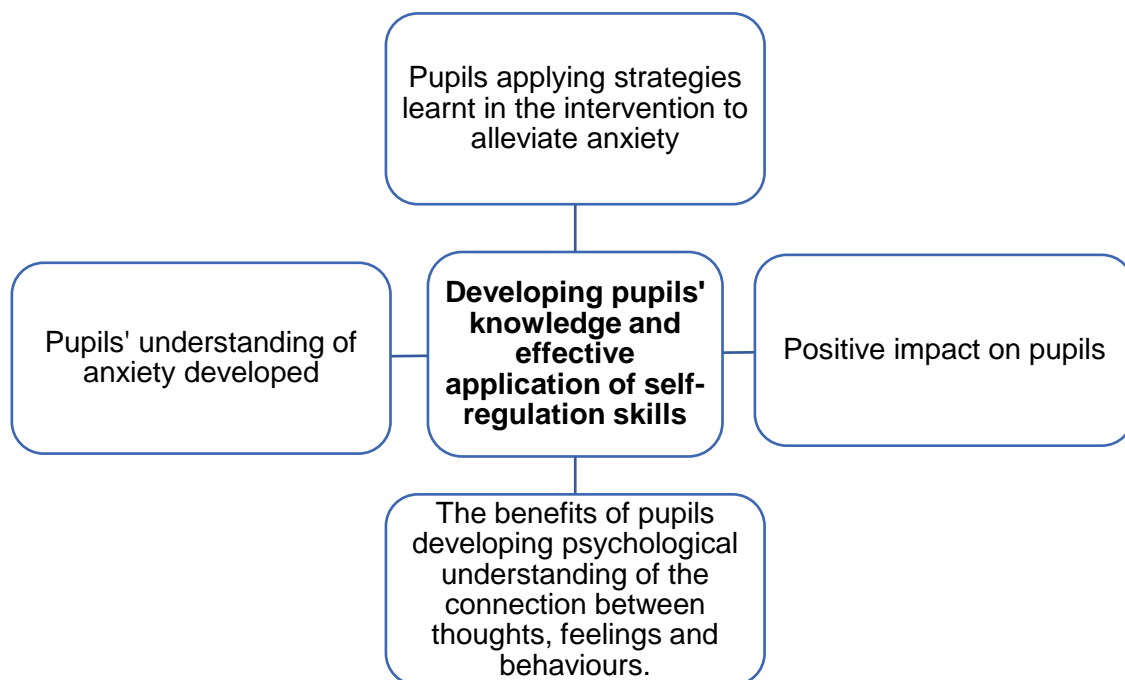
Figure 17: Facilitators' thematic map

4.2.2.1 Theme one: Developing pupils' knowledge and effective application of self-regulation skills.

Within 'developing pupils' knowledge and effective application of self-regulation skills', I identified four sub-themes: pupils applying strategies learnt in the intervention to alleviate anxiety; positive impact on pupils; the benefits of pupils developing psychological understanding of the connection between thoughts, feelings and behaviours; and pupils' understanding of anxiety developed (Figure 18).

Figure 18: Developing pupils' knowledge and effective application of self-regulation skills

Subtheme 1.1: Pupils applying strategies learnt in the intervention to alleviate anxiety.

Facilitators were pleased that they saw pupils applying strategies. Pupils had reported to them that they had applied strategies in different contexts such as school trips, at home and during school:

"…she said yeah I'm just calming myself at the moment…I had a couple of them talking … they said ooh I was doing my

breathing kind of thing. I was doing my kind of more mental imagery…before it got to the point…the anxiety was overtaking." (School-4, SENCO)

"I had a young lady…concerned [about travelling independently of her parents and walking through the airport]…we discussed it and…planned out for her which strategies she might use while she's away…she really liked the image one for the…challenging thoughts one…in combination with positive affirmations…I said how was it going through the airport by yourself without your family…she said I had my…little picture in my hand as I was walking through and I took a deep breath and I just pictured walking through the other side..." (School-3, Teaching-Assistant)

Facilitators reported that pupils were able to use strategies they felt worked well for them. Facilitators felt that the strategies required further time and on-going support for pupils to be able to apply them independently:

"…when I asked them which ones they were using… they didn't automatically say 'I would do deep breathing or PMR' for example… I think they still need the reminder of the different types they can use." (EPS, Assistant-EP2)

"…they much prefer doing things like the visualisation and the breathing..." (School-3, Teaching-Assistant).

School staff felt that their knowledge of alternative strategies was limited, and they felt that having a wider breadth of strategies to be able to guide pupils would enable them to improve pupils' independent application of strategies:

"…having…more strategies that [tie in] well with other ones…so that there was a bit more combinations of things that might help them to try…I only know what's in the pack, so if they say…I didn't like any of those then I'm like well then tough you just have to stay anxious then, because I don't…know anymore." (School-3, Teaching-Assistant).

Subtheme 1.2: Positive impact on pupils.

Facilitors reported that they enjoyed the sessions, as it was so nice to see the pupils reduce their anxiety by employing the strategies to overcome challenging situations:

> *"…seeing some levels of anxiety decreasing…that also made me really enjoy it." (EPS, Assistant-EP2)*

They also commented on the improved emotional wellbeing of pupils, linked to the development of new peer relationships, which was suggested to reduce the risk of vulnerable pupils who had previously not been recognised as needing support:

> *"…it improves the emotional wellbeing. It's also developed peer friendships…and peer loyalty amongst each other so if they see each other around they noticed that they're not quite themselves they'll ask them how they're doing and they'll have a conversation privately…and then they signpost that on to members of staff … so from a safeguarding point of view it's really good at reducing the risk of vulnerable students within our school that are suffering in silence." (School-1, Pastoral-Support)*

It was recognised that pupils' attendance and ability to manage the complex nature of secondary schools had seemed to improve:

> *"...by doing this course it's improved it [anxiety] for quite a few of the students their attendance has really improved but not just that it's their motivation in the class and their ability to be able to cope with different situations, whether it's a supply teacher or a change in the type of topics that they're studying in class." (School-1, Pastoral-Support)*

Subtheme 1.3: The benefits of pupils developing psychological understanding of the connection between thoughts, feelings and behaviours.

Faciliators felt that, through taking part in the intervention, pupils had developed their understanding of CBTA:

"…they probably haven't thought a lot about negative automatic thoughts and…the hot cross bun [a model depicting the relationship between thoughts, feelings, physical sensations and behaviour] and things like that they found quite useful." (School-3, Pupil-Premium-Lead)

Facilitators reported that this supported pupils to better understand their anxiety and develop alternative ways of thinking:

"…I've got…boys…who became interested in thinking about alternative ways this thing called CBT its improved their communication with each other…" (School-1, Mental-Health-First-Aider)

Subtheme 1.4: Pupils' understanding of anxiety developed

Facilitators reported that the intervention meant that they, and their pupils, normalised anxiety. It also meant that they recognised the impact of anxiety on the pupils' daily life:

"…think the group works really well because they all realise that actually lots of people feel anxious…" (EPS, Assistant-EP1)

"…it [anxiety] really affects their learning and day-to-day lives and quality of their lives..." (School-3, Pupil-Premium-Lead)

There was also mention that reflecting on their own personal experiences of anxiety with the pupils supported facilitators to normalise anxiety amongst all people:

"…it's important for them to see that actually we're all really vulnerable but we all demonstrate it in different ways and once they understand…that everyone experiences it in different levels then they find it a lot easier to accept and embrace the different coping strategies and the communication with everybody..." (School-1, Mental-Health-First-Aider)

4.2.2 Theme 2- Providing containment and the importance of attuned relationships.

I identified two sub-themes within 'providing containment and the importance of attuned relationships', including 'the benefits of a person-centred approach' and 'building attuned relationships within the groups between facilitators and peers; and between peers' (Figure 19).

The benefits of a person-centred approach

Providing containment and the importance of attuned relationships

Building attuned relationships within the groups between facilitators and peers; and between peers.

Figure 19: Containing experience and relationships

Subtheme 2.1: The benefits of a person-centred approach.

Facilitators reported that it was important pupils had the choice to attend the intervention. Whilst some were encouraged by staff to attend, all pupils were given the choice:

"…they've self-referred, so if they want to be there that's absolutely great. It's not compulsory I'm not forcing him to be there and so once he was made aware of that he fully engaged and he appreciated it a little bit more…" (School-1, Mental-Health-First-Aider)

"…the most important thing is…try and pick them up a little bit earlier down the line before the anxiety's kind of got to that point…making sure they have self-referred and that they are people who really want to engage…" (EPS, Assistant-EP1)

Facilitators respected pupils who chose to the leave group, as some pupils felt the group was not for them. They felt that only those willing to engage with the intervention benefitted from it:

"…there were a couple that dropped out one from my group I think two from the EPs group that didn't feel that it was for them and that's fine that's their choice…all the ones that participated all the way through said that they felt that they benefited from it…" (School-3, Pupil-Premium-Lead)

Subtheme 2.2: Building attuned relationships within the groups between facilitators and peers; and between peers.

Facilitators felt that building attuned relationships with the pupils was essential to making the intervention successful. Building these relationships supported pupils to be ready for independently managing their anxiety and applying strategies:

"…they felt that they had a relationship with me whereas I think some of them found it a bit hard when it was an unknown person coming in." (School-3, Teaching-Assistant)

Facilitators emphasised how having clear boundaries with regards to confidentiality was important in building a safe space for pupils to share their experiences:

"…I think the rules are quite important in the beginning…making rules together about confidentiality and gossiping…" (School-3, Teaching-Assistant)

Facilitators commented that putting groups together based on the group dynamics and characteristics of pupils (ensuring they complimented one another) facilitated meaningful participation in the groups:

"…what helps make the intervention successful is choosing the right students so it isn't for your highest profile students…if there [is] a character that may not necessarily mix particularly well with more vulnerable young learners…choosing that cohort carefully…" (School-3, Pupil-Premium-Lead)

Facilitators suggested that as pupils had more sessions, they became more open to share and engage in the intervention, whilst recognising their connections to others in the group and building stronger relationships:

"…what made a difference was, just the continuity, that we carried on meeting....and then people…became less…inhibited, more relaxed, more open, and that's when I think they started to get the benefits of…the offloading and sharing…" (EPS, EP)

It was felt to be important that facilitators were receptive and accommodating to the emotional needs of pupils in the sessions, thus developing attuned relationships between the facilitators and pupils:

"…when the kids have bought into it and that they're engaging with it then it's effective and it works but if it's something where a student doesn't feel comfortable or feels forced to do it then it isn't really having an impact from what I've seen…" (School-3, Pupil-Premium-Lead)

"…I think a lot of them kind of felt like they have been a bit overlooked before and actually they really liked the opportunity of just having someone to just listened to them… I think they really were like quite like taken back that people wanted to spend time actually like exploring what they were good and kind of giving some positive feedback…" (EPS, Assistant-EP1)

Giving pupils time and space to be heard was also felt to be key as they received the opportunity to be contained and supported by others:

"…we've got dedicated rooms where we can provide the support which aren't interrupted, so completely private…that's really important…" (School-1, Mental-Health-First-Aider).

"…you could tell that they were actually really enjoying the space and having that time…" (EPS, Assistant-EP2)

Facilitators also found sharing their own experiences increased the connectedness between them and their pupils:

"…offering examples from my life, I think was really valuable and also the SENCO offered a lot of information around her anxieties to the group, and I think that was a really valuable…everybody kind of shared examples and it was a really safe space…" (EPS, Assistant-EP2)

Facilitators felt that the intervention opened relationships and access to support that had previously not been recognised. It was suggested that some pupils would benefit from on-going support, such as some extra one-to-one sessions following the intervention:

"… when someone is really quiet and just gets on with their work and they don't ask for help. They don't get help but after the group what actually came from the group was then I started doing some one-to-one mentoring…so they had like that extra support that they probably would have never asked for before." (School-3. Teaching-Assistant).

Facilitators explained how the intervention also supported pupils to develop peer relationships and notice signs of anxiety amongst each other, as well as offering each other support:

"…it's also giving them different peer friendship groups…their supporting each other…" (School-1, Mental-Health-First-Aider)

It was mentioned that cases in which peers may be very close and friendly prior to the intervention could impact on engagement in the sessions. The

sessions also supported facilitators to reflect on the level of need and how appropriate it may be for higher-need pupils:

> *"… I ended up with two girls who knew each other very well and I think we're feeding off each other…one of them I don't think…moving forward is appropriate for this anxiety group I think there's…more significant issues going on…" (School-4, SENCO).*

4.2.2 Theme 3-Facilitative and systemic factors to quality assure the intervention and embed it at a whole-school level.

I identified three sub-themes within the broader theme of 'facilitative and systemic factors to quality assure the intervention and embed it at a whole-school level', including 'the need for a flexible therapeutic intervention'; 'reducing barriers to successful implementation' and 'building resilience in the system'. The latter sub-theme, was further divided into: 'supervision – providing facilitators with containment'; 'developing long-term support to ensure lasting effects'; 'training the facilitators; a cascading affect to develop positive mental health across the school' and 'the importance of a whole-school approach' (Figure 20).
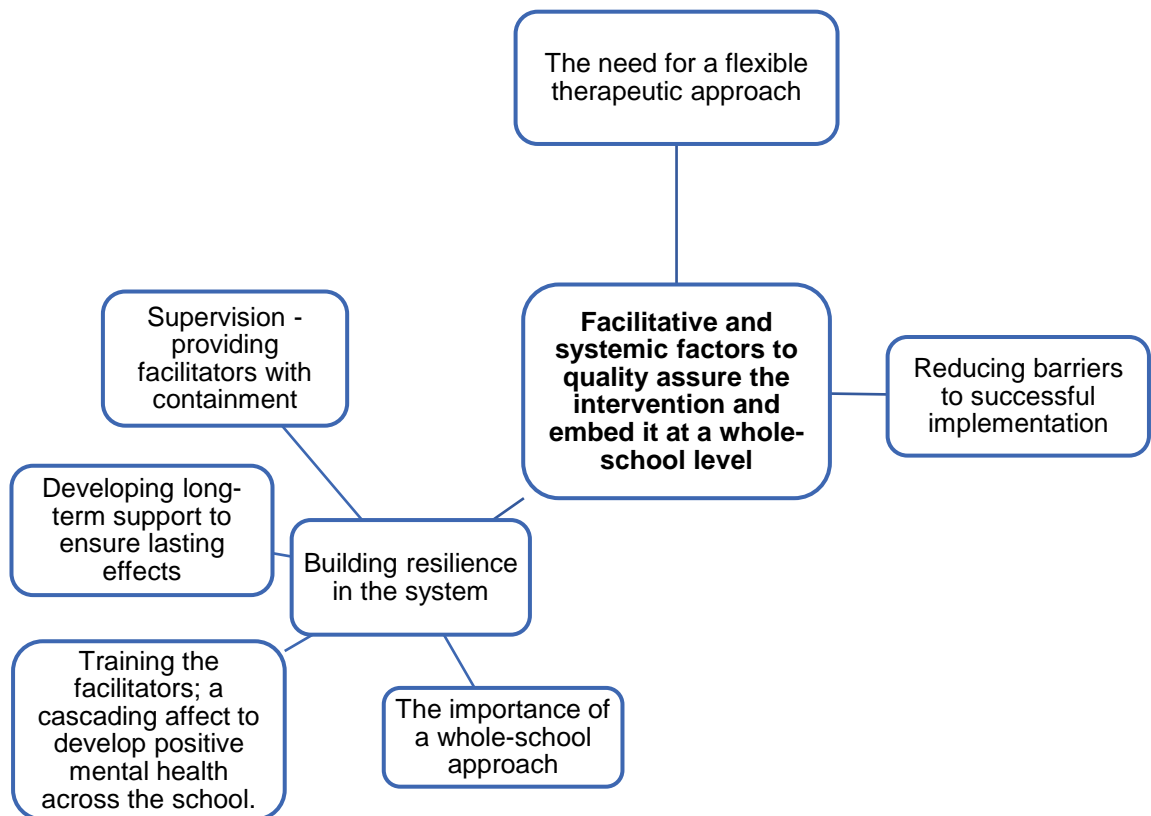
Figure 20: Facilitative and systemic factors to quality assure the intervention and embed it at a whole-school level

Subtheme 3.1: The need for a flexible therapeutic approach.

Facilitators suggested making the intervention more flexible to meet the needs of individual groups:

> *"…for example, one of the activities, after knowing the group, I thought actually I don't know if this is going to be suitable or I think it could have been adapted to suit the group more so I think there wasn't much flexibility…" (EPS, Assistant-EP2)*

Facilitators felt that sessions were rushed at times and therefore suggested that providing longer sessions would have been helpful. They also suggested that flexibility to have fewer activities in the sessions, if needed, would improve the intervention, as there would be more time for discussion:

"…time could have been an issue but it wasn't 'cause we started the group just before during mentor time, so we had a good hour, over an hour, for each session instead of just a 50 minute lesson which I think might have been a bit rushed. 'Cause actually, when I started the group last week, I only had them for the first 50 minutes and I couldn't get through everything in the first session really so I'm extending it this time..." (School-3, Teaching-Assistant)

"I think it would have been good to have it over [a] longer period of time and have less in each session, so there's more room for discussions." (EPS, Assistant-EP2)

Facilitators did, however, recognise that the flexibility of the intervention could lead to the fidelity of the intervention delivery being jeopardised:

"…some people…have their own ideas of how they would like to do it, and so…we don't know how closely they stuck to the modelling…" (EPS, Assistant-EP1)

"…I think…the other thing is that it gets diluted and watered down and it becomes nothing, hardly becomes recognizable…they don't get the full impact of it. I think…that's a danger." (EPS, EP)

Subtheme 3.2: Reducing barriers to successful implementation.

Facilitators mentioned that, for some pupils, writing thoughts and feelings down made them feel concrete and therefore provoked further anxiety. However, they also suggested that writing thoughts and feelings during the intervention enabled reflection:

"…some students…didn't want to write anything down…they found that it made it a concrete and very real if it was written down…but also, it then had the knock on effect when they were doing the reflecting the end of the programme, they didn't really have anything to reflect on, because they didn't have any sort

of notes…of their feelings at the start…" (School-3, Pupil-Premium-Lead)

Time for planning and preparation was also deemed pertinent. Facilitators appreciated that arranging the intervention could be difficult due to the complexity of secondary school calendars with exams and half-terms:

"… we've got so many exams …sports days and this, that and the other, so it was a little bit difficult to get the boys there..." (School-1, Pastoral-Support)

"I think I've got the right package there…if I do need anything, it will be time from the school." (School-1, Mental-Health-First-Aider)

Facilitators found the time taken to score the RCADS difficult:

"…RCADS are so long…it did feel like you're having a bit of a…data mine. …To run it again, something that's perhaps a streamlined version would be more user-friendly for in a school..." (School-3, Teaching-Assistant)

Facilitators found running two groups difficult on a pragmatic level, and drew attention to the funding barriers to successfully implementing interventions:

"…because the school staff member in both of my groups had a really busy schedule, they really struggled to fit their group in…" (EPS, Assistant-EP2)

"…we've always had a lot of interest from parents in terms of accessing some form of intervention, or mental health support…but obviously funding restricts that…there's loads of stuff that I've wanted to run before but I've not had the financial ability to do…well other than releasing a member of staff it's not a cost." (School-4, SENCO)

Subtheme 3.3: Building resilience in the system.

Facilitators reported that skilling-up systems around pupils to be able to support them with anxiety was a key outcome of the intervention. Developing a whole-school approach and home-school relationships were particularly highlighted. Facilitators gave recommendations to provide a more systemic approach: the importance of a whole-school approach; training the facilitators - a cascading affect to developing positive mental health in schools; developing long-term support to ensure lasting effects; and supervision – providing facilitators with containment. These are discussed in more detail below.

Sub-subtheme 3.3.1: The importance of a whole-school approach.

Facilitators emphasised the need for a more systemic approach to make the intervention more successful:

> *"…we report regularly on a school improvement plan and…the welfare and safety of students is paramount in that… it's a huge focus at this school…I think interventions like this are really important and the wider sort of management group see that as well..." (School-4, SENCO)*

> *"…a whole-school ethos around…supporting mental health and understanding what those triggers are and what they look like… it's really important as a whole-school to have that…" (School-1, Pastoral-Support)*

Facilitators stressed the importance of the support from senior management and their teams in providing MH interventions to pupils:

> *"…the senior management and head teacher here are very supportive of any mental health intervention as long as it's robust and there is an outcome and you can see a clear difference…to the children…" (School-4, SENCO)*

> *"… I've got a supportive team…you can feedback and…it will be taken on board, or you know, can I try this, or that group's*

not working well together. They're very open to you know suggestions…" (School-3, Teaching-Assistant).

Facilitators also commented on their personal investment in providing pupils with access to MH support:

"I'm a huge believer in supporting mental health for anybody…I recognise how difficult it is to access mental health support outside of an educational establishment, so if I can put something in place within the school, you got the kids there, you know it's easily accessible to them…" (School-4, SENCO)

"…I want there to be a next time and a next time and a next time, because I think it's so beneficial…" (School-1, Pastoral-Support)

Facilitators also considered the impact of the consistency of support provided both at school and at home:

"…I'm trying to encourage them to reach their full…actualisation and…I'm just wondering how that contrasts with when they get home when everything is a different world again…" (School-1, Pastoral-Support)

"…you will get the parents to sign the consent form to say yes they can do this, but then apart from the courtesy call to say we're starting it up…there wasn't anything that marked the end point…and to say that if you are still concerned, then this is what we would advise you do as the next step, or this is the contact all the resources that we've given the young people, so you're aware of it." (School-3, Pupil-Premium-Lead)

Facilitators further suggested that sharing information with teachers would support pupils with managing anxiety in the classroom, as well as supporting teachers to develop their understanding of the pupils and how to support them:

"…my group did a letter, an open letter to staff that was anonymous and every member of the group contributed in

some way to the letter…particular situations…caused them worry, and then providing examples of strategies that teachers could use that would help with their anxiety surrounding education in lesson time. So that was sent out to staff and the response from staff was actually quite positive..." (School-3, Pupil-Premium-Lead).

Sub-subtheme 3.3.2: Training the facilitators; a cascading affect to develop positive mental health across the school..

EPS facilitators felt that the training model, which included demonstrations of sessions, supported staff to understand how to deliver the intervention and feel comfortable delivering it:

"…I think even just even seeing it really makes them feel comfortable." (EPS, Assistant-EP2)

"…my particular school…really highly valued it [demonstration], because otherwise it's just an off-the-shelf program..." (EPS, EP)

As school facilitators felt that the intervention was clear and easy to deliver, it made it manageable for them to deliver it to the pupils:

"…the clear delivery of the programme it was quite sequential … it address[es] a different type of coping strategy every time, rather than bombarding them with lots of different things…" (School-4, SENCO)

"…well I think it was quite straightforward…I think I would have been able to do it without that [demonstration] anyway just with the information that was there…" (School-3, Mental-Health-First-Aider).

Facilitators also felt confident in delivering the intervention to the pupils:

"…they both said they felt comfortable…and confident running their groups after seeing (it) modelled...." (EPS, Assistant-EP2)

"…I just feel quite confident delivering it and I feel like it's quite straightforward and you can tweak it a bit for different groups and different levels of maturity…" (School-3, Mental-Health-First-Aider).

Facilitators commented on the self-doubt they felt. However, when they had fully delivered the intervention individually, they reported that their confidence grew:

"…I was looking at how (EP) was delivering the programme. It was really interesting to see what was done…when it was me delivering it. I was like 'I'm not going to do it as well'… I'm enjoying it more now that I'm doing it for the second time, because I've seen the whole program through…" (School-3, Pupil-Premium-Lead).

This, they reported, gave them the confidence to consider training others in the school to be able to deliver the intervention:

"…I wanted to evaluate the course as a whole and then with a view of training other members of staff to deliver it..." (School-4, SENCO)

They also mentioned that wider staff training would be needed to improve the school's understanding of pupils' MH more broadly:

"…I just think that more staff training on awareness of mental health needs and having a whole-school approach to it." (School-1, Pastoral-Support)

The whole-school approach did not, however, need to be entirely led by facilitators, with facilitators noting how the pupils themselves were sharing strategies they used to alleviate anxiety:

"One of the students did download an app that she used for deep breathing and she shared it with the group and she continued to use that after, which she found really useful, erm

so I thought that was a, quite a good way for the group to share strategies they were using…"(EPS, Assistant-EP2)

Sub-subtheme 3.3.3: Developing long-term support to ensure lasting effects.

Consideration was given to the importance of the follow-up session included in the intervention, which focused on positive psychology to provide continued support:

"They seemed to respond…well to the psycho-education…just general positive psychology like the broaden and build in the follow-up session…doing different stuff that like tries to illicit positive emotions…." (EPS, Assistant-EP1)

Facilitators also mentioned the need for ongoing follow-up sessions with pupils to ensure continued feelings of support:

"…I…think that it's important…to have that follow-up…offering to keep…track of people afterwards…sometimes…these interventions…just stop and they think that…no one cares…So I think… letting them know that there's someone there for them after the group as-well…" (School-3, Teaching-Assistant)

"…6 weeks is absolutely fine, but I think just an area where you can review and extend, or signpost on to other support groups or clubs…" (School-1, Pastoral-Support)

Sub-subtheme 3.3.4: Supervision – providing facilitators with containment.

Supervision for facilitators was considered essential in providing on-going support, to enable facilitators to feel confident in continuing to deliver the intervention:

"…knowing that you have a point of contact…on a weekly basis…it really built their confidence. "(EPS, EP)

"…it would be good to have either (Assistant-EP2) to touch base again as a refresher perhaps just to make sure that I'm doing it …right…Maybe a consultation meeting to just set through how it's going to work …" (School-4, SENCO)

However, EPS facilitators suggested that further consideration was needed on how supervision was used within the intervention:

"…I think other people kind of used that [supervision] more …some school staff kind of saw it more as a like practical,…admin time rather than a time for them to actually say 'ah I find this really difficult' or 'what do I do with this sheets [intervention resources]?'…so that took a bit of practice…of saying to them 'ok but how did you find this, and how did you find that?'…" (EPS, Assistant-EP1)

"…we would have a chat prior to the sessions…talking about what we would find when we ran ours to get a bit of feedback and…just be able to discuss how it's gone…it was really helpful…" (School-3, Pupil-Premium-Lead)

Summary of facilitators' experiences.

Facilitators' experiences of the intervention varied. However, there was an overriding sense of positivity and value attached to the intervention. Facilitators reported a range of benefits, including witnessing pupils applying strategies to overcome their anxiety, peer relationships developing and pupils developing a better understanding of their anxiety and what they can do to support it. Facilitators reported great value in pupils making their own choices to attend the sessions, as well as selecting strategies most effective for them. Facilitators reflected on barriers to the successful implementation (e.g. timings, funding and the complex secondary school diary) as well as sharing some useful suggestions to improve the intervention in the future (e.g. increasing the flexibility of the intervention and being mindful of jeopardising fidelity, embedding a whole-school approach, and ongoing support for school facilitators and pupils).

Chapter 5: Discussion

This research investigated whether a group-based intervention using CBTA in a secondary school could reduce the perceived anxiety of adolescents who self-referred to take part in the intervention. Additionally, it examined adolescents' and facilitators' experiences of the intervention. These aims were organised into three main research questions:

- RQ1: What are the outcomes of a therapeutic school-based group CBTA intervention on adolescents after the intervention and two months later?

- RQ2: What are the adolescents' experiences of the intervention group, including strengths and challenges, as reported by the adolescents?

- RQ3: What are the group facilitators' experiences of the intervention group, including strengths and challenges, as reported by the group facilitators?

The *outcomes* of the intervention outline the impact of the intervention, whereas the *experiences* explore the strengths and challenges of the intervention. This chapter will synthesise phase 1 and 2 of the research; to form an integrated discussion of the findings in line with current literature and address the research questions. Implications on EP practice will be contextualised within the PPCT model (Bronfenbrenner, 2005). Consideration will be given to the strengths and limitations of the research and its distinctive contribution to practice. Suggestions for future research will be made, followed by the conclusion of this thesis.

5.1 RQ1 – the outcomes of the school-based group CBTA intervention for adolescents, after the intervention and two months later

Mean RCADS scores decreased over time, however their variance increased across each time point, suggesting that the intervention was more beneficial for some pupils than others.

5.1.1 Overall change in mean RCADS scores.

RCADS scores demonstrated that, on average, the anxiety levels of the pupils in this study reduced (from pre-to-post intervention, and again two months following the intervention). Over half of the pupils showed a decrease in scores, demonstrating that the intervention had positive outcomes and reduced anxiety in the pupils in this study. The small sample size meant that statistical analysis was limited. However, Zahra and Hedge (2010) suggest that for small samples individual RCI's can demonstrate whether any changes across a data set are reliable. In relation to the individual findings obtained from the RCI analysis, whilst reliable change was found for all pupils whose RCADS scores decreased, some caution should be given to interpretation of this analysis. For example, the process of conducting the RCI was conservative, and this may have been too stringent for the population sampled in the current study. Additionally, the coefficient alpha and standard deviation used in the RCI were generated from an international sample (as no English sample data with the criteria needed (as stated in 4.1) was, to my knowledge, available). Yet, pupils and facilitators shared examples of pupils applying strategies learnt in the intervention across different contexts (e.g. at school, school trips, at home), demonstrating the transferability of skills gained during the intervention across different contexts. These findings support the existing literature that advocates the use of CBTA with anxious pupils (e.g. Neil & Christensen, 2009). Whilst the findings are positive, it is important to consider the impact of maturation on the findings. Unfortunately, a control sample (of pupils who did not receive the intervention) was unobtainable. Therefore, it is not possible to discount the possibility that extraneous variables may have influenced levels of anxiety (such as personal circumstances and maturation).

5.1.2 Variability

Overall, RCADS scores reduced; however, this was not the case for all pupils. Interestingly, the variance in scores increased across time, suggesting that whilst the intervention was beneficial to some pupils, others' anxiety levels remained constant, or in some cases got worse. Three pupils showing an increase in RCADS scores over the course of the intervention were from

School 3. Of the five pupils from School 3, only one pupil's RCADS scores decreased: another pupil showed no change in RCADS scores and three pupils' anxiety levels increased following the intervention. It is unclear *why* some pupils benefited from the intervention, whilst others showed no positive benefits.

Whilst limited benefits of the intervention were observed for most pupils in School 3, consent for interview was only given by one pupil (the pupil who had benefited from the intervention). Therefore, I was unable to examine reasons why pupils did not benefit from the intervention in this context. Nevertheless, I was able to interview the two facilitators who delivered the intervention, and document their perception of the impact of the intervention on pupils. Interestingly, the facilitators felt that the pupils had benefited from the intervention. They spoke positively about the pupils' choice to attend and described pupils applying newly learnt strategies in school. Furthermore, pupils had asked for more support from teachers and considered ways in which this may be done (e.g. sharing a letter to teachers with what they find helpful and what they had learnt from the intervention). This suggests that pupils wanted the intervention to take a more whole-school approach.

The disparity between the RCADS scores and facilitators' experiences in School 3 may be due to several factors. First, it may suggest that RCADS scores alone may not truly represent change, despite this measure being well evaluated and recommended for measuring anxiety (CORC, 2017). Thus, it is important to supplement quantitative measures with observed changes reported by pupils and adults who support them. These findings raise the question of whether taking part in such interventions increases self-awareness of the associated disadvantages of anxiety. Such interventions may raise anxiety before pupils are able to apply strategies more frequently in a preventative way to alleviate anxiety. Some pupils may take longer to find the strategies appropriate for them and learn to employ them independently without reminders from adults. Furthermore, these results were only observed in School 3. It is therefore important that contextual factors are considered and explored thoroughly. Facilitators shared that the staff within their school were

very supportive, with their team offering help with work when needed, and that pupil MH was a priority. As seen in Table 1 (Chapter 3.5.2), the school has a high percentage of pupils entitled to free school meals (FSM; pupils with low household income), as well as a high percentage of pupils with SEND. This is reflected in the data as the one pupil in the study diagnosed with autism was from School 3. With a high proportion of SEND and pupils entitled to FSM (which is associated with literacy difficulties [Carroll, Maughan, Goodman, & Meltzer, 2005]), it is possible that some of the pupils who accessed the intervention may have had additional needs, which reduced their ability to engage with the intervention (e.g. difficulties understanding language, expressing themselves, being able to read worksheets). Nevertheless, the intervention is aimed at pupils with low-level anxiety and not specifically targeted towards pupils with SEND. Therefore, when using the intervention with pupils with SEND, appropriate adaptations will need to be made with the support of specialists such as EPs. It could be appropriate to signpost pupils to alternative intervention programmes such as FRIENDS, for example, which are more tailored to those with SEND. Additionally, it further supports the need for training to support this cohort of young people, at a wider level (e.g., training teachers: raising its priority amongst the competing demands faced by teachers, and ensuring that government initiatives support this). Whilst school context and SEND may be confounding variables within the study, other confounding variables may include pupils personal circumstances, such as being a school non-attender and group dynamics (discussed below). Ideally, these would have been controlled for in the present study. Yet this was not possible due to the intervention being newly developed (and therefore piloted within this study), and difficulties recruiting a control sample. Future research may benefit from adding a control sample and considering group dyanmics and personal circumstances such as current or recent significant life events to explore the impact these may have on the outcome of the intervention. This was not possible in the current study due to the time restrictions of the doctorate; however it is believed that this would not impact the aims of the research to conduct an initial evaluation of the newly developed intervention.

5.1.3 The need for qualitative supplements.

Some pupils' RCADS scores did not differ from pre-intervention to two months after the intervention. Specifically, three pupils showed no positive benefit from the intervention (their scores remained constant across the three time points). Two pupils' scores increased from pre-to-post intervention, however, their scores returned to baseline levels two months after the intervention (2a & 3c). One pupil (4c) showed no change at pre, post and follow-up.

Pupils 2a and 3c showed a slight increase at post-intervention before returning to their original RCADS score at two-month follow-up; however, they did not give consent for interview, therefore this could not be explored further. Pupil 4c, on the other hand, whose RCADS score showed no change, gave consent to be interviewed and spoke positively about the intervention, sharing examples of times where she was able to apply newly learnt strategies to alleviate anxiety. This was not captured by the RCADS alone, further demonstrating that pupils' experiences may not be reflected in the RCADS and highlighting the need for supplementary qualitative data. Yet it should be mentioned that interview data were subject to social desirability bias, perhaps making pupils give answers felt to be most favourable to others. As a precursor, I told each participant before the interview that I was looking to examine the intervention and find out what works well and how the intervention can be improved. The interview data, whilst positive, also comprised useful suggestions for improving the intervention in the future; this might suggest limited desirability effects and a balanced argument for strengths and challenges of the intervention.

Pupils were extremely positive about the intervention. They reported a range of benefits, including: access to support; sharing experiences with others; developing a bank of tools to support their anxiety; and access to support. Similarly, facilitators spoke highly of the intervention, for example: witnessing pupils applying strategies to overcome their anxiety outside of the context of the intervention; pupils' peer relationships developing; and pupils developing a better understanding of their anxiety and what they can do to support it. This demonstrates a sense of homogeneity between pupils' and facilitators' experiences of the intervention. Both pupils and facilitators' data referenced

pupils' developed knowledge and application of self-regulation skills. Developing these skills early arguably prevents pupils from adapting self-taught strategies which may be more harmful, such as substance abuse.

One pupil shared that the intervention supported him to successfully reintegrate into school, as he was previously a school non-attender. Anxiety can have a significant impact on adolescents' access to learning, with absence and school non-attendance being linked to anxiety (Public Health England, 2016; Van Ameringen et al., 2003). It is important to recognise that adolescents are facing pressures such as examinations, decisions about further education and managing their self-identity (Garmy et al., 2015). Furthermore, in adolescence, young people become more aware of social comparisons and self-criticality increases (Weems & Stickle, 2005). Bearing this in mind, being able to manage the stressors associated with adolescence may support them to attend school and therefore improve their opportunities for educational attainment. With the increasing recognition of the importance of social, emotional and MH, comes the opportunity for EPs to support and provide schools with accessible, preventative interventions aligned with the current national agenda. The findings show that for a pupil who previously non-attended school, the intervention was successful in supporting their reintegration. However, more research would be needed with this specific cohort of children. Nevertheless, the findings pose a question as to whether the intervention may be beneficial in preventing pupils at risk of becoming school non-attenders.

The findings show that the intervention was successful in developing pupils' understanding of the connection between thoughts, feelings and sensations (a key element of psychoeducation) within CBTA. Pupils began to recognise the complexity of anxiety and how it can impact thoughts, feelings and physiology. However, little recognition was given to the behavioural symptoms of anxiety in the interview data. Additionally, whilst mindfulness has a limited evidence-base (Weare, 2013), the findings suggest that strategies advocated within mindfulness practice (e.g. breathing exercises, progressive muscle relaxation and body scanning), support pupils to feel 'anchored', and return wandering

minds when unwanted thoughts intruded. This allows pupils to explore their thoughts more rationally (Weare, 2013).

Reference was also made to the 'normalising' of anxiety. Pupils found comfort in recognising that they were not alone in the thoughts and feelings they were experiencing. Furthermore, staff and pupils reported recognising anxiety in others outside of the group and offered support or signposted pupils to support. It could be argued that the normalisation of anxiety enables people to speak out about their experiences and seek support where needed, as opposed to more extreme and riskier normalisation that may occur on the internet, such as suicide ideation or body dysphoria. This sharing of experiences and normalisation of anxiety can help to reduce the risk of longer-term difficulties. One way in which this could be extended, given the considerable influence of social media (Dabkowska & Dabkowska-Mika, 2015; Merikangas, 2005), is the use of video blogs that share healthy coping strategies. Accessible video blogs that students can use and share online may be beneficial at a community level. In the future, the intervention may benefit from more explicit discussion regarding the definition of anxiety and how it can have positive effects (such as keeping us safe) as well as anxiety being a normal adaptive response. Within this it is also important to not understate that where intensity is high, anxiety can significantly impair day-to-day functioning, and may lead to further difficulties in adolescence and adulthood (Stallard et al., 2014). Whilst the coping strategies in the intervention may support self-management of anxiety, professional support should be sought when needed.

Findings are in-line with Durlak, Weissberg, Dymnicki, Taylor, and Schellinger, (2011) who found that social and emotional learning interventions have a positive impact on MH. However, more longitudinal research is needed (Weeks, Hill and Owen, 2017). Whilst this research aimed to explore longitudinal effects, the longitudinal factor within this research was a two-month period. This may be an insufficient amount of time between post and follow-up; however, a longer time period was not manageable within the timescale of this research. Also, when originally planning this research, a control group was considered, and it was felt that the two-months would not

be too long a wait for the control group to receive the intervention. Nevertheless, when new skills are learnt it is important that due time is given to consolidate and generalise those skills. It is also important to appreciate that change is not necessarily achieved quickly. Longer-term research would better establish if positive outcomes are sustained, and what works for whom, to embed newly learnt self-regulation techniques into individuals' daily living.

In summary, based on the quantitative and qualitative data, the intervention outcomes were:

- o Reduced anxiety (on the RCADS) was seen for 10 out of 16 pupils, suggesting positive benefits post-intervention and 2 months after the intervention.
- o Despite its well recommended and evaluated background, the RCADS was not truly representative of the observed changes reported by facilitators and pupils.
- o Different contexts may respond differently to the intervention and this requires further exploration.
- o Pupils demonstrated increased understanding of anxiety, CBTA, and healthy self-regulation skills, which may reduce the risk of pupils developing risky coping strategies normalised and idealised across social media.
- o Pupils found comfort in normalising anxiety and feeling less isolated in their experiences.
- o Pupils began to recognise anxiety in their peers and offered support to others.
- o Pupils applied strategies across different contexts (e.g. home and school), suggesting that following the intervention they were able to apply self-regulation strategies beyond the intervention group.

5.2 RQ2 & RQ3 – Pupils' and facilitators' experiences of the intervention

As aforementioned, there was much similarity between pupils' and facilitators' experiences. Therefore, to avoid repetition, RQ2 and RQ3 will be discussed

together. Both adolescents and facilitators spoke fondly of the intervention. They both reported: pupils developing knowledge and effective application of self-regulation skills; and the importance of providing containment and having attuned relationships. Additionally, facilitators drew attention to facilitative and systemic factors to quality assure the intervention and embed the intervention at a whole-school level, whilst pupils suggested facilitative factors that could influence positive intervention engagement.

5.2.1 Pupils' developing knowledge and effective application of self-regulation skills

One of the aims of the intervention is to teach pupils coping strategies to alleviate anxiety. Whilst there is limited evidence for positive psychology interventions (Lomas et al., 2014) and mindfulness (Weare, 2013), pupils spoke highly of their influence in the intervention. The intervention sought to empower pupils by supporting them to understand and manage their anxiety with psychoeducation, and teaching and practising strategies. O'Reilly, Svirydzenka, Adams and Dogra (2018) suggest that skill development, such as teaching strategies, can have preventative effects, reducing the risk of more complex needs. Pupils spoke positively about the effective use of a range of strategies taught in the intervention (e.g. breathing, visualisation and progressive muscle relaxation). Interestingly, they spoke highly of the mindfulness-based strategies (e.g. deep breathing and body scans), demonstrating that pupils valued these techniques. Pupils reported that the strengths-focus, which guided them to consider positive factors in the week, was beneficial in supporting them to shift negative thinking to a more positive narrative. Whilst the intervention guidelines suggest that positive psychology is focused on at the end of the intervention, it could be argued that this approach was embedded throughout the intervention (alongside CBTA). Throughout the intervention, the pupils are encouraged to identify strengths, gratitude and affirmations for themselves. The interview data identified that the pupils responded well to the positive language.

Pupils reported their appreciation of the self-compassion and kindness the intervention encourages. The positive focus is a shift away from the deficit

focus previously applied in CBT (Fredrickson, 2004). Research suggests that self-compassion and kindness increase resilience to stress and anxiety (Poulin et al., 2013). As highlighted by Bolier et al., (2013), there is a need to build an evidence-base for positive psychology approaches. The findings from this study support the application of positive psychology approaches, such as the broaden and build theory (Fredrickson, 2004).

5.2.2 Facilitative factors that could influence positive engagement with the intervention.

Facilitators highlighted that the intervention seemed more beneficial to pupils who engaged in the sessions, suggesting that a person-centred approach (in which pupils had chosen to take part in the intervention) had a fundamental influence on impact. Prochaska and DiClemente's (1983) transtheoretical model suggests that there are six stages to change. Pupils choosing to come to the intervention demonstrates a degree of readiness to change and being within the 'action' stages of the transtheoretical model. These findings are aligned with previous research (Graham, 2005; Weeks et al., 2017), reporting that for CBT to be successful, CYP must acknowledge their difficulties and want to change.

Pupils were grateful for the opportunity to access support. Facilitators and pupils recognised a lack of MH support in schools and felt that the intervention improved their opportunities to access support. This finding supports Fonagy's (2015) claim that targeted interventions are less available for pupils who exhibit less externalised behaviours (such as those with anxiety), and therefore are not standing out in larger groups. In line with Vostanis, Svirydzenka, Dugard, Singh and Dogra (2013), it appears that providing support for quiet and compliant pupils is not an immediate priority in education settings.

The intervention's self-referral system provides a platform for pupils with more internalised behaviours to come forward and seek support (Graham, 2005; Stallard, 2009), in addition to those with externalised behaviours. This may be a productive way forward to address concerns that the recognition and access to support for anxiety is poor (NICE, 2014). The method of self-referral opens

opportunity to access support, without relying on adults to recognise and refer pupils. Arguably, this intervention can lead to adolescents receiving the support they want/need before difficulties become more complex and challenging.

With regards to the self-referral method, facilitators did not raise any difficulties with recruitment during the interviews, nor informally during discussions with schools. On the contrary, some schools had a high level of sign-up to the self-referral intervention leading to schools agreeing to deliver more groups and requesting additional staff to be trained to deliver the intervention. Pupils and staff discussed that encouragement was given from staff and parents to attend sessions in addition to the poster and tutorial announcements to advertise the group. Facilitators reported that pupils who chose to attend sessions benefited most from the sessions. Some pupils acknowledged that although they felt they did not have to be at the intervention after being encouraged by staff to join, that they benefited from the intervention. This begs the question of whether or not the self-referral method was true for all pupils. It may be seen as unethical to over encourage a pupil into a therapeutic setting. Therefore, it is essential that when running interventions such as these within secondary school settings, and when claiming to be 'self-referral', that this is honoured by school staff and parents. Whilst awareness of the potential benefits of the intervention and its availability may be raised to pupils, pupils must show willingness and readiness to attend, rather than being over-encouraged or coerced by staff and parents; as highlighted by Deci and Ryan (2008) and Graham (2005). Whilst it may be that parents and school staff are wishing the best for pupils and willing them to have access to support, it is important that when setting up such interventions pupils are giving fully informed consent and pressure is not placed on pupils to attend should they not wish to attend as CBTA is a collaborative approach (Fenn & Byrne, 2013).

If professionals want to act in a preventative way, and reduce the risk of more complex needs developing, more attention needs to be provided to quiet and compliant pupils, who may have more internalised anxieties that influence their daily functioning and quality of life. Although national initiatives aim to raise

awareness of MH difficulties, with a focus on working preventatively and providing support for pupils, these initiatives lack specificity, appropriate funding, and guidance on how to implement new ideas. With the prevalence of MH needs and anxiety difficulties increasing, meeting the demands of pupils can be challenging. However, with a preventative approach, EPs can support schools to implement interventions that are wide reaching, evidence- and/or practice-based, as well as being affordable and accessible for schools. Staff commented on the 'clear and easy' delivery of the intervention, demonstrating its accessibility to schools. Due to their extensive training, continuous professional development and close relationships with schools, EPs are well placed to offer schools support to think creatively, to promote a preventative approach, and to ensure that all children who need support have access to it (in line with current guidance).

Whilst a person-centred approach was deemed of high importance, there is often a power dynamic in schools, in which students' activities are led by staff. Additionally, research shows that it is mainly staff and parents who initiate the process of change, referring pupils to interventions rather than pupils making their own decisions (Graham, 2005; Stallard, 2009). Therefore, it is important to consider the pressure some students may have felt when 'encouraged' to attend the sessions, thus impacting their 'quality' of motivation to engage in the intervention and their readiness for change.

As highlighted through Self-Determination Theory (Deci & Ryan, 1985), 'quality' of motivation is an important predictor of outcomes, such as performance or MH. Motivation comprises automatic motivation (intrinsic and extrinsic motivation that identify value in an activity and an integrated part of the sense of self) and controlled motivation (driven by external factors e.g. reward/punishment). Autonomous motivation leads to more positive MH and maintained change (Deci & Ryan, 2008). Thus, it is important that pupils have autonomous motivation when taking part in an intervention and are not led or 'controlled' by external factors to improve the likelihood of sustained change. The motivation that drove the pupils to attend the sessions may explain the variance in the results. Whilst some chose to come to the intervention, others

were encouraged; therefore, their motivation may have been more controlled rather than autonomous, thus influencing their engagement with the intervention.

5.2.3 The importance of providing containment and having attuned relationships.

Pupils and facilitators also commented on the 'containing' experiences of the intervention. Containment refers to the reciprocity and space between a consultant and the consultee by providing feelings of safety, and being emotionally held (Bion, 1962). Pupils commented on the group dynamics (mixture of introverts and extroverts) and feeling safe and comfortable to share their experiences (feeling unjudged, listened to and feeling confident that confidentiality was respected). Facilitators felt that it was important to be receptive and accommodating to the pupils' emotional needs, thus highlighting the need for attuned relationships and 'unconditional positive regard' to provide containing experiences. Facilitators and pupils also commented on peers supporting one another and developing positive relationships.

Whilst containment from facilitators offered a safe space and enabled some participants to share their thoughts and feelings more comfortably, reference was also made to feelings of discomfort and the inability to share experiences due to the range of characters in the groups. For pupils who valued the feelings of attunement and containment, reference was given to feeling 'no judgement', which enabled pupils to share their thoughts. However, others felt that peers within the group did not offer the same sense of safety (some were uncomfortable sharing their thoughts and feelings). This demonstrates a lack attunement amongst some of the peers, which may have impacted upon pupils accessing the full benefit of the intervention. However, this was not unanimous. Whilst a 'therapeutic alliance' (Bordin, 1979) may have been established and have been found to be key to successful work with young people (Beaver, 2011; Bombèr, 2007), more consideration needs to be given toward peer alliances, to enable greater feelings of safety and non-judgement. This would enable more people to share their experiences and benefit further from the intervention. This raises the salient point that when pupils self-refer to the

intervention, adults need to confirm with participants that they are happy with the group set-up. This demonstrates one-way staff can support successful engagement with the intervention.

Within a therapeutic setting, considering the holistic approach of the PPCT model (Bronfenbrenner, 2005), this process of containment needs to be extended beyond the facilitator-pupil relationships to the facilitator with other professionals, 'containing the container'. For facilitators, this can be offered during supervision by trained professionals, which is a key structure enforced by psychologists' governing bodies (BPS, 2015; HCPC 2015). Whilst supervision is an embedded part of the intervention, this requires extensions in terms of continued, regular supervision after the intervention is demonstrated to the facilitators. Further clarity and support for school staff as to the purpose of supervision and how it could be used effectively was also highlighted. Supervision is not as readily available, nor an embedded structure, within the teaching profession. Therefore, this could be offered through the EPS.

Anxiety can be experienced internally, such as a 'quiet and compliant' presentation, and this is where anxiety interventions are often evaluated (Fisak et al., 2011; Stallard, 2009). However, anxiety can co-occur with other difficulties such as ADHD, which display more externalised behaviours. There is limited evidence, to the author's knowledge, for the impact of CBT for pupils with more externalised behaviours. Therefore, it would be beneficial to encapsulate this within future research. Furthermore, due to the significant impact of relationships on the engagement and outcome of the intervention, the intervention may benefit from incorporating this within staff training on intervention delivery. This may include more explicit training with regards to building attuned relationships and active listening skills.

5.2.4 Facilitative and systemic factors to quality assure the intervention and embed the intervention at a whole-school level.

Embedding a whole-school approach allows for a shared agenda and collaborative approach to supporting pupils' MH, as opposed to having one or a few people within school who hold the responsibility for pupils' MH. EPs' close relationships with schools enable them to support the proximal processes between different systems to ensure a shared understanding and the best way to support pupils, with consideration of the different systems working around the young person. EPs' extensive training, application of therapeutic approaches and support for anxiety and MH difficulties, makes them well-placed to deliver this support to school staff.

The current funding restrictions have been recognised by the LA and the intervention was offered for free. A facilitator mentioned that one of the main reasons this intervention was able to be implemented in their school was because the intervention was free. Current funding difficulties demonstrate that these interventions are difficult to manage and sustain. O'Reilly, Svirydzenka, Adams, and Dogra (2018) suggest that targeted interventions, opposed to universal whole-school interventions, are more manageable and sustainable. However, due to its prevalence, using a whole-school approach to target anxiety will enable a wider-reaching impact than small, group targeted interventions. As suggested by Bercow (2008), there is a need for universal, targeted and specialist services. Yet these services need to be commissioned, and it appears that there is not enough funding to meet the high demand of pupils who require support.

It could be argued that, with the current tightly-bound curriculum and teachers restricted-time due to competing demands (lesson plans, multiple roles, marking, new curriculums, pupil monitoring systems, high staff turnover), staff have less time and space to think creatively and include ample discussion time for pupils to share/explore their knowledge and experiences. Due to these restrictions, teachers can be led to be more directive in their pedagogy to ensure all content is covered. With the current shifts emerging in terms of

raising the presence of wellbeing within school agendas (Ofsted, 2019) comes a prime opportunity to embed more learning and discussion around pupils' wellbeing. This may be through protected tutor times, PSHE or ideally as a subject of its own.

Staff wellbeing is foundational to pupil wellbeing (Al-Ghabban, 2018). Therefore, it is paramount to ensure staff wellbeing is nurtured. Many of the facilitators spoke of their own experiences influencing their commitment and reasons for interest in the intervention. This suggests a degree of automatic motivation, which can be nurtured and reflected on through supervision. Thus, ongoing supervision could influence the long-term and lasting effects of the intervention as it offers support to staff to enable them to problem solve and overcome any challenges. This would ensure that the intervention continues to run successfully, whilst nurturing and developing the resilience of systems supporting pupils. Ideally, containment would be offered to all teaching staff, considering the overwhelming demands on teachers.

Training and support for staff was highlighted as a facilitative factor in embedding a whole-school approach to support MH. The intervention embeds well-structured training to deliver the intervention, with demonstration and supervision. However, it does not include any specific training regarding anxiety or CBTA, nor training on supporting anxiety for wider school staff. Pupils commented on their preference for teachers to better understand their needs and what can be supportive for pupils with anxiety, whilst facilitators suggested that wider school training would improve longer-lasting effects and support for pupils. These findings are harmonised with suggestions by Bachman (2015), who proposed two coping styles: emotion-focused, which aims to reduce physiological and emotional reactions; and problem-focused, whereby there is an attempt to modify the problem situation to make it more manageable. Whilst the development of internalised coping strategies is important and is established to some degree during the intervention, it is equally important to develop an understanding of why we behave the way we do as a result of situations we may find ourselves in and make attempts to adapt these situations. The 'problem-focused' coping strategies need to

include staff to support pupils to alleviate anxiety and not solely put the onus on pupils to self-regulate without recognition of the impact of systems around them. Furthermore, anxiety is a 'normative' response; therefore, systems around pupils would benefit from understanding strategies that can support pupils alleviate anxiety symptoms. Extending the training of the intervention through to all staff (including senior leadership teams; SLT) could lead to further reaching and longer-lasting positive benefits. Facilitators also raised the importance of SLT being invested in the intervention to allow appropriate time for planning and preparation for the intervention. Consideration needs to be given to the time commitment required to organise the materials and groups, as well as communicating with staff, pupils and parents.

Parsons et al. (2013) reflect on the importance of everyday context and practitioner involvement. Parsons et al. (2013) and Ringle et al. (2015) note that currently many interventions lack flexibility, yet school staff report the need for more flexibility to take into account the complexity of school settings. Accordingly, facilitators and pupils reflected on the need for more flexibility in the intervention. They reported that some pupils required more one-to-one time, some groups had more discussion, some tasks in the intervention were not suited to all pupils, and (at times) the content felt rushed in the one-hour session. Reference was also made to the complexity of school diaries and, at times, there being longer gaps between sessions due to holidays, exams, or school fixtures. Respecting and valuing practitioners' expertise is fundamental to successfully implementing interventions in the varied and complex settings of real-world classrooms. Professionals need to work closely with schools to think realistically about how to implement sustainable interventions and ensure that, whilst flexibility may be needed, interventions are still using evidence-based approaches to effectively support pupils' needs. Positive MH promotion in schools would benefit from schools continuing to provide pupils with intervention programmes. However, ongoing quality and evidence-base assurance of these interventions need to be monitored.

Whilst Neil and Christensen (2009) question the true fidelity of 'CBT' interventions, this intervention applies CBTA alongside positive psychology

approaches. As highlighted by Fonagy (2015), CBTA are not homogenous; tools can vary and be developed according to individual needs. However, it is important that the adaptations are accessible but do not miss the essence of the tools purpose (e.g. using the hot cross bun with pictures, as opposed to words; not making the hot cross bun into a wheel, which may change its meaning to be more cyclical, rather than recognising connections). Thus, the intervention being delivered flexibly poses the risk of inconsistent approaches to delivery, reducing the evidence-base to evaluate the intervention's impact. Therefore, it is essential to have a balance between prescriptive guidelines and flexible adaptations; this may be done by incorporating regular EP supervision to ensure safe and effective practise.

Pupils and facilitators also suggested one-to-one sessions in addition to the intervention. This could be something schools set up to enable pupils to receive more individualised support, if required. However, the current intervention is targeted at pupils with less complex needs and aims to act in a preventative (rather than reactive) way. Some pupils reported the need for more one-to-one support, whilst facilitators mentioned the need to offer one-to-one support following the intervention. In the future, when planning and organising the intervention with schools, this will need to be highlighted. When placing pupils into groups, professionals need to be mindful of the level of need and assess whether group intervention, one-to-one, or a combination would be best. With the current demand on services such as CAMHS and the EPS (Islam, 2013), alongside national funding difficulties, individualised intervention can be difficult to deliver and consequently is currently less sustainable and manageable in educational settings. However, considering the regular contact schools have with EPs and their extensive training in therapeutic approaches, the higher need children may be discussed in planning meetings and therapeutic work may be carried out by EPs.

In summary, the pupils' and facilitators' highlighted several strengths and possible improvements of the intervention (see Table 8).

Table 8: Strengths and potential improvements of the intervention

Strengths

- Pupils and facilitators valued the opportunity for containment (Bion, 1962) and building attuned relationships;
- Pupils were able to challenge negative thoughts and shift them to be more positive;
- Pupils valued the positive psychology approach (gratitude and affirmation) and practising the mindfulness-based strategies (e.g. breathing, body scan);
- Pupils and facilitators felt that the self-referral nature of the intervention improved pupils' access to support;
- Pupils 'normalised' anxiety and enjoyed sharing their experiences with others;
- Facilitators reported that the support of the SLT was fundamental in successfully implementing the intervention.

Potential improvements

- The need for more flexibility in the intervention, to facilitate a more person-centred approach and fit manageably within the context of complex secondary school settings;
- The need to embed a whole-school approach, training all staff and teachers, was thought to be helpful;
- Training facilitators regarding attunement, CBTA and anxiety to improve their understanding of implementing the intervention successfully;
- The development of an online network through which facilitators could share coping strategies through video blogs on social media to support pupils and share resources with other facilitators.
- Continued supervision of facilitators following the intervention demonstration;

- Groups need to consist of pupils who enable safe spaces that are conducive to developing attuned relationships.

5.3 EP implications of research in-line with PPCT model

Throughout the research, consideration was given to systems around pupils as well as the pupils themselves. The current study applies Bronfenbrenner's (2005) model to consider the influence of the pupils' environment, such as: the national context; consideration of resources available and motivation; the interaction between systems such as school, parents and EPS; and the time-context in which the study has been conducted. Table 9 gives an overview of the implications of findings, in-line with the PPCT model. Whilst the findings are context-specific to the LA, the secondary schools included and the intervention explored, the findings could also be used to inform other contexts (e.g. settings or interventions), however, this will need further exploration. Therefore, consideration was given to the implications for EPs, EPSs, schools and future MH policies.

Table 9: Summary of Implications

Process	• Interactions regarding access to support needs to be more dyadic between pupils and adults. • Sharing information between school staff, parents and professionals is highly important. • Senior leadership needs to be invested in the intervention to implement a whole-school MH approach and ensure successful implementation of the intervention. • Offering supervision allows staff the opportunity for containment, which is important, as staff wellbeing impacts pupils wellbeing. EPs are well placed to offer this.
Person	• Intervention groups should be organised with consideration to group dynamics that facilitate safe spaces and attuned relationships. • Adults should not over encourage pupils to join the intervention groups. Positive outcomes are more likely for automatically motivated pupils. • With consideration to the influence of social media, pupils may benefit from access to video blogs discussing coping strategies.

Context	• More clarity is needed in government initiatives promoting MH support in schools.
	• Individual circumstances need to be taken into consideration when including pupils in groups. Appropriate support for higher-level needs could be discussed with EPs.
	• Relationships need to be a high priority in schools. Staff may benefit from training in attunement principles and embedding relationships in school policies.
Time	• Interventions being implemented in secondary schools need to be manageable, sustainable and preventative.
	• Interventions would benefit from more flexibility to improve person-centred approaches and successful implementation of interventions in schools.

5.3.1 Process (Interactions in the immediate environment including form, power, content, and direction of proximal processes).

The implications in relation to the process include: more dyadic interactions between pupils and adults regarding access to support; the importance of sharing information between school staff, parents and professionals; senior leadership's investment in the intervention to implement a successful whole-school approach; and offering supervision enabling staff containment. The findings highlight key factors EPs, working at a systems level to support schools, can use to inform MH policy and practice and to address early intervention processes and practices, as highlighted by the Green Paper (DfE & DoH, 2017).

Pupils are usually referred to interventions by adults. However, with the internal nature of anxiety, the 'quiet and compliant' pupils are often under-recognised and consequently not prioritised for support. This intervention provides access to support for these pupils, due to its self-referral method. Opening a more two-directional interaction for pupils who require support, as opposed to the previous adult-led interaction, arguably gives more power to the pupils. Furthermore, this empowers pupils to seek support should they feel

they require it, particularly during adolescence (which has multiple factors that can lead to anxiety, e.g. exams, societal pressures, relationships).

Pupils and facilitators referred to sharing information outside of the intervention (e.g. with teachers and parents). Training others on anxiety and coping strategies could support the pupils to apply strategies across different contexts. As raised by Bachman (2015), this encompasses emotion-focused, as well as problem-focused, coping strategies. Whilst this intervention aimed to do this through the teaching of strategies and training the facilitators, it was felt that this needed to be extended to be a more whole-school approach, including improved inclusion of families. In the future, EPs may look to deliver training on these strategies for all staff and parents, as well as more information-based training (e.g. on CBTA, anxiety and attunement) for the facilitators (plus the current training model).

As highlighted by the facilitators, for such interventions to be successful, support and commitment is required from SLT. EPs can support the successful implementation of the intervention by facilitating meetings with SLT to ensure all factors are considered to enable a sustainable intervention to be implemented. Furthermore, with EPs facilitating conversations with SLT to implement the intervention, attention must be given to the time and space needed to deliver interventions successfully. Schools need to be honest and realistic when setting up interventions, so EPs can work collaboratively with the team around the pupils to ensure the intervention is effective and sustainable considering the context of the school, as well as ensuring that pupils feel supported e.g. using person-centred planning approaches such as Planning Alternative Tomorrows with Hope (Pearpoint, O'Brien, & Forest, 2016).

As highlighted by the BPS (2015) and HCPC (2015), interventions being delivered should be supervised by a trained professional. Therefore, whilst this intervention includes supervision throughout the demonstration of sessions, further consideration was given for the need for the supervision to continue. Given the rising prevalence of MH difficulties, and difficulties accessing services, arguably leading to pupils having more complex needs, school staff

require professional supervision to ensure safe practise and quality assurance as well as an opportunity for containment. This is because running therapeutic interventions can be a very rewarding, yet very challenging. It is important that EPs provide schools with accessible support, such as supervision, to ensure staff wellbeing, as we know this can impact pupils' wellbeing.

5.3.2 Person (Demand characteristic [biological/genetic make-up]; Resources available to them [emotional, daily living, education]; Force characteristics [temperament, motivation, persistence]).

The implications in relation to the person include: intervention groups should be organised with consideration to group dynamics that facilitate safe spaces and attuned relationships; adults should not over-encourage pupils to join the intervention groups; positive outcomes are more likely for automatically motivated pupils; and pupils may benefit from access to video blogs discussing coping strategies.

Pupils benefited from being in groups that were suited to their personality types (introvert/extrovert). This enabled feelings of safety and pupils felt they could share their thoughts and feelings. Thus, schools should aim to group pupils who self-refer into interventions that facilitate safe spaces and attuned relationships. EPs should look to support schools to think about group dynamics when setting up targeted intervention, as this could impact the success of interventions.

O'Reilly, Svirydzenka, Adams, and Dogra (2018) claim the 'crucial challenge' of universal and targeted interventions is to consistently and effectively engage pupils in the development and delivery of intervention. The findings of this research suggested that pupils engaged in the intervention and mostly benefited from it. In line with the transtheoretical model of motivation and change (Prochaska & DiClemente, 1983) and Graham (2005), the findings suggest that pupils who have motivation to engage with the intervention show better outcomes. However, whether their motivation was controlled or automatic was not measured, as it was not in the scope of this research.

Therefore, it is important that school staff are mindful not to allocate pupils to interventions without discussing the opportunity with them and ensure that the reasons for taking part in the intervention are primarily fuelled by their own automatic motivation, as opposed to more controlled motivation. EPs can apply psychological theories and their understanding of motivation to understand where they are in relation to the transtheoretical model. EPs can also discuss the suitability of interventions for different pupils, supporting schools to understand what works for groups of pupils and why.

In line with pupils' current zeitgeist, staff and EPs could begin to create video blogs of coping strategies to increase accessibility to support; raising awareness of MH needs and the impact of anxiety in schools, for adolescents.

5.3.3 Context (microsystem, mesosystem, exosystem, macrosystem, chronosystem).

The implications in relation to the context include: more clarity is needed in government initiatives promoting MH support in schools; individual circumstances of schools need to be taken into consideration when including pupils in groups; appropriate support for higher-level needs could be discussed with EPs; and relationships need to be a high priority in schools. Staff may benefit from training in attunement principles and embedding relationships in school policies.

As policies and statements that advocate the promotion of positive MH for pupils surface, there continues to be a lack of specificity as to how the initiatives are rolled out, who is best place to support them, and how they can be implemented across different school contexts who have a range of competing demands. Whilst the Green Paper (DfE & DoH, 2017) lacks clear guidance and support for designated MH leads, facilitators recognised and welcomed the 'easy and clear' to deliver intervention, as described by one of the facilitators. EPs are trained in communicating information in an accessible way to a range of audiences and have extensive training in therapeutic approaches. Therefore, when such policies are being developed, it is important to include EPs and school staff to co-construct manageable initiatives that feel

'easy and clear' to deliver. With consideration to the new Ofsted framework (Ofsted, 2019), EPs could work collaboratively with schools, supporting them through the pressures of the competing demands, to implement interventions such as the one in the current study. Ultimately, it is hoped that this would improve the emotional wellbeing outcomes of pupils.

When including pupils within group interventions, it is important to consider their individual circumstances. For pupils who may have more complex needs, school would benefit from liaising with their EP, or discussing the pupil in planning meetings. Additionally, it is important to consider school context. This is particularly important since pupils in School 3, which has a high percentage of pupils entitled to FSM and pupils with SEND, had varied outcomes. This demonstrates that specialists, such as EPs, need to work with schools to facilitate appropriate adaptations in order to increase the likelihood of the intervention being successful, based on individual context.

Pupils valued the attuned relationships with the facilitator and their peers. This elevates the importance of relationships (in the intervention and within schools) and how they can influence engagement with the intervention. The therapeutic alliance - the emotional and containment bond between the facilitator and the group - is key to the success of the intervention and learning relationship (Youell & Canham, 2018). As the findings placed great emphasis on relationships between the pupils, their peers and the facilitator, it could be argued that schools would benefit from training in attunement principles, which EPs are well-placed to deliver. Additionally, schools would benefit from including relationships within their policies to raise the importance and priority of relationships in schools. EPs should support schools to consider the importance of relationships and work closely with schools to increase their priority on school agendas. This may lead to better outcomes for pupils, both emotionally and academically.

Furthermore, within a traded delivery model, in which schools buy-in EP time, EPs need to work with schools to negotiate the most effective use of their time. Therefore, where school budgets are limited, providing staff training to deliver evidence-based interventions within schools will broaden capacity to support

CYP's MH. This may prevent CYP from developing more complex MH needs.

5.3.4 Time (What is happening during the course of the specific activity being studied?).

In relation to time, possible implications from the research include: interventions being implemented in secondary schools needing to be manageable, sustainable and preventative; and interventions benefiting from more flexibility to improve person-centred approaches (promoting the successful implementation of the intervention in schools).

As the prevalence of MH difficulties continues to rise, it is imperative that EPs are working with schools to support pupils and put in place therapeutic interventions that are accessible to all pupils (whilst due consideration is given to current financial challenges). Interventions must be manageable and sustainable for schools, considering the complexity of secondary education settings. Government initiatives continue to name schools as key stakeholders who play a key role in young people's MH, thus highlighting the importance of more preventative (as opposed to reactive) working, to prevent difficulties becoming more challenging. EPs should work with schools to ensure that interventions being implemented are manageable, sustainable and preventative where possible.

EPs can guide staff to use CBTA, such as challenging negative automatic thoughts, delivering psychoeducation and teaching strategies to support symptoms. This may support CYP with anxiety-traits to shift their way of thinking and develop positive coping strategies (Durlak et al., 2011). However, there are a range of challenges faced by EPs, such as a shortage of EPs, inaccurate perceptions of EPs' role, and the lack of funding for services (Islam, 2013). The best use of the role of the EPs may be to support staff to use CBTA with CYP with MH difficulties, such as anxiety.

A salient theme raised was the need for flexibility in interventions delivered in schools. Schools need to be open in sharing what will work for them, as well as ensuring protected time and space for the intervention to run successfully.

EPs can encourage schools to use interventions flexibly, through the use of supervision and support to evaluate interventions and ensure effective practice. With the continuing development of government policies, which name schools as key stakeholders in pupils' MH, professional development is key (Groom, 2006). EPs are well-placed to facilitate shared responsibility, training and the development of interventions. They are able to draw on their knowledge and understanding of evidence-based practices, practice-based evidence (Fox, 2011), schools and child development to enable others to develop their knowledge and understanding of promoting positive MH. EPs can also support those working in schools to utilise and develop effective interventions for staff or professionals to deliver. They can play a crucial role in providing support and training for staff to effectively engage and support children with MH difficulties (Farrell et al., 2006).

5.3.5 Implications to my own practice.

Already this research's implications have influenced my own practice. As highlighted by the research, a more whole-school approach is needed to support pupils with anxiety. Therefore, I have set up more whole-school trainings around the use of anxiety coping-strategies and have worked with schools to consider how these may be included within the school day. Additionally, when setting up group interventions in schools I have encouraged staff to consider group dynamics, as well as the use of open referral approaches – asking pupils whether they would like to join, rather than involuntary attendance. Furthermore, in continuing to embed this KS4 anxiety intervention in other secondary schools, I ensured SLT joined the planning, and allocated time for on-going supervision to offer group-facilitators containment. I feel confident in continuing to support staff to put in-place this intervention to ensure the outcomes continue to be positive; and increase pupils' opportunity to access support for anxiety. On starting my qualified post in the research's focus LA, I hope to begin to train school staff, particularly those delivering anxiety interventions, in attunement principles, to ensure that attuned interactions are embedded throughout their communication with pupils, but particularly within therapeutic work.

5.4 Strengths and limitations

A mixed methodology was applied throughout this research. Similar to Burke, Prendeville and Veale's (2017) study of the FRIENDS programme, the findings of the current study demonstrate that the outcomes of the intervention could not be captured in quantitative methods alone, with qualitative data adding great value (such as pupils developing their knowledge and understanding of self-regulation skills). As interviews were not conducted before the intervention, I was unable to compare and contrast responses from before and after the intervention. However, prior to interviews being conducted, interviewees were told that the purpose of the interview was to evaluate the intervention and examine their experiences; therefore, answers were guided to be focused on outcomes of the intervention. Interviewees also shared contextual factors such as school ethos and challenging periods, such as exam times, which enabled me to gain a broader understanding of the impact of the context on the intervention.

Recruitment was difficult, as schools had difficulties obtaining a control group due to the timing of the research and the need to promise the intervention to the control group whilst not knowing if or how the group could run after the summer term (e.g. considering staff turnover and KS4 pupils leaving the school). If the intervention were to be evaluated again, it would be beneficial to run the group earlier in the year, so that the control group would be able to receive the intervention before the academic year is complete. It would also be important to examine any differences in self-referrals at the beginning of the academic year, in comparison to the start of the spring term (which was closer to exam time). However, due to the time limitations of the current research, this was not in the scope of this project.

Difficulties gaining consent led to a limited sample size, which eliminated the possibility of statistical analysis of RCADS data. Therefore, the significance of the findings (e.g. via effect sizes) were unobtainable. Additionally, as the researcher was unable to obtain a control group, it was difficult to compare the impact of the findings of the experimental group with a group who did not take part in the intervention. This means it was difficult to link any changes solely

with the intervention, as opposed to other contextual factors and extraneous variables. However, the interviews enabled me to examine changes acknowledged by pupils and facilitators that were linked, in their perception, to the intervention. Perhaps with less time restraints, I may have been able to obtain a larger sample size, a control group and conduct interviews before and after the intervention took place. Nevertheless, this does not resolve the difficulties with gaining consent from secondary school parents. This may be due to the more distant home-school relationships within secondary schools, relative to primary schools. I then wondered if the lack of communication between home and school may be due to more quiet and compliant pupils receiving less attention from staff than more disruptive pupils. Regardless, systematically investigating the reasons for difficulty with recruitment was beyond the scope of this research. Future research should foster creative methods of obtaining consent from secondary school parents. It may also be useful to investigate why consent can be difficult to obtain and how processes could be improved.

Additionally, unlike many trials that have been used to evaluate CBT, the research was based in real-world settings (schools) rather than clinics (Weeks et al., 2017). As highlighted by O'Callaghan and Cunningham (2015) and Stallard et al., (2014) CBTA interventions can achieve successful results when delivered by trained school staff, which the findings of this research support. Therefore, this study contributes to the growing body of longitudinal research examining real-world CBTA application (such as within schools and with school staff delivering the intervention). The findings suggest ways in which the implementation of the intervention can be improved to be more manageable for schools, more person-centred for pupils and enable more lasting impact.

The intervention has sound theoretical underpinnings, with extensive research supporting the use of CBTA and growing support for the use of positive psychology. The findings align with previous research supporting the use of CBTA, but also extend the evidence-base for positive psychology approaches (Poulin et al., 2013; Waters, 2011). Additionally, although the longitudinal

element of the research examined the impact of the intervention two-months later, future research may benefit from longer intervals for measuring lasting impact.

Weist and Murray (2008) suggest that good quality interventions: use inclusive approaches; are programmes that are responsive to the student, school and between community needs; build connections between resources; focus on reducing barriers to student learning through evidence-based programmes; emphasise and provide support for systematic quality assessment and improvement; ensure staff are engaged and supported; ensure efforts are sensitive to development and diversity factors of students; and build interdisciplinary relationships in schools, strong teams and coordinating mechanisms. Whilst the intervention has aimed to achieve these, the current research looks to further improve the quality of the intervention, through including staff and pupils' suggestions for improving the intervention in future implementation.

The research provides initial evidence for the intervention; however, larger scale and more tightly controlled experimental studies are needed. Thus, the findings cannot be generalised widely, due to the contextual nature of the research and its limited sample size. This does not affect the aim of the study, which looked to provide an initial examination of the intervention and add to the growing evidence-base of what works for whom and why (Fonagy, 2015).

5.5 Reflections on reflexivity

Qualitative research cannot escape the theoretical and epistemological position of the researcher, because the process of developing themes is unavoidably influenced by the researcher's judgment and decision making (Braun & Clarke, 2006). It must be acknowledged that, as a current team member of the EPS that offered the intervention, school staff and members of the EPS were aware of my affiliations with the service and the university. This could have influenced how participants answered questions. However, participants were reminded that all responses remained confidential. It is my belief that this allowed participants to be honest and open about their

experiences, sharing factors that went well and how the intervention could be improved.

As aforementioned, my own views and beliefs could influence my interpretation of these data. However, to provide transparency and clarity, my philosophical stance (contextualism) and reflexivity were highlighted in Chapter 3.1 and 3.2. The use of regular supervision with academics and a practising EP university tutor, alongside regular peer supervision, enabled me to ensure an objective stance was taken. Throughout supervisions, I checked my interpretations and reviewed transcripts with colleagues, which evidenced that the findings drawn from these data had little influence of my own experiences, but reflected a more shared understanding (Appendix O).

Other aspects to raise within my reflections are the time limitations and well-being pressures associated with balancing the thesis alongside competing demands such as placement, family and university. Whilst this may have been challenging at times, I made effective use of supervision to manage my time and plan accordingly, giving time and space for the processes involved within the research as well as ensuring protected time for my own wellbeing. This allowed me to take an in-depth and reflexive approach to the research, overcoming barriers (such as recruitment) and being consistently patient, yet rigorous in collecting, examining and presenting the data. I believe this allowed me to give a coherent report of the outcomes and experiences in relation to the intervention.

5.6 Distinctive contribution of current research

As highlighted by Weeks et al. (2017), there is a need for more qualitative research when evaluating CBT-based interventions. This research addresses this through the inclusion of pupil and facilitator experiences of a CBT-based intervention, which brought to light valuable findings.

Whilst CBTA are extensively researched and highly recommended for supporting anxiety, the intervention addresses weaknesses of other interventions previously outlined by: incorporating staff training and support (Vostanis et al., 2013); and using self-referral so pupils opt into the intervention

opposed to adults selecting pupils, demonstrating motivation to change (Graham, 2005; Stallard, 2009). This research demonstrates the value of real-world research, considering pupils' contexts, using self-referral to improve access to interventions and finding that motivation can influence positive outcomes of an intervention. Furthermore, the intervention being examined incorporates elements of positive psychology, as suggested by Bolier et al., (2013). As such, it does not focus solely on deficits, but aims to shift narratives to be more positive. Pupils spoke fondly of the positive psychology approach and shared the impact this had in shifting negative narratives to more positive narratives.

The intervention also addressed the initial self-doubt felt by facilitators delivering CBTA in their early stages (Squires, 2010), including training and supervision for school staff (Wade, 2016). The research offers valuable suggestions to improve the implementation of the intervention in the future.

Additionally, research suggests that CYP lack an understanding of MH (Dogra et al., 2012; Rose, Thornicroft, Pinfold, & Kassam, 2007), thus highlighting a need to raise awareness, educate and provide interventions that promote positive MH. The intervention successfully supports students to recognise and self-manage their emotional state, so they are better able to access educational opportunities they are presented with. The findings also highlight useful suggestions to extend the training and support offered in the intervention (e.g. training staff, more flexibility in interventions, and ongoing supervision).

Unlike many studies claiming to use Bronfenbrenner's model maturely (Tudge, Mokrova, Hatfield, Rachana, and Karnik, 2009), this research uses the PPCT model rigorously throughout. All elements are adequately and transparently acknowledged, to uphold the integrity of the theory. The research uses Bronfenbrenner's model to consider the influence of CYP's environment, such as: the national context; resources available; motivation of the participants; the interaction between systems such as school, home and EPS; and the time-context in which the study was being conducted. Findings demonstrate the usefulness of the newly developed anxiety intervention with KS4 pupils who

self-refer. Additionally, it guides those who are developing and advocating interventions, such as EPs and policy makers, to what works for whom and why (Fonagy, 2015).

5.7 Future research

In light of the findings, and the strengths and limitations of the research, future research would benefit from considering:

- the inclusion of pre and post intervention interviews;
- extending the triangulation of data through including parent views;
- exploring the longitudinal impact beyond two months after the intervention;
- evaluating the intervention with a larger sample size including a control group;
- comparing intervention outcomes for pupils with controlled motivation with autonomous motivation;
- evaluating interventions using a combination of positive psychology and CBTA;
- additional evaluations of interventions and the fidelity of their application in real-world settings, considering the funding difficulties and complexity of secondary schools;
- evaluating the flexible use of interventions with the ongoing supervision of EPs; and
- further exploration of specific vulnerable groups to expand the growing research of what works well for whom.

5.8 Conclusion

With the increasing prevalence of MH difficulties and the vulnerability of adolescence, it is important that professionals target support in a preventative way. As schools are regularly highlighted as key stakeholders in pupils' MH, supporting them to meet pupils' needs is imperative. Whilst there may be a range of interventions available to schools, schools require interventions that are evidence and practice-based, which can be flexibly applied to the complex

secondary school setting. This may enable the interventions to be manageable and sustainable for schools.

To improve access and take-up, the research highlights the need for pupils to be able to self-refer to interventions. This improves access to support for pupils who may not demonstrate the externalised behaviours that receive the attention of adults. This intervention aimed to address the gaps in other interventions and previous research. The findings showed positive outcomes for the pupils (alleviated anxiety, peer support and developed knowledge and understanding of self-regulation skills) in addition to insightful suggestions for future interventions (more flexibility, embedding a whole-school approach, the importance of relationships). Implications for policy have also been discussed.

EPs are central to supporting emotional wellbeing (Rae, Cowell, & Field, 2017). The current context provides an opportunity for EPs to extend people's understanding of an EP's role in supporting pupils, families and schools to promote positive MH (Fallon et al., 2010; Farrell et al., 2006). The current austerity measures, shortage of EPs (Islam, 2013) and the perception of EPs as '*gatekeepers*' for educational provision (Wagner, 2000) can act as barriers in enabling EPs to provide regular services, such as facilitating interventions for pupils and families with MH difficulties. EPs can use legislation and policy to reinforce the importance of early intervention and encourage more negotiation with regard to preventative therapeutic work (Lee & Woods, 2017). EPs can draw upon both evidence-based research and practise-based evidence (Fox, 2003) to develop deeper understanding of what works for whom and in what context (Fonagy, 2015).

Anxiety is one of the most common MH difficulties in the UK and is increasing in both the adolescent and adult population, which has implications for employment, education and health prospects. This research conveys how an early school-based CBTA group intervention, delivered in four secondary schools in one LA, can improve accessibility to support and develop pupils' understanding of how to manage their anxiety during adolescence – a pivotal time in personal growth.

Chapter 6: References

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Chapter 7: Appendices

Appendix A – Approach to literature review and key terms.

The literature review comprised studies accessed through ERIC (EBSCO), ERIC (ProQuest), PsychINFO, Pubmed and Psych Articles, and recorded in a table (see below for an example). The search terms used include:

("cognitive behaviour therapy" AND "anxiety") OR ("cognitive behavior therapy" AND "anxiety") OR ("cognitive behaviour therapy" AND "anxiety" AND "pupil") OR ("cognitive behaviour therapy" AND "anxiety" AND "young people") OR ("cognitive behaviour therapy" AND "anxiety" AND "adolescents") OR ("cognitive behaviour therapy approaches" AND "anxiety" AND "adolescents") OR ("cognitive behaviour therapy approaches" AND "anxiety" AND "young people") OR ("cognitive behaviour therapy approaches" AND "anxiety" AND "pupil") OR ("cognitive behavior therapy approaches" AND "anxiety") OR ("cognitive behaviour therapy approaches" AND "anxiety").

To ensure quality of literature, limitations were applied to the search to only include articles in English and from peer reviewed journals. Furthermore, to ensure that research was up-to-date, only articles published since 2000 were included. This was because research conducted in the early millennium captures earlier work (usually within the Introduction sections of the papers); a decade is enough time to evaluate impact and change; and the recency of the articles captured current policies and changes that could impact the promotion of interventions to support positive mental health. As this study focuses on pupils with anxiety in secondary schools, I scanned abstracts of articles to ensure their relevance. However, many appeared to focus on specific outcomes, such as autism and family therapy. When removing such articles, 16 key articles were highlighted and those identified as having most relevance to this research were used throughout the Literature Review and Introduction. Additional searches were carried out using Google Scholar and UCL Library Services, including the following key terms:

("Mental health" AND "anxiety") OR ("wellbeing" AND "anxiety") OR ("Mental health" " AND "anxiety" AND "pupil") OR ("Mental health" " AND "anxiety" AND "young people") OR ("Mental health" " AND "anxiety" AND "adolescents") OR ("wellbeing " AND "anxiety" AND "adolescents") OR ("wellbeing " AND "anxiety" AND "young people") OR ("wellbeing" AND "anxiety" AND "pupil").

Additionally, articles were included using a snowballing strategy, to access relevant material from articles' reference lists as well as articles and book chapters signposted by supervisors and EPs.

Search Engine Used	Terms	Limiters	View results	Relevance
EBSCO (ERIC)	("cognitive behaviour therapy" AND "anxiety") OR ("cognitive behavior therapy" AND "anxiety") OR ("cognitive behaviour therapy" AND "anxiety" AND "pupil") OR ("cognitive behaviour therapy" AND "anxiety" AND "young people") OR ("cognitive behaviour therapy" AND "anxiety" AND "adolescents" NOT "autism" NOT "family therapy")	Peer Reviewed; Date Published: 20000101-20181231; Language: English Search modes - Boolean/Phrase	70 (16 relevant)	16 – articles included cognitive behaviour therapy related to young people in school settings and without specific difficulties (e.g. autism)

Key terms used throughout this thesis are defined below:

Table 10: Key terms and their definitions

Term	Definition
Adolescents	A person between the ages of 10–19 years
Anxiety	"*normative response designed to facilitate self-protection with the particular focus of the fear and worry varying according to the child's development and previous experiences.*" (Stallard, 2009, p.1)
Cognitive Behavioural Therapy (CBT)	A therapeutic intervention used to identify and explore the connection between thoughts, behaviours, physical sensations and emotions, with the aim of challenging and adapting negative thoughts and beliefs.
Cognitive Behavioural Therapy Approaches (CBTA)	Therapeutic approach using principles of CBT.

Appendix B – Transforming children and young people's mental health provision: a green paper

Key Information highlighted from the Green Paper (DfE & DoH, 2017).

Schools	• All state funded schools to have a '*designated lead'* for mental health, by 2025. • The *'Designated lead'* will be responsible for the school's approach to mental health issues, oversee the help the school provides to its pupils, and receive training. • They will advise other members of staff about how to support pupils' mental health • *'Designated leads'* will have the capacity to refer pupils to '*specialist services'.*
Mental Health Support Teams	• The paper states that mental health support teams *"will work alongside other people who provide mental health support including: school nurses;* **educational psychologists***; school counsellors; voluntary and community organisations and; social workers";* • These teams will offer support to young people with *"mild to moderate mental health conditions"* including anxiety, low mood and behavioural difficulties; • These teams will have the capacity to refer pupils for further specialist treatment; • The Green Paper describes the mental health support teams as *"the link between NHS services and schools and colleges";* The government would like to reduce waiting times for children and young people; • The government proposes to pilot a scheme rolled out in England in 2019 *"to try out different ways of working".* They aim to reduce waiting times to four weeks for young people who need *'very urgent help';* • The government aims to set up a 'national partnership' to improve mental health services for 16- to 25-year-olds. The initial phase will involve selection an area to focus on such as how universities, colleges, local authorities and health services can work together.
Mental Health Awareness	• The government will work with the Children's Commission to explore the effects of social media and the impact of technology on children and young people's mental health; • The government would like research on how to support families. They will gather information on how parents and carers can *"better bond with their child"* and how to support families who have higher risks of developing mental health difficulties. This will inform local areas about how they can improve the support available for families;

	• The Government will seek to train a member of staff in each school to *"spot signs of mental health issues in children"*, alongside the *"designated lead"* role;
	• Seek to teach children and young people about mental health through the school curriculum, this may be through Personal, Social and Health Education (PSHE);
	• A new mental health awareness course will be included as part of the National Citizen Service programme for 15- to 17-year-olds;
	• All staff will receive mental health awareness training looking at their wellbeing and the wellbeing of the young people they work with.
Language	• The language used within the paper refers to 'mental health disorders' and the 'treatment' of children frequently. This aligns with a medical 'within' child model opposed to a more interactionist approach that describes difficulties to be as a result of a combination of child and environmental factors;
	• The report uses the term 'mental health' rather than 'wellbeing', which may be problematic due to the stigma attached to mental health;
	• Although resilience has been mentioned three times, there is no reference to research nor the factors that support resilience such as teacher-student relationships and feelings of belonging and connectedness

Appendix C – Anxiety Disorder Definitions from NICE (2014)

➢ Generalised anxiety disorder
  o *'Excessive'* worry about events linked to heightened tension;
  o Feeling irritable and restless;
  o Easily tired and tense muscles;
  o Difficulties concentrating or sleeping';
  o *'Present for at least 6 months and should cause clinically significant distress or impairment in social, occupational or other important areas of functioning'.*

➢ Social anxiety disorder
  o Previously known social phobia;
  o *'Persistent fear of or anxiety about 1 or more social situations that involve interaction, observation and performance that is out of proportion to the actual threat posed'.*

➢ Post-traumatic stress disorder
  o Can develop after events that are stressful or exceptionally threatening; or catastrophic nature that is likely to cause pervasive distress;
  o Can develop as a result of events such as deliberate acts of interpersonal violence, severe accidents, disasters or military action;
  o Does not develop as a result of everyday traumatic events such as divorce, job loss or failing an exam.

➢ Panic disorder
  o *'Presence of recurring, unforeseen panic attacks followed by at least 1 month of persistent worry about having another panic attack and concern about the consequences of a panic attack';*
  o At least two unexpected panics attacks are required for this diagnosis. These panic attacks should not be explainable by the use of substances, general medication or another psychological problem.

➢ Obsessive-compulsive disorder
  o Presence of obsessions (unwanted intrusive thoughts) or compulsions (repetitive behaviours or mental acts that the person feels driven to perform), or commonly both.

➢ Body dysmorphic disorder
  o *'Excessive worry about appearance and a distorted view of how the person looks'.*

Appendix D – Stages of Change (Prochaska & DiClemente, 1983)

Stage	Description
Pre-contemplative	People may not acknowledge a difficulty nor may they see a need to change
Contemplative	Clients acknowledge a difficulty and a need to change. They may listen to information but will not actively want to make changes
Preparing	Clients are interested in making a change e.g. seek relevant support available
Action	Clients start to make modifications to their behaviour. During this stage, relapse and temptation is strong. However, people do benefit from support and advice with relapse in this stage
Maintenance	After 6 months it is thought that the change is consolidated and part of the clients' new lifestyle, therefore new behaviours have replaced the old as the change is sustained.
Termination	The difficult behaviour is no longer a desirable thing for clients.

Appendix E – Principles of attuned interactions and guidance

Adapted from Landor, Todd and Kennedy (2011).

Principles of attuned interactions and guidance

Being attentive	· Looking interested with friendly posture · Giving time and space for other · Turning towards · Wondering about what they are doing, thinking or feeling · Enjoying watching the other
Encouraging initiatives	· Waiting · Listening actively · Showing emotional warmth through intonation · Using friendly and/or playful intonation as appropriate · Naming what the child is doing, might be thinking or feeling · Naming what you are doing, thinking or feeling · Looking for initiatives
Receiving initiatives	· Showing you have heard, noticed the other's initiative · Receiving with body language · Being friendly and/or playful as appropriate · Returning eye-contact, smiling, nodding in response · Receiving what the other is saying or doing with words · Repeating/using the other's words or phrases
Developing attuned interactions	· Receiving and then responding · Checking the other is understanding you · Waiting attentively for your turn. · Having fun · Giving a second (and further) turn on same topic · Giving and taking short turns · Contributing to interaction / activity equally · Co-operating - helping each other
Guiding	· Scaffolding · Saying 'no' in the 'yes' cycle (attuned limit setting) · Extending, building on the other's response · Judging the amount of support required and adjusting · Giving information when needed · Providing help when needed · Offering choices that the other can understand · Making suggestions that the other can follow
Deepening discussion	· Supporting goal-setting · Sharing viewpoints · Collaborative discussion and problem-solving · Naming difference of opinion · Investigating the intentions behind words · Naming contradictions/conflicts (real or potential) · Reaching new shared understandings · Managing conflict (back to being attentive and receiving initiatives with the aim of restoring attuned interactions)

Copyright Kennedy, H (2011) Table 1 Chapter 1 in Kennedy, H., Landor, M. & Todd, L. Video Interaction Guidance: a relationship-based intervention to promote attunement, empathy and well-being London: JKP

Appendix F – The Intervention programme

The intervention comprises six sessions (45 minutes to an hour) and one review session two months after the final session (seven sessions in total). School staff get trained to deliver the intervention as each session is demonstrated by an EP or Assistant Psychologists with the agreement that school staff would then deliver the session to their own group, within the same week. Each session has a brief introduction, a recap of previous sessions, a brief 'round robin' (to see how people's weeks have been), followed by psychoeducation and ending with the use of a strategy. Throughout the psychoeducation aspect of the intervention, a range of resources, such as videos, tasks sheets and discussions are included. The use of psychoeducation and exercises aim to encourage pupils to reflect, recognise and self-manage their emotional states. The overview of sessions are outlined below in Table 11 with an example page of the manualised progamme below. (note that the test measures, including the Revised Children Anxiety and Depression Scale (RCADS), are explained in section 3.6).

Table 11: Overview of the intervention sessions

Session (Week)	Session content
Session 1 – Week 1	**Why are we here?** Ψ Introducing the group (developing self-awareness and providing coping strategies to reduce anxiety) (activity) Ψ Group rules (discussion and visuals) Ψ Administration of test measures (including RCADS) Ψ Introducing cognitive behavioural approach (psychoeducation/pair discussion and group discussion) Ψ Breathing practice (activity)
Session 2 – Week 2	**What is anxiety?** Ψ Practise breathing exercise Ψ Recap hot cross bun (discussion) Ψ Session aim – what anxiety is and where does it come from? Ψ Fight, flight or freeze (psychoeducation/ video clip/ discussion) Ψ Triggers (sheet work and discussion) Ψ Progressive Muscle Relaxation (PMR) technique (activity)
Session 3 – Week 3	**You are not alone** Ψ Practice PMR Ψ Round robin – check-in on everyone's week and strategies used. Ψ Discussions about how others may experience anxiety Ψ Negative Automatic Thoughts (NATS) - (psychoeducation and activity) Ψ Body scan technique (activity)

Session 4 – Week 4	Challenging thoughts
	Ψ Practise body scan
	Ψ Round robin
	Ψ Becoming more aware of our thinking means we can start challenging NATS that maintain negative thinking cycles. (psychoeducation and activity)
	Ψ Identifying negatives thought and giving alternatives (card game)
	Ψ Thought stopping technique (video clip/ activity)
	Ψ Core beliefs (activity and discussion)
	Ψ Practice visualisation (activity)
Session 5 – Week 5	Making changes
	Ψ Practice visualisation
	Ψ Round robin – check in on everyone's week and strategies used.
	Ψ Identifying strengths (activity and discussion)
	Ψ Promoting healthy living (activity and discussion)
	Ψ Practice Loving kindness meditation and compassion technique (activity)
Session 6 – Week 6	Drawing it all together
	Ψ Practice Loving kindness and compassion technique
	Ψ Round robin
	Ψ Test measures (including RCADS)
	Ψ Discussion about group
	Ψ Positive affirmations and off-loading.
	Ψ Reflections
Session 7 – 2 Months later	Follow-up session – reflecting on the group
	Ψ Round robin
	Ψ Feedback assessment result (discussion)
	Ψ Positive emotions (activity and discussion)
	Ψ Relaxation practice (activity)
	Ψ Reflection (discussion)

Session 1

Theme: Why are we here?

Welcome, introductions and purpose of the group

- ✓ Introduce yourself as the intervention leader.
- ✓ Information about the group: (how many sessions, time, and place etc.;
- ✓ What to expect: (mainly practical exercises with some research information, film clips etc.),
- ✓ Aims: (to develop self-awareness and help reduce anxiety by providing a bank of strategies that can be used in many different situations);
- ✓ Practical arrangements (these will relate to each particular school).

Getting to know each other:

Option a) Two Truths and a Lie
Go round the group, and have each person tell two things about themselves and one lie. The rest of the group must guess which things are true and which is a lie. You will learn two interesting things about each person, which you can use as conversation starters.

Option b) Desert Island
'You've been exiled to a deserted island for a year. In addition to the essentials, you may take one piece of music, one book (which is not the Bible) and one luxury item you can carry with you i.e. not a boat to leave the island! What would you take and why?'
Ask the young people to get into pairs and find out their partners answers. Share back to the group what your partner said.

Establishing Group Rules

- ✓ What's important when talking about feelings and anxiety?
- ✓ Invite members of the group to come up with some rules for the group (around 4 or 5)
- ✓ Ensure that the issue of confidentiality is raised

Developing self-awareness and an understanding of personal feelings of anxiety

We all have worries and these are a normal part of life. Sometimes our worries can get too much and make us feel overwhelmed.
The first step to managing anxiety is to acknowledge that it is there. Say that the group will have many opportunities to address their feelings.
- ✓ Invite the group members to fill in the Revised Children's Anxiety Scale (RCADS). Encourage them to ask questions if they want to.

Appendix G - Information and Consent Form for School

Evaluating an anxiety intervention; what is the impact on the development and understanding of coping strategies in key stage 4 pupils

January 2017 to July 2019

Information sheet for School

Who is conducting the research?
My name is Jillen Fatania and I am inviting you to take in part in my research project, 'Evaluating an anxiety intervention; what is the impact on the development and understanding of coping strategies in key stage 4 pupils'. I am currently a Trainee Educational, Child and Adolescent Psychologist at UCL Institute of Education, which means that I am currently studying to become an Educational Psychologist, who works with schools, families, children and young people and the community to support the learning and social emotional development of children and young people from 0 – 25. UCL Institute of Education has expertise in education and social science research. My personal areas of research include children and young people social, emotional wellbeing and memory. This research will be supervised and supported by my tutors at the university, Dr. Emily Midhouhas (Academic Supervisor) and Dr. Frances Lee (Educational Psychologist Supervisor).

I am hoping to find out if the intervention is effective and what the people involved in the intervention find as barriers and facilitators to making the intervention supportive in reducing anxiety.

I very much hope that you would like to take part. This information sheet will try and answer any questions you might have about the project, but please don't hesitate to contact me if there is anything else you would like to know.

Why are we doing this research?
"10% of children and young people (ages 5-16 years) have a clinically diagnosable mental health problem, yet 70% of children and adolescents who experience mental health problems have not had appropriate interventions at a sufficient early stage" (Children's Society, 2008). I would like to explore if the intervention has an impact on children and young people's anxiety levels and their use and knowledge of coping strategies. Should the intervention be found to be useful, it can be used within schools to support young people with anxiety. If the intervention is found to be successful, Educational Psychologists can use their knowledge and understanding of the package to develop capacity in schools and broaden opportunities for schools to support children and young people with anxiety difficulties before their needs become more complex.

What will happen if I choose to take part?

The intervention takes pre and post scores of the young people's anxiety levels. Some young people may receive the intervention after one of the groups is complete to provide the research with a comparison control group. By agreeing to take part in the research, you would approve of sharing this data with me and allowing me to re-measure six months after the intervention. I would also like to interview the intervention facilitators and some of the pupils who take part in the intervention to get a better understanding of their perceptions or what went well and what could be better. The interviews will be recorded via audio only and will explore pupil's understanding and use of coping strategies. School, parents and young people will be asked to give informed consent before taking part and their right to withdraw at any time will highlighted to them.

Will anyone know I have been involved?
Any information provided will be held securely and kept anonymous and destroyed on full completion of the research. If at any time, you wish to withdraw from the research please contact the researcher. One completion of the research a summary of the findings will be shared with the participants, and should the research go on to be published, all data will continue to remain anonymous.

Do I have to take part?
It is entirely up to you whether or not you choose to take part. We hope that if you do choose to be involved then you will find it a valuable experience. Should you not wish to take part, please be assured that this has no implication on the young person being able to take part in the intervention group.

Thank you very much for taking the time to read this information sheet.

If you would like to be involved, please complete the following consent form and return to ██████████████████████

If you have any further questions before you decide whether to take part, you can reach me at ███████████████████████ **or alternatively on** █████████████

This project has been reviewed and approved by the UCL IOE Research Ethics Committee

Institute of Education

Evaluating an anxiety intervention; what is the impact on the development and understanding of coping strategies in key stage 4 pupils

January 2018 – July 2019

If you are happy to participate, please complete this consent form and return to

▮▮▮▮▮▮▮▮▮▮▮

	Yes	No
I have read and understood the information leaflet about the research	☐	☐
I am happy for group facilitators and pupils to be interviewed should they give their consent.	☐	☐
I am happy for the interviews to be audio recorded should participants give their consent.	☐	☐
I understand that if any of my words are used in reports or presentations they will not be attributed to me, all data will remain anonymous.	☐	☐
I understand that I can withdraw from the project at any time, and that if I choose to do this, any data I have contributed will not be used	☐	☐
I understand that I can contact Jillen Fatania at any time	☐	☐
I understand that the results will be shared with all participants on completion of the research, and should the research go on to be published, all data will continue to remain anonymous.	☐	☐

Name _____   Role:_____

School Name _____

Signed _____   Date _____

Appendix H - Participant Recruitment Poster

Group Sessions

Intervention to help reduce Anxiety

WHO IS THIS FOR?
Are you in KS4 or above?
Do you stress or worry about things?
Do your worries stop you from doing or achieving things you want to?
Do you want to
Learn how to manage these feelings?
Then this intervention may be for you...

WHAT IS THE PURPOSE OF THIS GROUP?
These group sessions aim to reduce levels of anxiety and support young people to develop strategies that can help manage their feelings.

WHEN WILL THE GROUP TAKE PLACE?
Small groups will take place 1x week for about 45 mins to 1 hour. They will run for 6 weeks followed by Session 7 approximately 2 months after completion.

HOW DO WE GET INVOLVED?
Simple... give your name to your teacher or your form tutor and they will pass the details to a key member of staff who will contact you with more information.

WHO IS RUNNING THE GROUP?
A key member of staff will support you in all of the sessions.

WHAT ARE THE BENEFITS?
Your thoughts and ideas about how to cope with stress and anxiety and support yourselves and others in school will be sought and shared with key members of staff to promote the well-being of everyone in the school.

Evaluating an anxiety intervention; what is the impact on the development and understanding of coping strategies in key stage 4 pupils

January 2017 to July 2019

Information sheet for Intervention Facilitator

Who is conducting the research?
My name is Jillen Fatania and I am inviting you to take in part in my research project, 'Evaluating an anxiety intervention; what is the impact on the development and understanding of coping strategies in key stage 4 pupils'. I am currently a Trainee Educational, Child and Adolescent Psychologist at UCL Institute of Education, which means that I am currently studying to become an Educational Psychologist, who works with schools, families, children and young people and the community to support the learning and social emotional development of children and young people from 0 – 25. UCL Institute of Education has expertise in education and social science research. My personal areas of research include children and young people social, emotional wellbeing and memory. This research will be supervised and supported by my tutors at the university, Dr. Emily Midhouhas and Dr. Frances Lee.

I am hoping to find out if the intervention is effective and what the people involved in the intervention find as barriers and facilitators to making the intervention supportive in reducing anxiety.

I very much hope that you would like to take part. This information sheet will try and answer any questions you might have about the project, but please don't hesitate to contact me if there is anything else you would like to know.

Why are we doing this research?
'10% of children and young people ages 5-16 years) have a clinically diagnosable mental health problem, yet 70% of children and adolescents who experience mental health problems have not had appropriate interventions at a sufficient early stage" (Children's Society, 2008). I would like to explore if the intervention has an impact on children and young people's anxiety levels and their use and knowledge of coping strategies. Should the intervention be found to be useful, it can be used within schools to support young people with anxiety. Educational Psychologists can use their knowledge and understanding of the package to develop capacity in schools and broaden opportunities for schools to support children and young people with anxiety difficulties before their needs become more complex.

What will happen if I choose to take part?
The intervention takes pre and post scores of the young people's anxiety levels. Some young people may receive the intervention after one of the groups is complete to provide the research

with a comparison control group. By agreeing to take part in the research you would be agreeing to be interviewed, as the intervention facilitator, to help me to get an understanding of your perceptions of what went well and what could be better. The interviews will be recorded via audio only.

Will anyone know I have been involved?
Any information provided will be held securely and kept anonymous and destroyed on full completion of the research. If at any time, you wish to withdraw from the research please contact the researcher. On completion of the research a summary of the findings will be shared with the participants, and should the research go on to be published, all data will continue to remain anonymous.

Do I have to take part?
It is entirely up to you whether or not you choose to take part. We hope that if you do choose to be involved that you will find it a valuable experience. Should you not wish to take part, please be assured that this has no implication on the young person being able to take part in the intervention group.

Thank you very much for taking the time to read this information sheet.

If you would like to be involved, please complete the following consent form and return to ▇▇▇▇▇▇▇▇▇▇▇

If you have any further questions before you decide whether to take part, you can reach me at ▇▇▇▇▇▇▇▇▇▇▇**or alternatively on** ▇▇▇▇▇▇▇

This project has been reviewed and approved by the UCL IOE Research Ethics Committee

Institute of Education

Evaluating an anxiety intervention; what is the impact on the development and understanding of coping strategies in key stage 4 pupils

January 2018 – July 2019

If you are happy to participate, please complete this consent form and return to school or ██████████████████

	Yes	No
I have read and understood the information leaflet about the research	☐	☐
I am happy to be interviewed and for it to be audio recorded.	☐	☐
I understand that if any of my words are used in reports or presentations they will not be attributed to me and that all data will remain anonymous.	☐	☐
I understand that I can withdraw from the project at any time, and that if I choose to do this, any data contributed will not be used	☐	☐
I understand that I can contact Jillen Fatania at any time	☐	☐
I understand that the results will be shared with all participants on completion of the research, and should the research go on to be published, all data will continue to remain anonymous.	☐	☐

School/EPS: _____

Name _____   Role: _____

Signed _____   Date _____

Evaluating an anxiety intervention; what is the impact on the development and understanding of coping strategies in key stage 4 pupils

January 2017 to July 2019

Information sheet for Parents

Who is conducting the research?

My name is Jillen Fatania and I am inviting you to take in part in my research project, 'Evaluating an anxiety intervention; what is the impact on the development and understanding of coping strategies in key stage 4 pupils'. I am currently a Trainee Educational, Child and Adolescent Psychologist at UCL Institute of Education, which means that I am studying to become an Educational Psychologist, who works with schools, families, children and young people and the community to support the learning and social emotional development of children and young people from 0 – 25. UCL Institute of Education has expertise in education and social science research. My personal areas of research include children and young people's social, emotional wellbeing and memory. This research will be supervised and supported by my tutors at the university, Dr. Emily Midhouhas (Academic Supervisor) and Dr. Frances Lee (Educational Psychologist Supervisor).

I am hoping to find out if the intervention is effective and what the people involved in the intervention find as barriers and facilitators to making the intervention supportive in reducing anxiety.

I very much hope that you would like to take part. This information sheet will try and answer any questions you might have about the project, but please don't hesitate to contact me if there is anything else you would like to know.

Please explain the research to your child and discuss whether or not they want to take part. I will also ask the children before the task/interview and make it clear that they can drop out if they wish with no negative consequences.

Why are we doing this research?

"10% of children and young people (aged 5-16 years) have a clinically diagnosable mental health problem, yet 70% of children and adolescents who experience mental health problems have not had appropriate interventions at a sufficient early stage" (Children's Society, 2008). I would like to explore if the intervention has an impact on children and young people's anxiety levels and their use and knowledge of coping strategies. Should the intervention be found to be useful, it can be used within schools to support young people with anxiety. If the intervention is found to be successful, Educational Psychologists can use their knowledge and understanding of the

package to develop capacity in schools and broaden opportunities for schools to support children and young people with anxiety difficulties before their needs become more complex.

What will happen if I choose to take part?
The intervention takes pre and post scores of the young people's anxiety levels. Some young people may receive the intervention after one of the groups is completed to provide the research with a comparison control group. By agreeing to take part in the research, you would approve of sharing this data with me and allowing me to re-measure six months after the intervention. I would also like to interview the intervention facilitators and some of the pupils who take part in the intervention to get a better understanding of their perceptions or what went well and what could be better. The interviews will be audio recorded and aim to explore pupil's understanding and use of coping strategies. School, parents and young people will be asked to give informed consent before taking part and their right to withdraw at any time will highlighted to them.

Will anyone know I have been involved?
Any information provided will be held securely and kept anonymous and destroyed on full completion of the research. If at any time, you wish to withdraw from the research please contact the researcher. One completion of the research a summary of the findings will be shared with the participants, and should the research go on to be published, all data will continue to remain anonymous.

Do I have to take part?
It is entirely up to you whether or not you choose to take part. We hope that if you do choose to be involved then you will find it a valuable experience. Should you not wish to take part, please be assured that this has no implication on the young person being able to take part in the intervention group.

Thank you very much for taking the time to read this information sheet.

If you would like to be involved, please complete the following consent form and return to school or j▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮

If you have any further questions before you decide whether to take part, you can reach me at ▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮ **or alternatively on** ▮▮▮▮▮▮▮▮▮

This project has been reviewed and approved by the UCL IOE Research Ethics Committee

Evaluating an anxiety intervention; what is the impact on the development and understanding of coping strategies in key stage 4 pupils

January 2018 – July 2019

If you are happy to participate, please complete this consent form and return to school or

███████████████████████

	Yes	No
I have read and understood the information leaflet about the research	☐	☐
I am happy for my child to be interviewed should they give their consent.	☐	☐
I am happy for the interviews to be audio recorded should they give their consent.	☐	☐
I understand that if any of my child's words are used in reports or presentations they will not be attributed to my child and all data will remain anonymous.	☐	☐
I understand that my child can withdraw from the project at any time, and that if they choose to do this, any data contributed will not be used	☐	☐
I understand that I can contact Jillen Fatania at any time	☐	☐
I understand that the results will be shared with all participants on completion of the research, and should the research go on to be published, all data will continue to remain anonymous.	☐	☐
I have discussed the information sheet with my child	☐	☐

Name _____

Name of Young Person_____   Age_____   Year group _____

Gender: F / M / Prefer not to answer

Any known special educational needs or disabilities? Y/N (If yes please give brief details below)

_____

Signed _____   Date _____

Institute of Education

**Evaluating an anxiety intervention; what is the impa
the development and understanding of coping strate
key stage 4 pupils**

January 2017 to July 2019

Information sheet for Young People

Who am I and why am I writing to you?
Hello, My name is Jillen Fatania (Jill). I am inviting you to take part in my research project which is looking to see if the anxiety intervention you are taking part in is helpful. I go to university in London and work at the [LA] Educational Psychology Service. Educational Psychologists work with schools, parents, children and young people and the community to make learning and wellbeing better for young people.

I really hope that you would like to take part. This leaflet will try and answer any questions you might have about the project, but please contact me if there is anything else you would like to know.

Why are we doing this research?
"10% of children and young people (ages 5-16 years) have a clinically diagnosable mental health problem, yet 70% of children and adolescents who experience mental health problems have not had appropriate interventions at a sufficient early stage" (Children's Society, 2008). I would like to help schools to support young people manage anxiety. I want to look at what is good about the intervention and what might make it better.

What will happen if I choose to take part?
The intervention takes pre and post scores of anxiety levels. Some young people may receive the intervention after one of the groups is finished. By agreeing to take part in the research, you would agree to being happy to share this information with me and allow me to ask the same questions six months after the intervention. I would also like to interview some of the pupils who take part in the intervention to get a better understanding of what went well and what could be better. The interviews will be audio recorded.

Will anyone know I have been involved?

Any information provided will be held securely and kept anonymous and destroyed when the research is finished. If at any time, you wish to not be part of the research anymore please contact me and all the information will be taken out for the research. When the research is finished I will write to you and share the findings.

Do I have to take part?
It is entirely up to you whether or not you choose to take part. I hope that if you do choose to be involved then you will find it a valuable experience. Should you not wish to take part, then you are you are still more than welcome to be part of the intervention group.

Thank you very much for taking the time to read this information sheet.

If you would like to be involved, please complete the following consent form and return to school or ███████████████████

If you have any further questions before you decide whether to take part, you can reach me at ███████████████████ **or alternatively on** ███████████

This project has been reviewed and approved by the UCL IOE Research Ethics Committee

Institute of Education

UCL

Evaluating an anxiety intervention; what is the impact on the development and understanding of coping strategies in key stage 4 pupils
January 2018 – July 2019

If you are happy to participate, please complete this consent form and return to school or ███████████████████

	Yes	No
I have read and understood the information leaflet about the research	☐	☐
I am happy to be interviewed which will be audio recorded.	☐	☐
I understand that if any of my words are used in reports or presentations that no one will know it is.	☐	☐
I understand that I can withdraw from the project at any time, and that if I choose to do this, any data contributed will not be used	☐	☐
I understand that I can contact Jillen Fatania (Jill) at any time	☐	☐
I understand that the results will be shared me when the research is finished.	☐	☐

Name _____ Age_____ Year group _____

Gender: F / M / Prefer not to answer

Signed _____ Date _____

Appendix L - Revised Children's Anxiety and Depression Scale (RCADS)

Date: _____   Name/ID: _____

RCADS

Please put a circle around the word that shows how often each of these things happen to you. There are no right or wrong answers.

1. I worry about things	Never	Sometimes	Often	Always
2. I feel sad or empty	Never	Sometimes	Often	Always
3. When I have a problem, I get a funny feeling in my stomach	Never	Sometimes	Often	Always
4. I worry when I think I have done poorly at something	Never	Sometimes	Often	Always
5. I would feel afraid of being on my own at home	Never	Sometimes	Often	Always
6. Nothing is much fun anymore	Never	Sometimes	Often	Always
7. I feel scared when I have to take a test	Never	Sometimes	Often	Always
8. I feel worried when I think someone is angry with me	Never	Sometimes	Often	Always
9. I worry about being away from my parents	Never	Sometimes	Often	Always
10. I get bothered by bad or silly thoughts or pictures in my mind	Never	Sometimes	Often	Always
11. I have trouble sleeping	Never	Sometimes	Often	Always

12. I worry that I will do badly at my school work . .	Never	Sometimes Often	Always
13. I worry that something awful will happen to someone in my family	Never	Sometimes Often	Always
14. I suddenly feel as if I can't breathe when there is no reason for this	Never	Sometimes Often	Always
15. I have problems with my appetite	Never	Sometimes Often	Always
16. I have to keep checking that I have done things right (like the switch is off, or the door is locked)	Never	Sometimes Often	Always
17. I feel scared if I have to sleep on my own.	Never	Sometimes Often	Always
18. I have trouble going to school in the mornings because I feel nervous or afraid	Never	Sometimes Often	Always
19. I have no energy for things	Never	Sometimes Often	Always
20. I worry I might look foolish	Never	Sometimes Often	Always
21. I am tired a lot	Never	Sometimes Often	Always
22. I worry that bad things will happen to me	Never	Sometimes Often	Always

23. I can't seem to get bad or silly thoughts out of my head.	Never	Sometimes	Often	Always
24. When I have a problem, my heart beats really fast	Never	Sometimes	Often	Always
25. I cannot think clearly	Never	Sometimes	Often	Always
26. I suddenly start to tremble or shake when there is no reason for this	Never	Sometimes	Often	Always
27. I worry that something bad will happen to me . .	Never	Sometimes	Often	Always
28. When I have a problem, I feel shaky	Never	Sometimes	Often	Always
29. I feel worthless	Never	Sometimes	Often	Always
30. I worry about making mistakes	Never	Sometimes	Often	Always
31. I have to think of special thoughts (like numbers or words) to stop bad things from happening. . .	Never	Sometimes	Often	Always
32. I worry what other people think of me	Never	Sometimes	Often	Always
33. I am afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds)	Never	Sometimes	Often	Always
34. All of a sudden I feel really scared for no reason at all	Never	Sometimes	Often	Always

35. I worry about what is going to happen	Never	Sometimes	Often	Always
36. I suddenly become dizzy or faint when there is no reason for this	Never	Sometimes	Often	Always
37. I think about death	Never	Sometimes	Often	Always
38. I feel afraid if I have to talk in front of my class	Never	Sometimes	Often	Always
39. My heart suddenly starts to beat too quickly for no reason	Never	Sometimes	Often	Always
40. I feel like I don't want to move	Never	Sometimes	Often	Always
41. I worry that I will suddenly get a scared feeling when there is nothing to be afraid of	Never	Sometimes	Often	Always
42. I have to do some things over and over again (like washing my hands, cleaning or putting things in a certain order)	Never	Sometimes	Often	Always
43. I feel afraid that I will make a fool of myself in front of people	Never	Sometimes	Often	Always
44. I have to do some things in just the right way to stop bad things from happening . .	Never	Sometimes	Often	Always
45. I worry when I go to bed at night	Never	Sometimes	Often	Always

	Never	Sometimes	Often	Always
46. I would feel scared if I had to stay away from home overnight	Never	Sometimes	Often	Always
47. I feel restless	Never	Sometimes	Often	Always

Appendix M - Prompts for Semi-Structured Interviews

Semi-Structured Interview Questions

Research Questions

RQ1 – What are the outcomes of a therapeutic school-based group CBTA intervention on adolescents, after the intervention and 2 months later?

RQ2 – What are the adolescents' experiences of the intervention group, including strengths and challenges, as reported by the adolescents?

RQ3 – What are the group facilitators' experiences of the intervention group, including strengths and challenges, as reported by the group facilitators?

Educational Psychology Service Group Facilitators

1. How did you become involved in the intervention?
2. What was your role in the intervention group? *What did that look like? What psychological concepts did you find useful?*
3. What does 'anxiety' mean to you?
4. What does 'coping strategies' mean to you?
5. On a scale of 0 – 10 where 0 is did not enjoy the intervention at all and 10 is really enjoyed the intervention; to what extent did you enjoy delivering the intervention groups? *Why?*

| Did not enjoy delivering at all | The intervention | Really enjoyed delivering the |
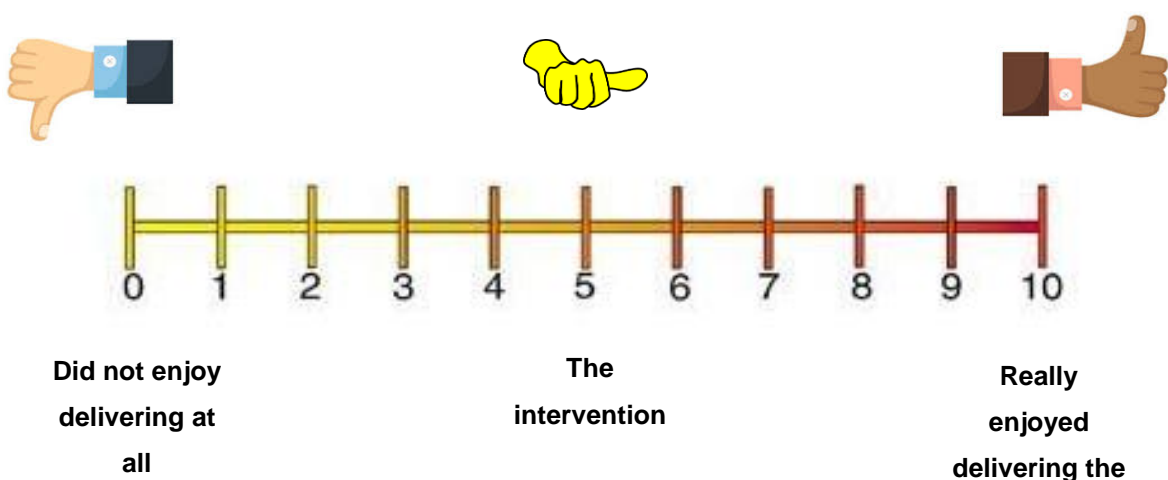
6. On a scale of 0 – 10 where 0 is not helpful at all and 10 is really helpful, How helpful was modelling the intervention to enable staff to deliver the intervention independently? *Why? What impact did modelling the intervention have?*

Not useful at all   **It was OK**   **Really useful**

0 1 2 3 4 5 6 7 8 9 10
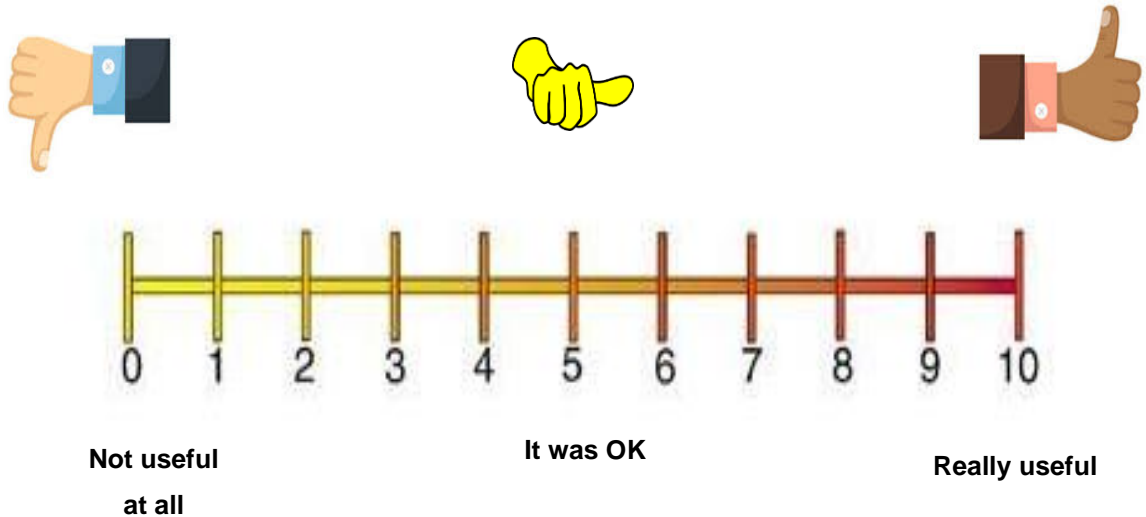
7. How could the process of training staff to deliver the intervention be improved?

8. What impact do you feel the intervention had on the young people? *Why? What do you think it was that made the difference? Were any parts of the intervention more helpful than others?*

9. What barriers might there be to the intervention being more successful? *Could you envisage any barriers on the delivery of the intervention on a wider scale?*

10. On a scale of 0 – 10 where 0 is not supportive at all and 10 is really supportive how supportive do you feel the intervention was in developing young people's;

    a. knowledge of coping strategies to manage anxiety?

b. use of coping strategies to manage anxiety?

Not supportive at all	**Sort of supportive**	**Really supportive**
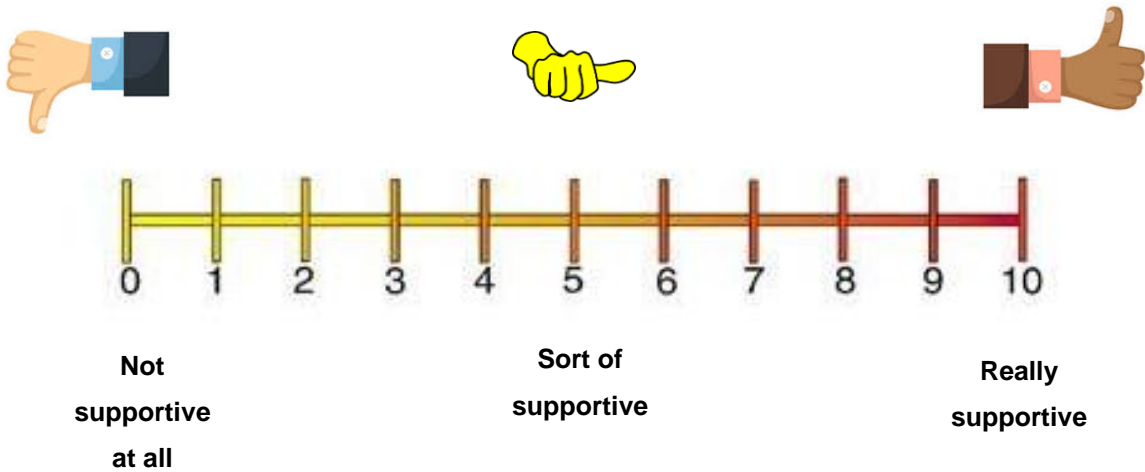
11. To what extent do you feel the young people would be able to use the strategies outside of the group? *Why? Can you tell me more?*

12. On a scale of 0 – 10 where 0 is not confident at all and 10 is really confident, how confident do you feel the staff are to be able continue running the intervention groups?

|		
Not confident at all	**Sort of confident**	**Really confident**
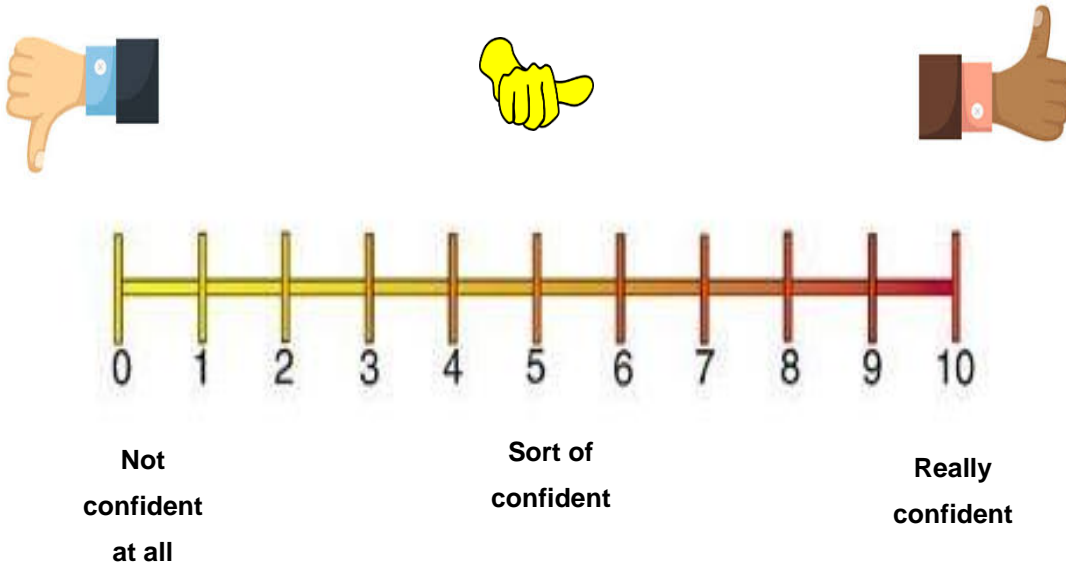
13. Is there anything you feel would be support school to continue the intervention groups?

14. Is there anything else you would like to share with regards to the intervention and its impact on anxiety?

School Group Facilitators

1. How did you become involved in the intervention?
2. What was your role in the intervention? *What did that look like?*
3. What does 'anxiety' mean to you?
4. What does 'coping strategies' mean to you?
5. On a scale of 0 – 10 where 0 is did not enjoy the intervention at all and 10 is really enjoyed the intervention how much did you enjoy delivering the intervention groups? *Why?*

| Did not enjoy delivering | The intervention | Really enjoyed delivering |
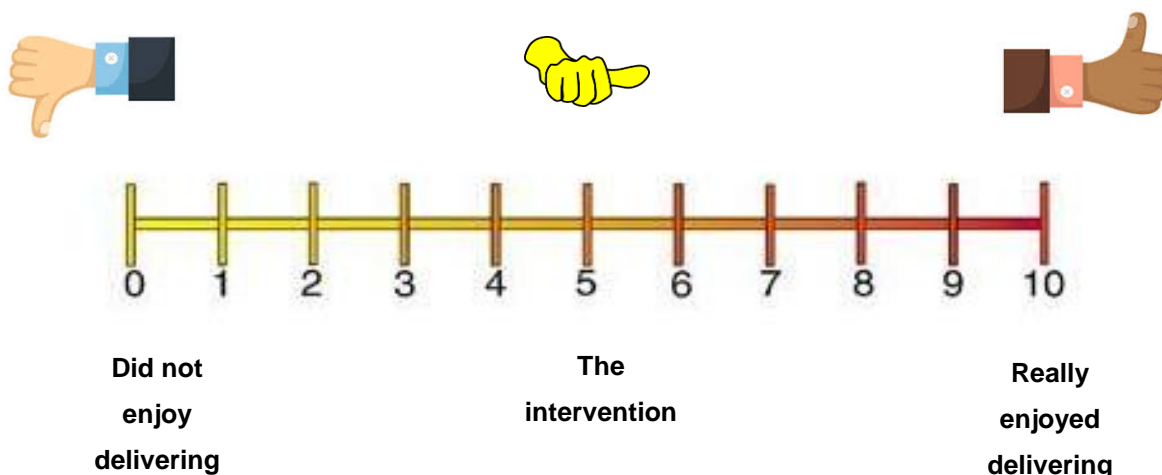
6. Can you tell me how the school ethos and environment may have influenced the impact of the intervention? *Can you tell me more about that?*
7. What experiences do you feel supported you to deliver the intervention?
8. To what extent, do you feel the intervention supported the group? *Why/How? Did it impact their anxiety levels?*
9. What barriers were there to the group being more successful? *Could you envisage other barriers across different settings?*
10. On a scale of 0 – 10 where 0 is not supportive at all and 10 is really supportive how supportive do you feel the intervention was in developing young people's;
    a. knowledge of coping strategies to manage anxiety?

b. use of coping strategies to manage anxiety?

Not supportive at all   **Sort of supportive**   **Really supportive**
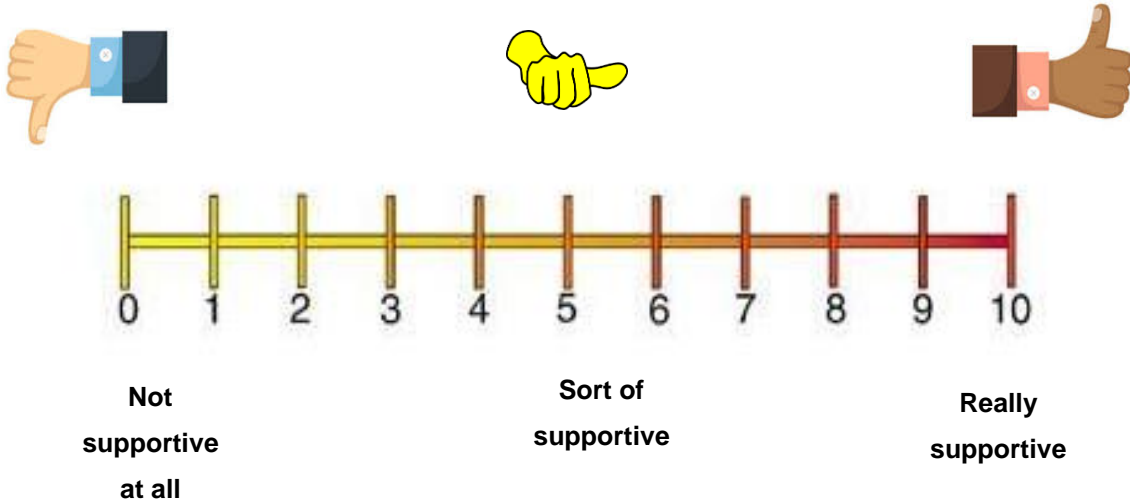
11. Can you give an example of when you have seen the strategies being used outside of the group?

12. On a scale of 0 – 10 where 0 is not confident at all and 10 is really confident, how confident do you feel to be able continue running the intervention groups?

Not confident at all   **Sort of confident**   **Really confident**
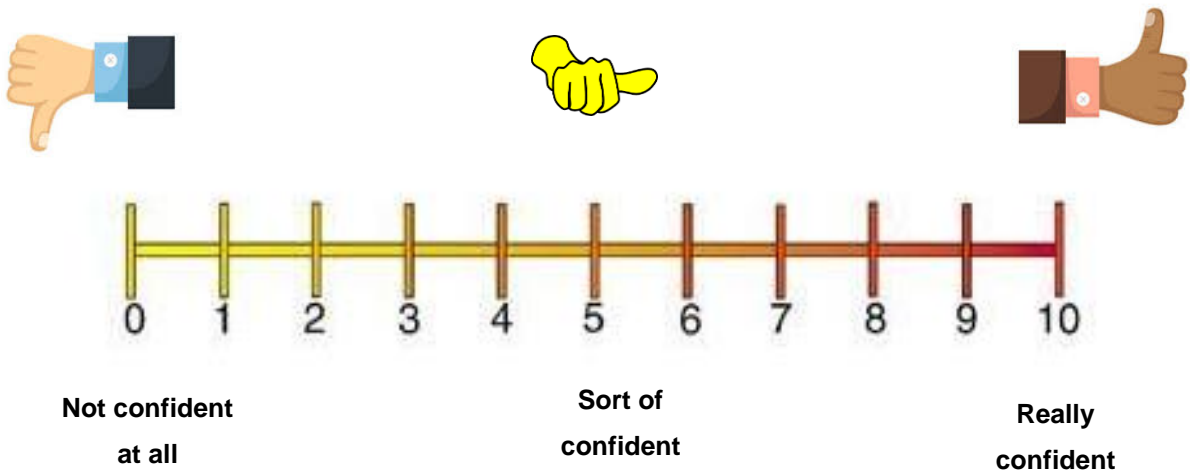
13. Is there anything you feel would support you to continue the intervention groups?

14. Is there anything else you would like to share with regards to the intervention and its impact on anxiety?

Pupils who took part in the intervention

1. On a scale of 0 – 10 where 0 is did not enjoy the intervention at all and 10 is really enjoyed the intervention did you enjoy the intervention groups? *Why?*

| Did not enjoy the intervention | The intervention was OK | Really enjoyed the intervention |
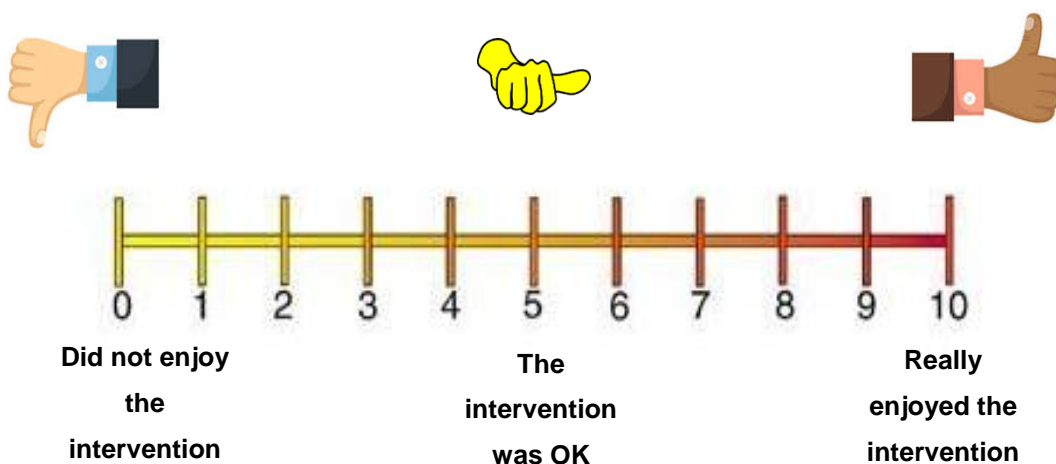
2. How did you become involved in the intervention? *What made you want to sign up for the intervention? How did you hear about it?*

3. Can you tell me what the intervention was about? *Can you tell me more about that?*

4. What does 'anxiety' mean to you?

5. What does 'coping strategies' mean to you?

6. In your opinion how did the intervention help you? *How about to manage anxiety? If so how?*

7. What was helpful about the intervention? *What else? How did it help you with managing your anxiety?*

8. What could be better about the intervention? *What else?*

9. Which strategies do you remember that were taught in the intervention? *Can you tell me a little bit more about them?*

10. What strategies if any, have you found useful? *Why?*

11. Can you tell me a time where you have used strategies to manage your anxiety? *How did it make you feel after? Can you tell me more?*

12. I am now going to read you 3 different scenarios and ask you some questions:

    a. Sam is finding the class task difficult. Sam see's people whispering and is worried that they are talking about him and saying he is not clever, what could Sam do?

    b. Tony has to read a poem in tutor time tomorrow morning and is feeling anxious, what could they do to manage their anxiety?

    c. Claire has had a long and busy day at school, she wants to relax but is not sure how, what would you suggest Claire does to relax and feel calmer?

Appendix N – Research Timeline

Task	Deadline
Research proposal	**20/10/17**
Consent and information forms	**20/11/17**
Semi-structured interview schedule	**20/11/17**
Ethical approval	**20/11/17**
Recruit participants	**15/12/17**
Start intervention (pre-test)	**w/c 1/1/18**
Finish intervention (post-test)	**w/c 5/2/18**
Write up literature review	**31/03/18**
Write up method	**15/04/18**
2 month review (interviews with facilitators and CYP)	**April 18**
2 month review (post-post-test)	**April/May/June 2018**
Analyse quantitative data	**30/08/18**
Analyse qualitative data	**05/11/18**
Write up interpretation of data	**01/02/19**
Write up discussion of research	**08/03/19**

Appendix O – Example of peer-reviewed transcript with codes.

I: So interview one with young person HT

I: OK so erm on a scale, this scale of 1-10, 0 to 10 sorry, where 0 is 'didn't enjoy the intervention at all' and 10 is 'really enjoyed the intervention' did you enjoy the intervention group?

P: Yeah I would say like an 8 probably

> Commented [BNR1]: Liked the intervention

I: An 8, and why would you give it an 8?

P: Well they were everyone was really like, like nobody minded what you were saying like for like saying any issue I had any like any like I took in the strategies, and it like it was really helpful so I really enjoyed it yeah

> Commented [BNR2]: Open space to share issues
> Commented [BNR3]: Having strategies to take was good
> Commented [BNR4]: Group was helpful
> Enjoyed the group

I: So what helped you feel like you could talk in the group?

P: So it was like, er only like 5 or 6 people in the group so I didn't mind like saying anything and they were really like, like interested in what I had to say, like I had a piano exam and I could erm like I was really nervous for it and they were like really like telling me like I'd be fine and stuff like that and that like made me like enjoy it more so I knew I wouldn't have to be like be worried about things and then I got like fine in my piano exam, so yeah

> Commented [BNR5]: Group of only 5-6 helped open up
> Commented [BNR6]: Group members were interested in what pupil shared
> Group reassured pupil they would be fine
> Reassurance from the group helped pupil enjoy sessions
> Commented [BNR7]: Group reassurance about worries helped in piano exam

I; Oh well done, so it sounds like the sort of group and being able to talk within in the group and the support of the group..

P: yeah it was really supportive, yeah

> Commented [BNR8]: The group felt supportive

I: erm and how did you become involved in the intervention?

P: What like how before how i started it?

I: Yeah

P: Well ermm our form tutor just told us all all about it, just told everyone about it and no one really said anything about it, like no one really wanted to do it but I was like 'well we've got exams coming up and stuff like that' so I thought it could be really helpful and like I have a lot of stuff to stay like which I haven't like really said before, so I got all that out and said that to everyone and that was really nice yeah. So I was like, here was only like me and 4 or 5 other people that did it so yeah found out about it and then erm just like signed a form it was really easy, yeah.

> Commented [BNR9]: Tutor told tutor group about the intervention
> Commented [BNR10]: No one in class spoke about intervention when they were told
> No one else wanted to do the intervention
> Commented [BNR11]: Pupil thought group would help with exams
> Pupil thought group would help say things they hadn't said/told before
> Commented [BNR12]: Group was with 4-5 other people
> Commented [BNR13]: Pupil signed form to join group
> Signing up was easy

I: Oh so that sounds really nice so your form tutor talked to you about it and you thought this might be useful with exams coming up?

P: Yeah

I: erm and what made you want to sign up, so was it the.. sounds like exams coming up, was there anything else that made you want to sign up?

P: Well I mean I thought it would be, cause I've never really done anything like it like they don't have anything erm like in school like that like nothing to help you with like they help you with exams obviously but not like fear of it and stuff like that and not just exams everything in general so I thought ermm it would be like it would really help me with any, 'cause I do obviously like I said piano and like loads of stuff and it would be like really good for me to erm understand more about anxiety and stuff like that.

I: So it sounds like there's not a lot in school at the minute and it was an opportunity for you to then have some support, sounds really good, so can you tell me a bit about what the intervention was about?

P: So there were different like activities that we did, so they started with just telling us all about like what we were going to do for the 6 sessions I think it was and there were different activities that we did like in pairs we just with each other like talking about ones where we had to talk about good things in our life and think about that like bad things like giving ourselves like positive thoughts and negative thoughts just to make it all like easier for us to deal with things like exams and stuff.

I: That sounds good, erm and what does anxiety mean to you?

P: erm I'd say like not necessarily just like I think everyone has it , everyone like copes, like copes with stuff like that like not just nerves but just like the fear of stuff that might not be as fearful as it really is like it's not as bad as it is but you just get really worked up about it, that's what I think it means

I: That's good and what does coping strategies mean to you?

P: erm ways to get like over over the fear stuff to make you just feel more relaxed and calm

I: So support for when you're feeling

P: Yeah

I: A bit anxious?

P: Yeah

I: erm and in your opinion how did the intervention help you?

P: erm well definitely what I've been saying is like the best thing for me is it's taught me like loads of like you've just said coping strategies, like I feel so much better with if I ever do get anxious then I can like sort of stuff they've said like different strategies like just imagining like it all sounds a bit strange but like a spot light, like a yellow spot light like just like making you feel really relaxed if you can't like sleep and stuff like that and that I just like do that like if I can't sleep I do that, if I'm really like nervous and stuff I just do that, it's really helpful yeah.

I: So it sounds like erm it helped you learn strategies, would you say to manage your anxiety ? or is there anything else that it had an impact on?

Appendix P – Examples of Codes and Quotes – Pupils

Pupils' developing knowledge and effective application of self-regulation skills		
Sub themes	**Codes to illustrate**	**Examples of Quotes**
Positive thinking and reframing; applying CBTA	- helped to acknowledge good things - reframing thoughts - learning to re-focus energy - time for self-reflection - a lot of people have anxiety	"…there was like like I said acknowledging the good things…" 2B "it made me feel calmer because I know I wasn't going to do amazing on them but I knew I can try my hardest and that's all I can do and that got me through it." 3E "…erm, they could just erm try to feel better about themselves and feel more confident and feel that they can do it and they shouldn't be so worried about it…" 1C "…we're not the only ones who have these emotions and how to control them and how to kind of help with these emotions that we are feeling…" 1A "…when you finish the whole sessions you reflect on it and that kind of my mind go exploding because I found out what my other point of view was what was how much has changed." 1D

Pupils developing understanding of anxiety from a holistic perspective	- developing knowledge and understanding of anxiety - anxiety is something you think is really bad-scary but isn't - anxiety is something that holds me back from doing normal things - anxiety can cause isolation - helped to think about people around you	"...where I don't feel safe about myself being around new people or even even friends when I don't want to be around anyone..." 1D "...holds me back from doing normal things in my life..." 4C "...like your body won't let you do it..." 1B "yeah it like shuts down and like my butterflies in your stomach." 1B
Physical and emotional impact of applying self-regulation strategies	- helped to control emotions - if the strategy doesn't work straight away you need to remember to keep trying - something to help you be calm in the week - strategies help you to relax - helped to think about people around you	"it's given me techniques to try and calm myself down if I'm in stressful situations or situations where my ((pause)) kind of my ((pause)) emotion might overcome me, so its kind of given me help in that sense" 1A "...I guess so because it made me, like I said it made me calmer and it kind of while I was calmer it made me new ways to think of new things and deal with those things." 1D "I think it helped me with the panic attacks I don't get them as much anymore because I've learnt a few techniques on how to stop them ...it's like helped with the, yeah the breathing stuff." 4C

| Applying a range of self-regulation strategies. | - able to apply strategies in different contexts
- strategies help to think more clearly
- listen to calming music or videos
- apply strategies before stressful situations
- exercise to manage physical sensations | "…if I've just done a lot of revision I would go into my room and sit and breath for maybe 5 maybe 10 minutes just relaxing and then go back to it, cause otherwise I'll just get anxious by burning myself out on it. I could be, I realised that I have 3 exams in the next few days and I haven't revised for any of them when yet breathing lets me think, this is how I'm going to do that this is how I'm going to do that and let me plan and what I'm going to do" 1C

"So it's exercising like it makes you feel free and clears your mind" 1D

"…like how you deal with the, like how you deal with it? for example like if I want to go on a ride at Chessington and it's like really scary I'll do some like breathing activities and stuff like to make me go on it and face my fears." 1B

"…find a quiet place, to start breathing quietly or just rest, sleep was a good one because it just lets your body rest and let it kind of recharge so we were feeling a bit calmer and ready when you wake back up again…" 1C |
| | | |

	Facilitative factors that influence positive engagement with the intervention	
Sub themes	**Codes to illustrate**	**Examples of Quotes**
The benefits of a person-centred approach.	- recommended and then signed up by choice - I wanted to be better with my life - signed up to intervention - not feeling you needed to be there - felt it would be helpful because anxiety is bad	"I didn't 100 percent feel like I needed to be there." 3E "I wanted to be better with my life." 1D "I didn't really mind because kinda I kinda that would be like helpful 'cause my anxieties got quite bad so…" "Miss took me out of the lesson one day and asked if I wanted to do it and I said sure and that's really how it happened." 3E "…I got told about it in I think it was a tutor yeah it was a tutor time and erm was told about it an was like oh ok ill go and have a look at it. went down to one of the rooms and it was like yeah this can help me so I signed up for it and erm yeah I'm really enjoying it…" 1C
Improving the frequency and structure of the sessions.	- too much repetition in the sessions - personal sessions would make it better - would be better if there is a range of ages - frequent sessions important - gaps between sessions can lead to forgetting	"…fortnightly would start losing kind of like losing what we learnt from it…" 1C "…I don't know instead of being in like a group sesh a personal kind of Session with just one person and a teacher…" 1D

| Valuing a systemic approach | - parental support important
- learning something that could be used out of school
- benefit from more talk about peoples' communities
- better if more daily school examples
- benefit from more talk about how school can help | "…we were going over the same stuff a little bit too much apart from that it was good, it was definitely helpful." 1C

"…a week in between that's quite a long time…" 2B

"…more ways to deal with like lower level anxiety because those the things that's the kind of stuff that interferes with my daily life…" 4C

"…like talking about erm helping with like the school and stuff we think that about like having time out of classrooms if we feel a bit anxious and I think we could talk, talk like more about that, about like our own like community after schools…" 2B

"…It helped with learning coping mechanisms at home…" 1C

"…my parents are quite supportive of it…" 1C

"…in that month instead of just doing once a week I guess because some people have hard time and it would just be easier to do focuses on them, multiple times, and then just do it once a week…" 1D |

Providing containment and the importance of attuned relationships

Sub themes	Codes to illustrate	Examples of Quotes
Creating a safe space	- opportunity to talk about problems - having adults who were understanding - being able to open up to the group is important - safety and confidentiality of group was important - group empathy is important	"…people there that I didn't really want to open up to and I tell about my insecurities and stuff." 4C "…That's probably why I felt a bit out 'cause they're all quiet and shy and talk to each other…" 3E "…they were really like, like interested in what I had to say…" 2B "I didn't feel like they would judge me for whatever I said…" 2B
Improving access to support	- nothing else in school that teaches this stuff - something you wouldn't have been able to access before	"…cause I've never really done anything like it like they don't have anything erm like in school like that like nothing to help you with like they help you with exams obviously but not like fear of it and stuff like that and not just exams…" 2B "…it was something that without I wouldn't have done as well as I think I would of…" 1C
Valuing the experience	- something to look forward to in the week - got me out of a few lessons - useful - enjoyed the intervention - fun exercises	"…it was quite useful…" 4C "…it was fun to be there…" 3E

"…I took in the strategies, and it like it was really helpful so I really enjoyed it…." 2B
"…it couldn't really improve, it's perfectly fine as it is, it helps a lot." 1A *"…it was something I knew I could look forward to in the week…" 1C*

Appendix Q – Examples of Codes and Quotes – Facilitators

Sub themes	Developing pupils' knowledge and effective application of self-regulation skills	
	Codes to illustrate	Examples of Quotes
Pupils applying strategies learnt in the intervention to alleviate anxiety	- coping strategies help to identify feelings - by session 7 pupils still needed reminders for coping strategies - concrete techniques - intervention would benefit from more strategies for the pupils to take away - towards the end of the sessions more pupils were applying the strategies - pupils applied strategies - pupils had the opportunity to choose from lots of strategies - pupils used breathing exercises	"…really concrete relaxation techniques so at the end of every session we practised a different relaxation technique…" EPS, Assistant-EP1 "…one good thing they did have lots of choice…" EPS, Assistant-EP1 "…although their knowledge had gone up, when I asked them which ones they were using, again they weren't automatically using the ones from the intervention, they were still going back to their ones…" EPS, Assistant-EP2 "…most of them really love the breathing exercises…" EPS, EP "The breathing techniques definitely with one of the girls she came over for some quiet space…" School 4, SENCO "yeah maybe just just as like a you know if you enjoyed the visualisation then this particular website all this app all this

Positive Impact on Pupils	- pupils motivation in class improves - pupils attendance improved - pupil got strategies to use in different contexts - good at reducing risk to pupil suffering in silence - improved pupil wellbeing	*book just so then it's a bit more tailored to what the students prefer…" School 3, Teaching-assistant.* *"…now have the tools to go on and use them and use them in their own families and their own own safety network…" School 1, Mental-health-first-aider.* *"…it's really good at reducing the risk of vulnerable students within our school that are suffering in silence." School 1, Pastoral* *"…it was really interesting because when they when they finish the session the RCAD data wasn't very different and you think oh god I've done that's dreadfully and that you know it's not working but then speaking to them a few weeks later and when you talk to them and they say yeah…" School 1, Teaching-assistant* *"…had a really positive impact on all of them I think and they certainly expressed that." School 4, SENCO* *"they used it and you know, there were suggesting that they're going to use it before exams and, there is a spelling test. There are lots of examples of them using it across contexts. being able to being able to generalize it…"EPS, EP*

Theme	Codes	Quotes
The benefits of pupils developing psychological understanding of the connection between thoughts, feelings and behaviours	- CBT - hot cross bun is explicit - pupils more aware of anxiety and NATS - pupil developed understanding of CBTA - pupil learnt alternative ways of thinking - reframing pupils' perceptions of themselves	"…making the CBT hot cross bun really explicit so the students erm they seemed the respond quite well to the psycho-education…" EPS, Assistant-EP1 "…the negative automatic thoughts as well that was really interesting again because that was kind of a turning point where the young person opened up quite a lot about times they'd had these thoughts and shared examples so I really enjoyed that as well." EPS, Assistant-EP2 "…most of them have kind of taken away a bit like 'oh actually yeah like I am like quite a good person like maybe people do actually think I am capable of doing something' erm but I think that was probably the nicest part of it." EPS, Assistant-EP1 "…what I do know is, I've got what 10 15 boys ((pause)) who became interested in and thinking about alternative ways, this thing called CBT its improved their communication with each other…" School 1, Mental-health-first-aider.
Pupils understanding of anxiety developed	- anxiety can stop you doing things you want to - anxiety is a massive part of pupils' life - by the end pupil understood anxiety better - everyone experiences anxiety	"…think the group works really well because they all realise that actually lots of people feel anxious and like it wasn't such a big deal as they perhaps thought…" EPS, Assistant-EP2

Sub themes	Codes to illustrate	Examples of quotes
	- the intervention was good at normalising anxiety	"…massive part of some pupils' lives…" EPS, Assistant-EP1 "…certainly think all of them had a better understanding of their anxiety." School 4, SENCO "…it really affects their learning and day-to-day lives and quality of their lives. so anything that can help is good." School 3, Pupil-Premium-Lead

Providing containment and the importance of attuned relationships

Sub themes	Codes to illustrate	Examples of quotes
The benefits of a person-centred approach	- some pupils were encouraged by staff to attend - expressed interest - self-referral = more engaged - important not to force pupils to engage - important that pupil self-refer so they really want to engage	"…know school put it out as self-referral but I think some young people were kind of encouraged to at least come along to the first session…" EPS, Assistant-EP1 "…I mean there were a couple but dropped out one from my group I think two from the EPs group that didn't feel that it was for them and that's fine that's their choice but erm all the ones that participated all the way through said that they felt that they benefited from it." School 3, Pupil-premium-lead "…they've self-referred so if they want to be there that's absolutely great…" School 1, Pastoral "…which is totally fine for them not to do that it's not compulsory…" School 3, Teaching-assistant

Sub themes	Codes to illustrate	Examples of quotes
Building attuned relationships within the groups between the groups between facilitators and peers; and between peers	- smaller groups or 121 may be better for some - pupils had an opportunity to talk and feel listened to - important to show pupil that they are heard - facilitators shared their coping strategies which is valuable	"…actually they really liked the opportunity of just having someone to just listened to them…" EPS, Assistant-EP1 "…it builds up little clusters of boys who are have some knowledge of how to get their buddies and themselves out of trouble." School 1, Mental-health-first-aider. "…I said it worked for all of us and they I think they sort of took that on board and it made them feel a bit easier about things." School 3, Pupil-premium-lead "…safe space is quite important (mm, yeah) where to sort of tucked away non-disturbed private…" School 1, Pastoral

Facilitative and systemic factors to quality assure the intervention and embed it at a whole-school level

Sub themes	Codes to illustrate	Examples of quotes
The need for a flexible therapeutic approach	- better to have less in each session - structure of programmes means it can be inflexible to what works well for individual group - students wanted longer and more sessions - some sessions ended up rushed - future groups would benefit from some flexibility in tasks	"…I think might have been a bit rushed. 'cause actually when I started the group last week I only had them for the first 50 minutes and I couldn't get through everything in the first session really so I'm extending it this time this week." School 3, Pupil-premium-lead

		"…I think there's some students that need a bit longer time so the length of session would be beneficial maybe an 8 or 10 week course." School 1, Pastoral "…especially one of my groups they had a lot of discussions which is why I struggled with the time, but the discussions were so valuable I didn't want to stop them…" EPS, Assistant-EP2 "…but in the future going forward it might be nice to have a little bit of flexibility in the intervention so you can alter it for your group, that would be great." EPS, Assistant-EP2
Reducing barriers to successful implementation	- writing things down was difficult for some pupil as it made feelings concrete - give time to planning and setting up intervention - busy staff struggle to fit in 2 groups a week - difficult to run during exam times - RCADS time consuming to score	"…you don't get much for nothing anymore and I think that I'll be honestly I think that was one of the main reasons I went for it as well other than the fact that I'm obviously an advocate for mental health I think the fact that it wasn't at cost to the school is a huge advantage and moving forward we've all as schools I just you know there's loads of stuff that we've wanted to run before but I've not had the financial ability to do it…" School 4, SENCO "…e need to look at our own calendars and see where there are no interruptions ((pause)) because it was interrupted

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Theme	Points	Quotes
		disrupted as I was saying by sports day etc…" School 1, Mental-health-first-aider *"…especially those are RCADS when it was like the first one and then the follow-up and then the last one I was like oh not another one…" School 3, Pupil-premium-lead* *"…time to do the data and prepare and stuff." School 3, Pupil-premium-lead* *"…pragmatically it was difficult getting another group for the intervention facilitator…" EPS, Assistant-EP2*
Building resilience in the system - **The importance of a whole-school approach** - **Training the facilitators; a cascading affect to develop positive mental health across the school.**	- difficult to access mh support out of school so its important for schools to have something in house - school focus on SEMH - important for SLT to be on board - pupil used it to help others - modelling and supervision helped staff to deliver it independently - would benefit from more signposting at the end - more time for strengths needed - continued supervision is needed	*"…it was it was very much like I, when I was offered to do it I was like well I'm not I've got absolutely no qualifications that would mean that I delve into any aspects of mental health in any great detail what you know what could I bring to it so that when they were saying that we could then watch it made me feel better in that I had some form of training to be able to see what a successful sort of session would look like and to what extent I would be involved in you know managing and facilitating that side of mental health awareness." School-3, Pupil-premium-lead.*

- **Developing long-term support to ensure lasting effects** - **Supervision – providing facilitators with containment**	*"…I think the facilitators, the school facilitators found it useful just to kind of see how you actually go about it and what it would look like in practice…" EPS, Assistant-EP1* *"…they both said they felt comfortable, comfortable and confident running their groups after seeing modelled so I think it is an effective…" EPS, Assistant-EP2* *"…A whole-class level I think it would be useful for ermm some SLT to kind of get involved in the intervention, to be more aware of it erm to try kind of roll it out a whole class level…" EPS, Assistant-EP2* *"…I think all the practical aspect like making sure that the school values it enough to set aside a committed member of staff, the room, you know, everything that's needed, properly, you know, all the resources prepared and that kind of thing…" EPS, EP* *"…we've done my group did a letter an open letter to staff that was anonymous and every member of the group contributed in some way to the letter which was how students felt the particular situations that caused them worry, and then providing examples of strategies that teachers could use*

	that would help with their anxiety surrounding education in lesson…" School 3, Pupil-premium-lead *"…I just think that more staff training on awareness of mental health needs and having a whole-school approach to it…." School 1, Pastoral*

Appendix R – Table of procedures for mixed methods research to ensure trustworthiness and validity of findings taken from Creswell and Plano Clark (2018).

TABLE 7.1 ■ Recommended Quantitative and Qualitative Data Analysis Procedures for Designing Mixed Methods Studies

Quantitative Data Analysis Procedures	Steps in Data Analysis	Qualitative Data Analysis Procedures
• Assign a numeric value to each response in a database (e.g., Excel, SPSS) • Clean the database (e.g., check for data entry errors) • Recode items and compute new variables (e.g., summed scores) • Establish a codebook (name and definition of each quantitative variable)	Prepare the data for analysis	• Transcribe the data • Check transcripts for accuracy • Organize the data by data type, participant, or case • Format the data to facilitate the analysis (by hand or with software)
• Visually inspect trends in the data and check whether data are normally distributed • Conduct descriptive analyses for each major variable • Conduct basic assessments of the reliability and validity of the measures • Address any issues of missing data	Explore the data	• Read through the data to obtain a sense of it all • Write memos about initial thoughts • Develop a few initial codes (all projects) and develop a qualitative codebook (only appropriate for some projects)

• Select appropriate inferential statistical tests based on research questions, scale type, number of variables, and distributions
• Analyze data using quality statistical software (e.g., SPSS, SAS, R, JMP) to answer quantitative research questions and test hypotheses
• Conduct inferential tests and calculate effect sizes and confidence intervals
	Analyze the data	• Select the analysis approach(es) based on the research questions
		• Use qualitative data analysis software programs (e.g., MAXQDA, NVivo, Atlas.ti)
		• Implement a coding process:
		  ○ Code the data
		  ○ Develop description and themes by grouping codes
		  ○ Interrelate themes (or categories) based on overall qualitative approach or develop abstract categories into a smaller set of themes

• Summarize statistical results (e.g., statistics and p values) in the text, tables, and figures • Follow style guidelines (e.g., APA style) for reporting results	Represent the data analysis	• Represent the findings in discussions of description, themes, or categories • Provide evidence for the themes/ description, such as quotes, multiple perspectives, and rich description • Present visual models, figures, and/or tables about the descriptions or themes • Follow style guidelines (e.g., APA style) for reporting findings
• Summarize the major quantitative results • Compare the results to hypotheses or interpret in terms of the research questions • Examine results with respect to prior predictions or explanations drawn from the literature • Identify limitations of the study • Identify implications for future research and for audiences	Interpret the results	• Summarize the major qualitative findings • Interpret how the findings answer the research questions • Relate findings to past literature and/or theories • Bring in a personal assessment of the meaning of the findings • Identify limitations of the study • Identify implications for future research and for audiences

• Use external standards
• Establish the reliability and construct validity of the obtained scores:
  ○ in the data collection section (from past uses of the instruments) and
  ○ in your analysis (from current study) such as by assessing the internal consistency of the scores or test-retest results
• Use procedures that reduce threats to internal validity (which is the extent to which cause-and-effect claims can be made)
• Use procedures that reduce threats to external validity (which is the extent to which the results can be generalized to other persons, settings, or times)
	Validate the data and results	• Use researcher, participant, and reviewer standards
		• Check for the accuracy of the account—extent that the information is credible, transferable, dependable, and confirmable
		• Use at least three of the following validation strategies:
		  ○ member checking,
		  ○ triangulating data from several sources or individuals,
		  ○ spending extended time in the field,
		  ○ reporting disconfirming evidence, or
		  ○ conducting an external review of the data and procedures (e.g., peer review or audit)
		• Employ limited procedures for checking reliability (e.g., the extent to which multiple coders agree on codes)

Source: Adapted from Creswell & Plano Clark (2011).

Appendix S – Ethical Considerations

Data Baring Service (DBS) – I have a clear DBS which allowed me to work with vulnerable children and adults.

Managing adolescents' *anxiety* – If a child becomes distressed during the session they would have be given the opportunity to withdraw from the session and talk about their concerns after the session with the group facilitator. Should the school feel they needed further support with this process, they were told to contact their Educational Psychologist. This was agreed with the local authority as the Educational Psychology Service had a joint interest in piloting and evaluating the intervention.

Intervention participation – the information and consent form highlights that not taking part in the research will not influence the adolescent's opportunity to take part in the intervention group. This will be further illustrated by staff running the groups.

Informed consent – I fully informed the Educational Psychology Service, school staff, parents and the young person about the purpose and nature of research. All participants who took part were fully informed and consent was obtained prior to starting the data collection. Schools were invited to opt in to taking part in the research (Appendix E). After schools agreed, parents/guardians/carers of the young people were asked for consent for their adolescents to take part in the research and the young people themselves were invited to take part in the research using fully informed consent forms (Appendix H, I & J). The purpose of the research and what participation entails was outlined in the written information sheet which was sent to schools, parents and the young people. The information sheet highlighted participant's right to withdraw at any time and reassured participants that all information is held securely and kept anonymous. Adolescents were reassured from staff and the group facilitators that not taking part in the research would not influence their opportunity to be part of the intervention group.

Confidentiality and anonymity – All information remained anonymous in the report and confidentiality has been respected as my supervisors and I only have knowledge of the schools involved and children's names. All participants were issued an ID number. If a pupil or intervention facilitator had decided to have their information withdrawn after participating in the study I could remove their responses after referring to the participant number linked to their name. This list of names and ID numbers is kept in a locked filing cabinet at the IOE.

Reporting – The report is anonymous replacing children's schools and names with letter/ number codes i.e. 1a.

Data storage - The data will be held in a locked secure storage for a maximum of 10 years.

Dissemination and use of findings – The research was used to test the effectiveness of the intervention. The findings will be shared with schools, and the Educational Psychology Service, then a short debriefing poster to share the outcomes of the intervention as well as what pupils and facilitators valued and how the intervention can be improved.

Appendix T – Descriptive map of pupil themes

Overarching Themes	Themes
1.1 Pupils developing knowledge and effective application of self-regulation skills *Pupils' understanding of self-regulation, in terms of understanding anxiety from a psychological perspective and how to manage emotions, developed over the course of the intervention.*	**1.1.1 Positive thinking and reframing; applying CBTA** *Pupils had begun to challenge negative automatic thoughts, reframing situations more positively and engaging in self-reflection.* **1.1.2 Pupils developing understanding of anxiety from a holistic perspective** *Pupils developed their understanding of the impact of anxiety and drew connections between physical sensations, thoughts and feelings.* **1.1.3 Physical and emotional impact of applying self-regulation strategies** *Pupils recognised the impact of strategies and used them across different contexts.* **1.1.4 Applying a range of self-regulation strategies** *Pupils learnt a range of strategies to support their self-regulation.*
1.2 Facilitative factors that influence positive engagement with the intervention *Pupils suggested a range of barriers and facilitators to the intervention, describing what they enjoyed about the intervention and what could make it even better.*	**1.2.1 The benefits of a person-centred approach** *Pupils chose to be involved or not in the intervention. This choice indicates a level of readiness to acknowledge and change difficulties with anxiety.* **1.2.2 Improving the frequency and structure of the sessions** *The frequency and structure of the sessions could be developed further to better support individuals within the groups.* **1.2.3 Valuing a systemic approach** *Pupils wanted to share strategies across different contexts, home and school. They wanted all staff and parents to be aware and inclusive of their needs.*
1.3 Providing containment and the importance of attuned relationships	**1.3.1 Creating a safe space** *Developing attuned relationships within the group, between peers and their facilitator, was key in providing a safe space for pupils to share their thoughts and feelings as well as providing an opportunity for containment.*

The intervention provided pupils with experiences that were otherwise unavailable. It provided an opportunity to access support, develop self-awareness and feelings of containment.	**1.3.2 Improving access to Support**
	Access to support is limited and this intervention provided support that would have otherwise not been available.
	1.3.3 Valuing the experience
	Pupils enjoyed taking part in the intervention and felt it supported them to be able to manage their anxiety.

Appendix U – Descriptive map of facilitators themes

Overarching Themes	Themes	Sub-themes
2.1 Developing pupils' knowledge and effective application of self-regulation skills *Pupils developed their psychological understanding of anxiety and were able to apply the strategies learnt in the sessions to reduce their anxiety.*	**2.1.1 Pupils applying strategies learnt in the intervention to alleviate anxiety** *Pupils applied strategies across different contexts.* **2.1.2 Positive impact on pupils** *Facilitators enjoyed seeing pupils reduce their anxiety and employ strategies to overcome challenging situations.* **2.1.3 The benefits of pupils developing psychological understanding of the connection between thoughts, feelings and behaviours** *Pupils developed their understanding of Cognitive Behavioural Theory.* **2.1.4 Pupils understanding of anxiety developed** *Pupils and facilitators were able to normalise anxiety and recognise the impact of anxiety on daily life.*	
2.2 Providing containment and the importance of attuned relationships *The engagement of pupils in the intervention was fundamental.*	**2.2.1 The benefits of a person-centred approach** *It was important that pupils who were part of the group had chosen to be there.* **2.2.2 Building attuned relationships within the groups between facilitators and peers; and between peers.** *Building attuned relationships was essential to making the intervention successful. Building these relationships supported pupils to be ready for independence. Zones of proximal development suggest that attuned relationships support learning.*	

	2.3 Facilitative and systemic factors to quality assure the intervention and embed it at a whole-school level		
	The intervention was new to schools and how to successfully implement this and embed this within school was discussed.	**2.3.1 The need for a flexible therapeutic approach**	
		Consideration of how to make the intervention more flexible to meet the needs of individual groups. However further consideration was also given to purity of how the intervention is delivered if it were to be delivered more flexibly.	
		2.3.2 Reducing barriers to successful implementation	
		The pragmatics of running such interventions in schools is discussed, with consideration to complex secondary school timetable, funding and time for planning and organisation.	
		2.3.3 Building resilience in the system.	
		Skilling up systems around pupils to be able to support pupils with anxiety was a key outcome of the intervention. Developing a whole-school approach and home-school relationships were particularly highlighted. Further recommendations were also suggested.	**2.3.3.1 The importance of a whole-school approach**
			Facilitators suggested a more systemic approach to make the intervention more successful, such as sharing strategies with class teachers.
			2.3.3.2 Training the facilitators; a cascading affect to develop positive mental health across the school.
			The training was demonstrated to a member of staff which developed their confidence to deliver the training and go to train others in the schools. Additionally, pupils discuss supporting their peers with anxiety.

	2.3.3.3 Developing long-term support to ensure lasting effects *Facilitators suggested ways in which the intervention supported long-term effects and how this could be advanced.*
	2.3.3.4 Supervision - providing facilitators with containment *Although supervision is embedded within the intervention, how it is used needs further consideration.*

Appendix V – Facilitators scaling question responses

In addition to interviews, facilitators were asked scaling questions throughout the interviews. In the interviews, these were probed further to examine the meaning behind the scores given.

Scaling question responses

Questions	Mean	Standard Deviation	Range
EPS and School facilitators- How supportive was the intervention in developing young people's use of coping strategies to manage anxiety?' (0 = not at all, 10 = extremely)	8	1.5	6-10
EPS and School facilitators- How supportive was the intervention in developing young people's knowledge of coping strategies to manage anxiety? (0 = not at all, 10 = extremely)	8	0.83	8-9
EPS facilitators- How helpful was modelling the intervention to enable staff to deliver the intervention independently?' (0 = not at all, 10 = extremely)	8	1.73	7-10
EPS facilitators - How confident do you feel the staff are to be able to continue running the intervention groups?' (0 = not at all, 10 = extremely)	8	0.58	7-8
School facilitators - How confident do you feel to be able to continue running the intervention groups?' (0 = not at all, 10 = extremely)	9	1.41	7-10