Perspectives on Cognitive-Behavioural Therapy from Children and Young People Receiving Support and Practitioners Providing Support

James Redburn

D.Ed.Psy Educational and Child Psychology

Thesis Volume 1, 2022

University College London

Abstract

Cognitive-behavioural therapy (CBT) helps children and young people (CYP) understand their thoughts, feelings, and behaviours; and teaches them techniques to reduce emotional distress. Quantitative evidence, using randomised controlled trials (RCTs), has established that CBT is effective for many people. However, many people, perhaps up to 50%, do not achieve positive outcomes from CBT. The Review Paper sought to explore how CYP conceptualise 'positive outcomes' from CBT and how CYP view the facilitators and barriers to positive outcomes. A systematic literature search identified 19 studies for review. A thematic synthesis identified 34 conceptualisations of positive outcomes, 57 facilitators, and 49 barriers. Descriptive and analytic themes were identified. The latter were worded as practice recommendations: acknowledge CYP's perspectives on outcomes, teach tangible CBT techniques, balance autonomy and support, frame CBT as 'upskilling', explore nuanced barriers to engagement, and consider the power of group dynamics.

The Empirical Paper explored how practitioners use a non-manualised CBT workbook (Think Good – Feel Good, TGFG) when working with CYP. In RCTs, manualised protocols are used to ensure practitioners deliver the same treatment to all participants. However, in reality, practitioners have mixed views about the value of manuals, with some preferring to work based on professional judgment. For the current study, a convergent mixed-methods design was employed, with an online survey producing qualitative and quantitative data from 238 respondents and semi-structured interviews with 6 practitioners. Data were analysed separately using content and statistical analysis (surveys) and thematic analysis (interviews) before being integrated using a joint display. Findings are discussed in terms of how practitioners decide to use TGFG, how TGFG is employed in practice, and the role of supplementary resources within the therapeutic space. Recommendations for practice, recommendations for future research, and limitations are discussed.

Table of contents

List of tables

List of figures

Acknowledgements

Chapter 1: Introduction to the Thesis

1.1 Introduction

This chapter introduces the thesis by describing the rationale for topic selection, exploring the relationship between the review and empirical papers, outlining the philosophical considerations, and providing an overview of the thesis.

1.2 Rationale for topic selection

Mental health and wellbeing are dynamic concepts that eschew clear definition. Some traits of mentally healthy people include being aware and in control of their emotions, empathising with others, coping with normal life stressors, contributing productively to society, and being free from significant distress (Galderisi et al., 2015; World Health Organization, 2018). Promotion of mental health is enshrined as a right of children and young people (CYP) (United Nations, 1990).

In the United Kingdom (UK), around one in six adults (one in five women, one in eight men) experience a common mental health difficulty (such as anxiety or low mood) in any given week (McManus et al., 2016). Among 5-19-year-olds, around one in twelve (from a sample of 9,117) were assessed to have at least one 'emotional disorder', with anxiety being three times more prevalent than low mood (National Health Service [NHS], 2018). For adults and CYP, reported rates are rising over time. In the context of the Covid-19 pandemic, mental health difficulties have been exacerbated by school closures and public health concerns (Rider et al., 2021).

Developing and delivering effective ways to alleviate mental health difficulties is a crucial function of modern society. Among the best-researched mental health interventions is cognitive-behavioural therapy (CBT), an approach that explores thoughts, feelings, and behaviours (Beck, 1970; Hofmann et al., 2012). CBT was developed to extend behavioural therapies, which focussed on antecedents, consequences, and breaking the association between negative emotions and problematic behaviours (Skinner, 1974). CBT shifted the focus to interpretations of

events, rather than events themselves, proposing that changing one's cognitive perspective can relieve emotional distress and help one find alternatives to maladaptive behaviours (Beck, 1970). These outcomes can be achieved through a range of therapeutic components including psychological education; developing a positive therapeutic relationship; monitoring and managing thoughts, feelings, and behaviours; and developing problem-solving skills (Stallard, 2018).

Engaging effectively in CBT requires self-awareness, motivation to change, and verbal language skills (Stallard, 2021). Whilst these are associated with cognitive maturity, research suggests children as young as three can engage with parts of CBT (Minde et al., 2010; Quakley et al., 2004). By the age of seven, most children can comfortably participate in CBT (Stallard, 2018). Activities and concepts should be creatively adapted to suit the developmental level of CYP such as by incorporating CYP's interests (Rosenstiel & Scott, 1977), using play (Ronen, 1992) and metaphors (Friedberg & Wilt, 2010) to explain concepts, telling stories (Collins-Donnelly, 2013), and using visuals (Scheeringa et al., 2011). There are benefits of CBT taking place in schools (rather than clinics) because schools may feel less stigmatising, and therefore more familiar and acceptable, to CYP (Department of Health and Department of Education, 2017).

Educational psychologists (EPs) possess expert knowledge of school systems and mental health (Farrell et al., 2006; Rait et al., 2010). Typically, EPs are peripatetic, employing a collaborative consultation model alongside families and school staff (Wagner, 2000). EPs' experience with systemic working places them in a good position to work therapeutically with CYP in complex school and family systems (MacKay, 2008; Squires, 2010; Weeks et al., 2017). A survey of UK-based EPs found that 92% delivered therapeutic interventions, 63.4% using CBT (Atkinson et al., 2011). The sample of 455 represented around 20% of the professional population, suggesting these findings can be generalised with confidence. A survey of 21

Principal EPs in Scotland found that 90% of services offered individual therapy (Greig et al., 2019). Comprehensive guidance has been produced by the British Psychological Society (BPS) on delivering therapy in schools which highlights theoretical, ethical, training, and contextual factors (Dunsmuir & Hardy, 2016). A review of EPs' delivery of therapeutic interventions identified sixteen studies, with nine focussing on CBT; whilst all studies identified at least some positive social-emotional outcomes, six identified no change on certain measures, and four identified some negative impacts (Simpson & Atkinson, 2021).

Research on CBT with CYP, particularly when delivered in schools by EPs, is sparser and less conclusive than research on adult CBT (Stallard, 2018). Given the importance of early intervention for achieving positive outcomes (Department for Education [DfE], 2015) and the prevalence of mental health difficulties among CYP (NHS, 2018), Chapters Two and Three of this thesis seek to expand the research base on CBT for CYP.

The majority of CBT research employs quantitative methods to measure effects of interventions averaged across groups using standardised measures (Barker et al., 2016). Qualitative methods analyse individual views, including those expressed by people receiving CBT, enabling researchers to better understand how CBT is perceived. Three previous qualitative reviews explored how therapeutic relationships affect engagement (Lynch et al., 2020), experiences with technology-assisted CBT (McCashin et al., 2019), and experiences with trauma-focussed CBT (Neelakantan et al., 2019). Chapter Two builds on these by reviewing qualitative literature on how CYP experiencing anxiety and depression conceptualise 'positive outcomes' from CBT and what they perceive as facilitators and barriers to these outcomes.

Whilst Chapter Two analyses CYP's views, Chapter Three analyses practitioners' views. Typically, CBT research uses manualised protocols to ensure participants receive the same treatment (Kiesler, 1994). However, many practitioners object to

manualization, reporting that it feels inflexible and diminishes professional expertise (Shedler, 2018). CBT workbooks offer materials and advice without prescribing a particular approach, potentially offering a compromise. However, to this researcher's knowledge, no prior research has explored practitioners' usage of workbooks. Chapter Three seeks to address this gap by analysing practitioners' views on a workbook, Think Good – Feel Good (TGFG) (Stallard, 2002, 2018).

1.3 Philosophical considerations

In addition to practical decision-making, the research process involves philosophical considerations. There are four levels to consider, in descending order of specificity: epistemology, the theory of how knowledge is created; theoretical perspective, the philosophical orientation taken by the researcher; methodology, the strategy and rationale behind the research; and methods, the concrete techniques and procedures for gathering data (Crotty, 1998; Moon & Blackman, 2014). Crotty suggests taking a bottom-up approach to philosophical considerations, beginning with research questions and methods before reflecting on theory and epistemology. Whilst this suggestion was pursued by the researcher when reflecting, considerations are outlined in the opposite order below to best illustrate how the levels are linked.

Regarding epistemology, this thesis took a constructionist position. This holds that meaning is created by people's interactions with their surroundings (Moon & Blackman, 2014). This position applied to participants, who offered views about CBT, and researchers, who designed data collection methods, analysed data, and interpreted data. Whilst elements of an external reality exist, such as the TGFG workbook, their meaning is determined by individuals' experiences, beliefs, and cultural background. Constructionism contrasts with objectivism (objective meaning exists within objects regardless of how they are perceived) and subjectivism (external reality does not exist, all meaning is created in the mind) (Moon & Blackman, 2014).

Regarding theoretical perspective, this thesis took a pragmatist position. This holds that knowledge is important so far as it is useful and practical for human endeavour (Barker et al., 2016; Creswell & Clark, 2017; Moon & Blackman, 2014). Pragmatism is compatible with a constructionist epistemology because it is flexible, allowing for consideration of multiple perspectives, and action-focussed, aiming to shape and prompt reflection on the meanings people assign to external reality (Cornish & Gillespie, 2009). Pragmatism was pursued in Chapter Two, by concluding with practice recommendations, and Chapter Three, by exploring the real-world implementation of a widely-used CBT workbook and making practice recommendations. A criticism of pragmatism is that it allows researchers to avoid considering ethical and moral issues, meaning it could be co-opted to justify thoughtless or damaging endeavours. As with all research, the use of ethical codes is vital to ensure researchers privilege participants' wellbeing above the utility of outcomes (BPS, 2012; Health and Care Professions Council [HCPC], 2016). An alternative theoretical perspective would have been phenomenology, which holds that the goal of research is to understand people's unique perspectives separate from the researcher's own experiences (Barker et al., 2016). This was not chosen because the researcher wanted to make tentative generalizable claims of practical use to practitioners, rather than analysing individual experiences and contexts in depth.

Regarding methodology, the empirical paper took a mixed methods approach (Creswell & Clark, 2017). This was compatible with a pragmatist theoretical perspective because data collection methods were chosen to provide useful information and used in combination. Online surveys were chosen to reach a wide audience whilst interviews were chosen to analyse individual perspectives in detail. Data collection methods complemented one another, addressing weaknesses that could be levelled at either one in isolation, and facilitated triangulation of findings (Jick, 1979).

A pragmatic approach to methods was required during the course of this thesis. The researcher originally intended to collect video data of practitioners using TGFG but experienced difficulties with recruitment and complications from the Covid-19 pandemic. This necessitated consideration of alternative methods that could address the original research questions from a different perspective and were realistic within time and resource limitations, leading to the use of online interviews. This illustrates the links between the philosophical considerations outlined above, showing that the creation of meaning is influenced not only by individuals but by the methods used to study them.

1.4 Thesis overview

Chapters Two and Three were conceptually linked by exploring CYP's and practitioners' views of CBT respectively. Chapter Two was a systematic literature review which identified 19 studies exploring the review questions:

- How do CYP experiencing anxiety and depression conceptualise 'positive outcomes' from CBT?
- What are the facilitators and barriers to 'positive outcomes' from CBT, according to CYP experiencing anxiety and depression?

The Weight of Evidence framework was used to evaluate the methodological quality, methodological relevance, and topic relevance of each study (Gough, 2007). A thematic synthesis was conducted, identifying descriptive themes (remaining interpretively close to primary studies) and analytic themes (generating new interpretive insight) (Thomas & Harden, 2008). The latter were worded as practice recommendations to prompt reflection about how CYP experience CBT, what they find helpful, and what outcomes they value. The review concluded that practitioners should acknowledge CYP's perspectives on outcomes, teach tangible CBT techniques, balance autonomy and support, frame CBT as 'upskilling', explore

nuanced barriers to engagement, and consider the power of group dynamics. Future research could explore whether positive outcomes link to goals set at the start of CBT and compare the views of practitioners about positive outcomes, facilitators, and barriers.

Chapter Three was an empirical investigation, taking a convergent mixed methods approach to explore practitioners' views of TGFG (Creswell & Clark, 2017; Stallard, 2002, 2018). Online surveys collected quantitative and qualitative data from 238 participants whilst interviews collected qualitative data from six participants. The research questions were:

- How do practitioners typically use TGFG?
- What is helpful about supplementary resources for practitioners providing mental health support?

A range of analytic techniques were employed including descriptive statistics, inferential statistics, and content analysis (Krippendorff, 2018) for the surveys; and thematic analysis for the interviews (Braun & Clarke, 2013). Data were analysed separately before being integrated with a joint display table to explore meta-inferences about whether survey and interview results showed confirmation, discordance, or expansion (Teddlie & Tashakkori, 2009). The mixed methods approach provided new insight that would not necessarily have arisen from either dataset alone (Creswell & Clark, 2017). Research question 1 was answered in two parts: how practitioners decide whether to use TGFG and what use practitioners make of TGFG. Research question 2 widened the scope of enquiry to consider the role and influence of external objects (such as a workbook or worksheets) within the therapeutic space. Overall, practitioners used TGFG flexibly, adapting its content or combining it with other therapeutic modalities, and found resources explaining cognitive elements of CBT most useful. There were mixed views about the degree of training practitioners should have to use TGFG, with some feeling greater accessibility

was positive and others expressing concern about under-trained usage. Supplementary resources were thought to play a powerful role within the therapeutic space, from helping explain content to containing emotional intensity and contributing to therapeutic alliance. Future research could explore the effectiveness of combining therapeutic modalities, CYP's views about manualization, and the potential for school staff to deliver CBT using TGFG.

Chapter Four explored the concepts of evidence-based practice and practice-based evidence (Kratochwill & Shernoff, 2004), considered implications for practice and research, and outlined the strategy for disseminating the research to benefit stakeholders in academic, professional, and societal domains.

1.5 References

Atkinson, C., Bragg, J., Squires, G., Muscutt, J., & Wasilewski, D. (2011). Educational psychologists and therapeutic interventions: Preliminary findings from a UK-wide survey. *DECP Debate*, *140*.

Barker, C., Pistrang, N., & Elliott, R. R. (2016). *Research methods in clinical psychology: An introduction for students and practitioners* (3rd ed.). Wiley-Blackwell.

Beck. (1970). Cognitive therapy: Nature and relation to behavior therapy. *Behavior Therapy*, *1*(2), 184–200. https://doi.org/10.1016/S0005-7894(70)80030-2

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. Sage.

British Psychological Society. (2012). *Code of human research ethics*.

Collins-Donnelly, K. (2013). *Starving the anxiety gremlin: A cognitive behavioural therapy workbook on anxiety management for young people*. Jessica Kingsley Publishers.

Cornish, F., & Gillespie, A. (2009). A pragmatist approach to the problem of knowledge in health psychology. *Journal of Health Psychology*, *14*(6), 800–809. https://doi.org/10.1177/1359105309338974

Creswell, J. W., & Clark, V. L. P. (2017). *Designing and conducting mixed methods research* (3rd ed.). Sage.

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. Sage.

Department for Education. (2015). *Special educational needs and disability code of practice: 0 to 25 years*.

Department of Health and Department of Education. (2017). *Transforming children and young people's mental health provision: A green paper*.

Dunsmuir, S., & Hardy, J. (2016). *Delivering psychological therapies in schools and communities*.

Farrell, P., Woods, K., & Lewis, S. (2006). *A review of the functions and contribution of educational psychologists in England and Wales in light of "Every child matters: Change for children."*

Friedberg, R. D., & Wilt, L. H. (2010). Metaphors and stories in cognitive behavioral therapy with children. *Journal of Rational-Emotive and Cognitive-Behavior Therapy*, *28*(2), 100–113. https://doi.org/10.1007/s10942-009-0103-3

Galderisi, S., Heinz, A., Kastrup, M., Beezhold, J., & Sartorius, N. (2015). Toward a new definition of mental health. *World Psychiatry*, *14*(2), 231–233. https://doi.org/10.1002/wps.20231

Gough, D. (2007). Weight of evidence: A framework for the appraisal of the quality and relevance of evidence. *Research Papers in Education*, *22*(2), 213–228. https://doi.org/10.1080/02671520701296189

Greig, A., MacKay, T., & Ginter, L. (2019). Supporting the mental health of children and young people: A survey of Scottish educational psychology services. *Educational Psychology in Practice*, *35*(3), 257–270.

https://doi.org/10.1080/02667363.2019.1573720

Health and Care Professions Council. (2016). *Standards of conduct, performance and ethics.*

Hofmann, S. G., Asnaani, A., Vonk, I. J. J., Sawyer, A. T., & Fang, A. (2012). The efficacy of cognitive behavioral therapy: A review of meta-analyses. *Cognitive Therapy and Research*, *36*(5), 427–440. https://doi.org/10.1007/s10608-012-9476-1

Jick, T. D. (1979). Mixing qualitative and quantitative methods: Triangulation in action. *Administrative Science Quarterly*, *24*(4), 602–611.

Kiesler, D. J. (1994). Standardization of intervention: The tie that binds psychotherapy research and practice. In P. F. Talley, H. H. Strupp, & S. F. Butler (Eds.), *Psychotherapy research and practice: Bridging the gap* (pp. 143–153). Basic Books.

Kratochwill, T. R., & Shernoff, E. S. (2004). Evidence-based practice: Promoting evidence-based interventions in school psychology. *School Psychology Review*, *33*(1), 34–48. https://doi.org/10.1080/02796015.2004.12086229

Krippendorff, K. (2018). *Content analysis: An introduction to its methodology* (4th ed.). Sage.

Lynch, L., Moorhead, A., Long, M., & Hawthorne-Steele, I. (2020). What type of helping relationship do young people need? Engaging and maintaining young people in mental health care - A narrative review. *Youth and Society*, 1–24. https://doi.org/10.1177/0044118X20902786

MacKay, T. (2008). Educational psychology: The fall and rise of therapy. *Educational and Child Psychology*, *25*(4), 94–105.

McCashin, D., Coyle, D., & O'Reilly, G. (2019). Qualitative synthesis of young people's experiences with technology-assisted cognitive behavioral therapy: Systematic review. *Journal of Medical Internet Research*, *21*(11). https://doi.org/10.2196/13540

McManus, S., Bebbington, P., Jenkins, R., & Brugha, T. (2016). *Mental health and wellbeing in England: Adult psychiatric morbidity survey 2014.*

Minde, K., Roy, J., Bezonsky, R., & Hashemi, A. (2010). The effectiveness of CBT in 3-7 year old anxious children: Preliminary data. *Journal of the Canadian Academy of Child and Adolescent Psychiatry*, *19*(2), 109–115.

Moon, K., & Blackman, D. (2014). A guide to understanding social science research for natural scientists. *Conservation Biology*, *28*(5), 1167–1177. https://doi.org/10.1111/cobi.12326

Neelakantan, L., Hetrick, S., & Michelson, D. (2019). Users' experiences of trauma-focused cognitive behavioural therapy for children and adolescents: A systematic review and metasynthesis of qualitative research. *European Child and Adolescent Psychiatry*, *28*(7), 877–897. https://doi.org/10.1007/s00787-018-1150-z

NHS. (2018). *Mental health of children and young people in England, 2017.*

Quakley, S., Reynolds, S., & Coker, S. (2004). The effect of cues on young children's abilities to discriminate among thoughts, feelings and behaviours. *Behaviour Research and Therapy*, *42*(3), 343–356. https://doi.org/10.1016/S0005-

7967(03)00145-1

Rait, S., Monsen, J. J., & Squires, G. (2010). Cognitive behaviour therapies and their implications for applied educational psychology practice. *Educational Psychology in Practice*, *26*(2), 105–122. https://doi.org/10.1080/02667361003768443

Rider, E. A., Ansari, E., Varrin, P. H., & Sparrow, J. (2021). Mental health and wellbeing of children and adolescents during the Covid-19 pandemic. *BMJ*. https://doi.org/10.1136/bmj.n1730

Ronen, T. (1992). Cognitive therapy with young children. *Child Psychiatry & Human Development*, *23*(1), 19–30. https://doi.org/10.1007/BF00706697

Rosenstiel, A. K., & Scott, D. S. (1977). Four considerations in using imagery techniques with children. *Journal of Behavior Therapy and Experimental Psychiatry*, *8*(3), 287–290. https://doi.org/10.1016/0005-7916(77)90068-4

Scheeringa, M. S., Weems, C. F., Cohen, J. A., Amaya-Jackson, L., & Guthrie, D. (2011). Trauma-focused cognitive-behavioral therapy for posttraumatic stress disorder in three-through six year-old children: A randomized clinical trial. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, *52*(8), 853–860. https://doi.org/10.1111/j.1469-7610.2010.02354.x

Shedler, J. (2018). Where is the evidence for "evidence-based" therapy? *Psychiatric Clinics of North America*, *41*(2), 319–329. https://doi.org/10.1016/j.psc.2018.02.001

Simpson, J., & Atkinson, C. (2021). The role of school psychologists in therapeutic interventions: A systematic literature review. *International Journal of School and Educational Psychology*, *9*(2), 117–131. https://doi.org/10.1080/21683603.2019.1689876

Skinner, B. F. (1974). *About behaviorism*. Cape.

Squires, G. (2010). Countering the argument that educational psychologists need specific training to use cognitive behavioural therapy. *Emotional and Behavioural Difficulties*, *15*(4), 279–294. https://doi.org/10.1080/13632752.2010.523211

Stallard, P. (2002). *Think good - feel good: A cognitive behavioural therapy workbook for children and young people*. John Wiley & Sons, Ltd.

Stallard, P. (2018). *Think good - feel good: A cognitive behavioural therapy workbook for children and young people* (2nd ed.). John Wiley & Sons, Ltd.

Stallard, P. (2021). *A clinician's guide to CBT for children to young adults* (2nd ed.). John Wiley & Sons, Ltd.

Teddlie, C., & Tashakkori, A. (2009). *Foundation of mixed methods reseach: Integrating quantitative and qualitative in the social and behavioral sciences*. Sage.

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology*, *8*, 1–10. https://doi.org/10.1186/1471-2288-8-45

United Nations. (1990). *The United Nations convention on the rights of the child*.

Wagner, P. (2000). Consultation: Developing a comprehensive approach to service delivery. *Educational Psychology in Practice*, *16*(1), 9–18. https://doi.org/10.1080/026673600115229

Weeks, C., Hill, V., & Owen, C. (2017). Changing thoughts, changing practice: Examining the delivery of a group CBT-based intervention in a school setting. *Educational Psychology in Practice*, *33*(1), 1–15. https://doi.org/10.1080/02667363.2016.1217400

World Health Organization. (2018). *Mental health: Strengthening our response*. https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response

Chapter 2: Review Paper

Facilitators and Barriers to 'Positive Outcomes' from Cognitive-Behavioural Therapy, According to Children and Young People Experiencing Anxiety and Depression: A Thematic Synthesis

2.1 Abstract

CBT aims to help CYP better understand their thoughts, feelings, and behaviours and teach them techniques to reduce emotional distress (Beck, 1970). Quantitative evidence, using randomised controlled trials (RCTs), has established that CBT is effective for many people, particularly those experiencing anxiety, leading to it being recommended by the NHS (Barker et al., 2016; Hofmann et al., 2012; Sigurvinsdóttir et al., 2020). However, a considerable number of people, perhaps up to 50%, do not achieve positive outcomes from CBT (Loerinc et al., 2015). This qualitative review sought to explore how CYP conceptualise positive outcomes from CBT and how CYP view the facilitators and barriers to positive outcomes. A systematic literature search identified 19 studies for review. A thematic synthesis (J. Thomas & Harden, 2008) identified 34 conceptualisations of positive outcomes, 57 facilitators, and 49 barriers. Descriptive and analytic themes were identified. The latter were worded as practice recommendations: acknowledge CYP's perspectives on outcomes, teach tangible CBT techniques, balance autonomy and support, frame CBT as 'upskilling', explore nuanced barriers to engagement, and consider the power of group dynamics. Recommendations for practice, recommendations for future research, and limitations of the review are discussed.

2.2 Introduction

2.2.1 CBT

CBT refers to a set of practices that aims to alter maladaptive thoughts and beliefs to reduce emotional distress and problematic behaviours (Beck, 1970). CBT involves exploring links between negative thoughts, emotions, bodily sensations, and behaviours. Once key factors that are maintaining problems are identified, the therapist and CYP work together on ways to manage better. CBT involves cognitive elements – such as interpretations of events, psychoeducation, and restructuring thought patterns – and behavioural elements – such as graded exposure, relaxation exercises, and behavioural experiments (Stallard, 2018).

2.2.2 Quantitative research on CBT

A vast amount of quantitative literature exists examining whether CBT is effective; one review identified 269 meta-analyses (Hofmann et al., 2012). Typically, quantitative studies approach the question 'is CBT effective?' using RCTs. These are considered the gold standard of efficacy research for their ability to isolate effects of the intervention as the independent variable through participant randomisation, allowing causal relations between intervention and outcomes to be established (Barker et al., 2016). A meta-analysis evaluated individual CBT for childhood anxiety (Sigurvinsdóttir et al., 2020). The authors calculated odds ratios (OR) comparing participants with favourable and unfavourable outcomes. There was a large average effect size (OR 9.53, 95% CI [5.48, 16.58]) across 12 studies comparing CBT with wait-list control groups not receiving treatment. There was a medium effect size (OR 2.55, 95% CI [1.32, 4.93]) across six studies comparing CBT with attention control groups who had non-therapeutic contact with psychotherapists, controlling for participants' expectations of change (Wampold et al., 2005). Such evidence has led to consensus on the value of CBT for addressing anxiety and depression in CYP. CBT is recommended by the NHS and the National Institute for Clinical Excellence.

While CBT is effective for many people, it does not help everybody. One review of 87 studies suggested 49.5% of adults receiving CBT for anxiety had positive responses post-therapy, rising to 53.6% at follow-up (Loerinc et al., 2015). Definitions of 'response rates' differed between studies, with those incorporating multiple criteria, measuring a clinically significant reliable change index, and employing blind independent assessors being considered methodologically higher quality. The review suggested these factors may lead to lower, but more accurate, response rates. A meta-analysis of 48 studies of adolescents in mental health care reviewed dropout rates, defined as ending therapy without the mutual agreement of client and therapist (de Haan et al., 2013). In efficacy studies, the average dropout rate was 28.4% whilst, in effectiveness studies, the average rate was 50% and ranged up to 72% in some studies.

This leads to the research question of why CBT is effective, and the practice question of which CBT elements should be implemented and how this should be done to maximise positive outcomes. One research strand examines process variables (mechanisms of change), shifting the focus of measurement from *outside* the therapy room (questionnaires about mental health symptomatology) to *inside* the therapy room (observations of interactions between therapist and person receiving therapy) (Orlinsky & Howard, 1986). While there are myriad process variables that could affect CBT outcomes, key variables include therapeutic alliance (quality of relationship between therapist and child), therapist competence, and adherence to CBT principles (Rapley & Loades, 2019). A review of alliance-outcome relationships for adolescents (aged 12-19) receiving CBT found a moderate correlation of $r = .34$, 95% CI [.21, .37], accounting for 8%-12% of variability in treatment outcome (Murphy & Hutton, 2018). These results are comparable to those found in adult populations and suggest a strong alliance facilitates positive CBT outcomes. Unexpectedly, the review found that the quality of therapeutic alliance was affected equally by child and therapist

characteristics, unlike adult studies, which find that therapist differences primarily affect alliance. This suggests there may be methodological limitations to alliance measures for children and that more nuanced means of data collection may be necessary to enhance understanding.

2.2.3 Qualitative research on CBT

Such nuance may be provided by qualitative research, which is distinguished by its fluid use of language as data and its typical ideological aim of giving voice to participants (Barker et al., 2016). Where quantitative research aims for standardisation and generalisation across groups, qualitative research aims for diversity, individuality, contextualisation of findings, and identification of themes (Braun & Clarke, 2013).

Regarding CBT research, qualitative methods offer several potential advantages (Midgley et al., 2014). First, the fact that RCTs are controlled to maximise internal validity means they have reduced external validity, often not closely resembling typical practice conditions; this is referred to as the 'implementation gap' (Britten, 2010). In contrast, interviews can be held with people who have direct experience with mental health services as they are delivered in practice. Second, qualitative methods can explore CBT effectiveness from the perspectives of those receiving treatment rather than those delivering it. Standardised questionnaires are constructed by researchers based on theoretical understandings of psychological constructs, but they may be reductive in terms of defining 'positive outcomes' as reductions in symptomatology. A review found that over 90% of quantitative studies of CBT with CYP reported on 'mood and affect' as an outcome, but fewer than 5% of studies reported on any other outcomes including resilience, family functioning, and friendships (Krause et al., 2019, 2020). This narrow definition of 'outcome' may not be meaningful to those receiving CBT, who commonly report a greater variety of outcomes (Krause et al., 2020). Furthermore, this may lead to false positives and false negatives, if CYP appear to

have (not) improved according to standardised measures but have differing experiences in other areas of life. One suggestion to remedy this issue with RCTs is the use of 'core outcome sets', which measure and report outcomes agreed by all stakeholders (M. Clarke & Williamson, 2015). Third, through their focus on group outcomes, RCTs aim to generalise results to larger populations. However, this comes at the expense of nuance, since RCTs cannot unpick why some people respond to CBT and others do not. Qualitative methods provide an equal platform to participants whatever their experience of CBT, allowing for exploration of diversity and factors that researchers may not consider.

Historically, qualitative research has been under-represented, not just in the field of CBT but in the whole arena of evidence-based medicine (EBM), due to perceived lack of rigour (Britten, 2010). EBM is the integration of clinical expertise, patient values, and research evidence in the decision-making process regarding healthcare (Masic et al., 2008). Given this definition, and the advantages outlined above, qualitative research has a unique and integral role in exploring the values of people receiving CBT and in bridging the 'implementation gap' between research and practice.

2.2.4 Qualitative research on CBT with CYP

A handful of qualitative reviews have been conducted in the field of CYP mental health. One review looked at how aspects of the therapeutic relationship affect engagement, identifying three superordinate themes across 22 studies: trust and confidentiality, rapport, and collaboration (Lynch et al., 2020). The highest priority in establishing a therapeutic relationship was trust, built on an assurance that confidentiality would be protected. Once trust was established, CYP valued a positive, empathetic, stable relationship with a therapist who gave high-quality advice but was willing to give them control over the therapeutic process.

A second review looked at CYP's experiences with technology-assisted CBT (including apps, games, websites, virtual reality, and telecommunications), identifying

five superordinate themes across 14 studies: helpfulness of technology-assisted CBT, therapeutic process, transferability to everyday life, gameplay experience, and limitations (McCashin et al., 2019). A key finding was that some CYP preferred technology-assisted CBT to face-to-face CBT due to it being easier to engage with, less associated with stigma, easier to control the pace, and involving less talking. These resonate with the findings of Lynch et al. (2020), particularly the importance of having control during therapy and concerns around confidentiality and stigma. However, the point about less talking with technology conflicts with the importance of a warm, empathetic relationship with an adult. It may be that CYP need to be pushed out of their comfort zone in face-to-face psychotherapy to ultimately bring about greater benefits. This interpretation is supported by the fact that a limitation of technology-assisted CBT was too much reading and writing, suggesting CYP may have wished not to engage with challenging material. This highlights a possible drawback of qualitative research, because it is unclear to what extent CYP's views constituted basic preferences versus comments on what they believed was helpful about technology-assisted CBT in achieving positive mental health outcomes.

A third review looked at CYP's experiences with trauma-focussed CBT, identifying three superordinate themes across eight studies: engagement, experience of treatment components, and therapeutic outcomes (Neelakantan et al., 2019). Similar to Lynch et al. (2020), participants identified empathy and feeling listened to as key therapist characteristics. Importantly, a poor alliance was associated with negative outcomes. The fact that the same process variable (therapeutic alliance) is associated with positive views in its strong form and negative views in its weak form, suggests it plays a crucial role from CYP's perspectives. A few other treatment barriers were identified, such as lack of resources for participation and confidentiality issues within the group format. Moreover, positive outcomes were elaborated, such as improved coping strategies, reduced symptomatology, and better social relationships.

2.2.5 The current review

The current review expands upon existing qualitative reviews in three key ways. First, in relation to mental health difficulties experienced by participants. The reviews outlined above were limiting in their inclusion criteria, exploring findings about the type of helping relationship, technology-assisted CBT, or trauma-focussed CBT. The current review explores views of participants who have experienced the most common and best-evidenced forms of CBT: in-person therapy for issues relating to anxiety and depression.

Second, in relation to defining 'positive outcomes' from CYP's perspectives. RCTs typically employ limited measurements to establish whether CBT is effective. Neelakantan et al. (2019) explored several positive outcomes from trauma-focussed CBT. The current review expands these findings for participants who have received CBT for anxiety or depression, to better understand how CYP conceptualise whether CBT has been helpful.

Third, in relation to barriers and facilitators to positive CBT outcomes. Understanding which factors reduce the likelihood of positive outcomes can help researchers understand why around 50% of people may not respond positively to CBT. While Neelakantan et al. (2019) provided some findings on barriers, they were limited to practical matters and vague references to poor alliance. The current review elaborates findings about barriers, and facilitators, to positive outcomes from CBT to include a broader range of factors relating to the therapeutic process.

There are two review questions (RQs):

- How do CYP experiencing anxiety and depression conceptualise 'positive outcomes' from CBT?
- What are the facilitators and barriers to 'positive outcomes' from CBT, according to CYP experiencing anxiety and depression?

2.3 Critical review of the evidence base

2.3.1 Literature search

A systematic literature search was conducted from 24-25 June 2021 using six online databases: Web of Science, Educational Resources Information Center (ERIC), Cumulative Index of Nursing and Allied Health Literature Plus (CINAHL Plus), British Education Index, PsycINFO, and Child Development and Adolescent Studies. Search terms are listed in Table 2.1. The SPIDER formulation (Sample, Phenomenon of Interest, Design, Evaluation, Research type) was used to organise search terms because it is appropriate for qualitative literature reviews (Cooke et al., 2012). A scoping literature search was conducted using Google Scholar. Citation searches were conducted on articles included in the review.

Table 2.1

Terms Used in the Literature Searches

SPIDER	Search terms	Rationale
S - sample	child* or teen* or juvenile* or minor* or kid* or youth* or young* or adolescen* or parent* or mother* or father* or carer* or guardian* AND	This review seeks to evaluate experiences and opinions of CYP and their parents / carers
	anxi* or "selective mut*" or phobia or ptsd or "post-traumatic stress disorder" or "social phobia" or ocd or "obsessive compulsive" or "panic disorder" or "panic attack*" or SAD or GAD or agoraphobia or separation or depress* or "low mood" or internali* or "mood disorder" or bipolar AND	This review seeks to evaluate experiences of CYP with internalising mental health difficulties
PI – phenomenon of interest	cbt or "cognitive behavi*" or "cognitive therapy" AND	This review seeks to evaluate experiences of CYP who have undergone CBT
D – design	questionnaire* or survey* or interview* or "focus group*" or "case stud*" or observ* or "thematic analy*" or "content analy*" or ethnog* or "interpretative phenomenological	This review seeks to evaluate studies which collect and analyse qualitative (verbal or textual) data

SPIDER	Search terms	Rationale
	analysis" or ipa or "field stud*" or "lived experience*" or "narrative analy*" or "discourse analy*" or "grounded theor*" AND	
E – evaluation	view* or experienc* or opinion* or attitude* or perce* or belie* or feel* or know* or understand* or thought* or theme* or facilitat* or barrier* or positive* or negative* or relapse AND	This review seeks to evaluate studies which seek participants' thoughts and opinions about their own experiences
R – research type	Qualitati* or multi-method* or mixed-method* or "mixed meth*" or "multi meth*"	This review seeks to evaluate studies which use qualitative methods

Note. Truncation (*) was used to include any ending of root words. Speech marks ("")

were used to include exact phrase matching.

2.3.2 Article screening

Database searches yielded 619 results. Following removal of 152 duplicates, 467

articles underwent title and abstract screening to determine eligibility for inclusion in

the review (see Table 2.2 for criteria); 394 articles were excluded (see Figure 2.1 for

reasons). Nine articles were identified through ancestral and citation searching.

Eighty-two articles were screened at full text. Sixty-three studies were excluded (see

Appendix A for references and reasons), leaving 19 studies eligible for review (Table

2.3). A flow diagram of article selection is provided in Figure 2.1.

Table 2.2

Criteria for Inclusion in the Review with Rationale

	Criterion	Inclusion	Exclusion	Rationale
1	Type of publication	The article is published in a peer-reviewed journal	The article is not published in a peer-reviewed journal	This ensures the article has been subject to quality control by trained researchers
2	Language of publication	The article is written in English (the research can be conducted in any country)	The article is not written in English	This ensures the article can be understood by the author without being translated
3	Date of publication	The article is published on or before 25/06/2021	The article is published after 25/06/2021	This ensures all relevant articles available on the date of the literature search are included
4	Primary data	The article consists of original research	The article is a review or meta-analysis	This review seeks to evaluate original research
5	Intervention	Participants have received CBT	Participants have only received other forms of psychotherapy or have not received psychotherapy	This review seeks to evaluate CYP's experiences with CBT
6	Intervention delivery	CBT is delivered in-person by trained therapists	CBT is delivered online or through technology-assisted means	This review seeks to evaluate in-person CBT, since a previous review has evaluated technology-assisted CBT (McCashin et al., 2019)

	Criterion	Inclusion	Exclusion	Rationale
7	Participants	Participants are aged between 0-25 – parents / carers can be of any age	Participants are older than 25, or primarily parents / carers or therapists take part in the research	This review seeks to evaluate the experiences of CYP with whom EPs work and parents / carers
8	Mental health difficulties of participants	Participants received CBT for difficulties relating to anxiety, depression, or other internalising mental health difficulties	Participants received CBT solely for externalising difficulties, such as anger management	This review seeks to evaluate CYP's experiences of CBT for internalising mental health difficulties
9	Outcome data	There is qualitative data, including themes, on CYP's experiences receiving CBT (data on parents' / carers' experiences may also be included)	There is only quantitative data, only qualitative data from parents / carers, or qualitative data that has not been analysed thematically	This review seeks to conduct a qualitative analysis, primarily of CYP's experiences with CBT
10	Trauma-focussed approach	The intervention does not involve a trauma-focussed approach	The intervention involves a trauma-focussed approach	A previous review has evaluated experiences with trauma-focussed approaches (Neelakantan et al., 2019)

Figure 2.1

Flow Diagram of Literature Search and Article Screening

Databases searched
Web of Science: n=255
Psycinfo: n=184
CINAHL Plus: n=151
ERIC: n=14
Child Development and Adolescent Studies: n=10
British Education Index: n=4
Google Scholar: n=1

Total from databases
n=619

Duplicates removed
n=152

Title and Abstract screening
n=467

Excluded (n=394)
Criterion 1: n=3   Criterion 6: n=55
Criterion 2: n=8   Criterion 7: n=172
Criterion 4: n=41   Criterion 8: n=8
Criterion 5: n=82   Criterion 9: n=15
                    Criterion 10: n=10

Ancestral and Citation searches
n=9

Full text screening
n=82

Excluded (n=63)
Criterion 1: n=1   Criterion 7: n=13
Criterion 2: n=1   Criterion 8: n=12
Criterion 5: n=14   Criterion 9: n=11
Criterion 6: n=1   Criterion 10: n=10

Eligible for review
n=19

Table 2.3

References of Articles Included in the Review

	Reference of eligible article
1	Myburgh, N., Muris, P., & Loxton, H. (2021). Promoting braveness in children: A pilot study on the effects of a brief, intensive CBT-based anxiety prevention programme conducted in the South African context. *Child Care in Practice*, 1-23. https://doi.org/10.1080/13575279.2021.1902785
2	Taylor, L., Creswell, C., Pearcey, S., Brooks, E., Leigh, E., Stallard, P., Waite, P., Clark D. M., Stephens, G., & Larkin, M. (2021). Delivering cognitive therapy for adolescent social anxiety disorder in NHS CAMHS: A qualitative analysis of the experiences of young people, their parents and clinicians-in-training. *Behavioural and Cognitive Psychotherapy, 49*, 398-412. https://doi.org/10.1017/S1352465821000047
3	Howells, L., Rose, A., Gee, B., Clarke, T., Carroll, B., Harbrow, S., Oliver, C. & Wilson, J. (2020). Evaluation of a non-diagnostic 'Psychology of Emotions' group intervention within a UK youth IAPT service: A mixed-methods approach. *Behavioural and Cognitive Psychotherapy*, *48*(2), 129-141. https://doi.org/10.1017/S1352465819000407
4	Jones, W. T., Peters, S., Byrne, R. E., Shiers, D., Law, H., & Parker, S. (2020). "It felt very special, it felt customised to me" — A qualitative investigation of the experiences of participating in a clinical trial of CBT for young people at risk of bipolar disorder. *Psychology and Psychotherapy: Theory, Research and Practice*. https://doi.org/10.1111/papt.12313
5	Krause, K., Midgley, N., Edbrooke-Childs, J., & Wolpert, M. (2020). A comprehensive mapping of outcomes following psychotherapy for adolescent depression: The perspectives of young people, their parents and therapists. *European Child & Adolescent Psychiatry*, 1-13. https://doi.org/10.1007/s00787-020-01648-8
6	Loucas, C. E., Sclare, I., Stahl, D., & Michelson, D. (2020). Feasibility randomised controlled trial of a one-day CBT workshop ("DISCOVER") for 15-18 year olds with anxiety and/or depression in clinic settings. *Behavioural and Cognitive Psychotherapy, 48*(2), 142-159. https://doi.org/10.1017/S1352465819000286
7	Wilmots, E., Midgley, N., Thackeray, L., Reynolds, S., & Loades, M. (2020). The therapeutic relationship in cognitive behaviour therapy with depressed adolescents: A qualitative study of good-outcome cases. *Psychology and Psychotherapy: Theory, Research and Practice*, *93*(2), 276-291. https://doi.org/10.1111/papt.12232
8	Claus, N., Marzano, L., Loechner, J., Starman, K., Voggt, A., Loy, F., Wermuth, I., Haemmerle, S., Engelmann, L., Bley, M., Schulte-Koerne, G., & Platt, B. (2019). Qualitative evaluation of a preventive intervention for the offspring of parents with a history of depression. *BMC psychiatry*, *19*(1), 1-14. https://doi.org/10.1186/s12888-019-2273-6

Reference of eligible article

9   Cunningham, N. R., Fussner, L. M., Moorman, E., Aydin, P. O. A., Brunner, H.
     I., & Kashikar-Zuck, S. (2019). Development and pilot testing of the
     treatment and education approach for childhood-onset lupus (TEACH):
     A cognitive behavioral treatment. *Pediatric Rheumatology*, *17*, 9.
     https://doi.org/10.1186/s12969-019-0307-8

10   Kandasamy, P., Girimaji, S. C., Seshadri, S. P., Srinath, S., & Kommu, J. V. S.
     (2019). Interventions for childhood anxiety disorders - what works best
     from a child's perspective: A Qualitative Study. *Indian Journal of
     Psychological   Medicine*,   *41*(3),   235-239.
     https://doi.org/10.4103%2FIJPSYM.IJPSYM_509_18

11   O'Keeffe, S., Martin, P., Target, M., & Midgley, N. (2019). 'I just stopped going':
     A mixed methods investigation into types of therapy dropout in
     adolescents with depression. *Frontiers in Psychology*, *10,* 75.
     https://doi.org/10.3389/fpsyg.2019.00075

12   Donald, I. N., Carey, T. A., & Rickwood, D. J. (2018). Therapeutic change in
     young people: A qualitative investigation of client and therapist
     perspectives. *Counselling and Psychotherapy Research*, *18*(4), 402-
     411. https://doi.org/10.1002/capr.12191

13   McKeague, L., Morant, N., Blackshaw, E., & Brown, J. S. (2018). Exploring the
     feasibility and acceptability of a school-based self-referral intervention
     for emotional difficulties in older adolescents: Qualitative perspectives
     from students and school staff. *Child and Adolescent Mental Health*,
     23(3), 198-205. https://doi.org/10.1111/camh.12234

14   Clarke, C., Hill, V., & Charman, T. (2017). School based cognitive behavioural
     therapy targeting anxiety in children with autistic spectrum disorder: A
     quasi-experimental randomised controlled trail incorporating a mixed
     methods approach. *Journal of Autism and Developmental Disorders*,
     47(12), 3883-3895. https://doi.org/10.1007/s10803-016-2801-x

15   Jones, S., Hassett, A., & Sclare, I. (2017). Experiences of engaging with
     mental health services in 16- to 18-year-olds: An interpretative
     phenomenological   analysis.   *Sage   Open*,   *7*(3).
     https://doi.org/10.1177%2F2158244017719113

16   Lundkvist-Houndoumadi, I., & Thastum, M. (2017). Anxious children and
     adolescents non-responding to CBT: Clinical predictors and families'
     experiences of therapy. *Clinical Psychology & Psychotherapy*, *24*(1),
     82-93. https://doi.org/10.1002/cpp.1982

17   Shahnavaz, S., Rutley, S., Larsson, K., & Dahllöf, G. (2015). Children and
     parents' experiences of cognitive behavioral therapy for dental anxiety:
     A qualitative study. *International Journal of Paediatric Dentistry*, *25*(5),
     317-326. https://doi.org/10.1111/ipd.12181

18   Bru, L., Solholm, R., & Idsoe, T. (2013). Participants' experiences of an early
     cognitive behavioral intervention for adolescents with symptoms of
     depression. *Emotional and Behavioural Difficulties*, *18*(1), 24-43.
     https://doi.org/10.1080/13632752.2012.675138

19   Donnellan, D., Murray, C., & Harrison, J. (2013). An investigation into
     adolescents' experience of cognitive behavioural therapy within a child

Reference of eligible article
and adolescent mental health service. *Clinical Child Psychology and Psychiatry*, *18*(2), 199-213. https://doi.org/10.1177%2F1359104512447032

2.3.3 Weight of evidence

Included studies were critically appraised using the Weight of Evidence (WoE) framework (Gough, 2007). Dimensions considered were methodological quality (WoE A), methodological relevance (WoE B), and topic relevance (WoE C).

WoE A was a generic judgment of research design quality including findings, design, sample, data collection, analysis, reporting, reflexivity and neutrality, ethics, and auditability. A published coding protocol was used (Spencer et al., 2003). WoE B and C were judgments relating to the RQs, using author-developed coding protocols. It was not considered necessary to conduct separate WoE C appraisals since the two RQs were conceptually highly similar. WoE D was the average of WoE A, B, and C. A summary of WoE ratings is provided in Table 2.4. Full details of appraisal criteria and rationale are provided in Appendix B. An example coding protocol for WoE A is provided in Appendix C.

Table 2.4

Summary of Weight of Evidence Ratings

Study	WoE A: Methodological quality	WoE B: Methodological relevance	WoE C: Topic relevance	WoE D: Overall rating
Myburgh et al. (2021)	1.83 Medium	1.5 Low	1.4 Low	1.58 Medium
Taylor et al. (2021)	2.33 Medium	2.25 Medium	3 High	2.53 High
Howells et al. (2020)	1.78 Medium	1.5 Low	1.6 Medium	1.63 Medium
Jones et al. (2020)	2.39 Medium	2 Medium	2.2 Medium	1.63 Medium
Krause et al. (2020)	2.11 Medium	1.75 Medium	2.2 Medium	2.02 Medium
Loucas et al. (2020)	2.39 Medium	1.75 Medium	1.6 Medium	1.91 Medium
Wilmots et al. (2020)	2.67 High	3 High	2.8 High	2.82 High
Claus et al. (2019)	2.61 High	2.25 Medium	1.4 Low	2.09 Medium
Cunningham et al. (2019)	2.11 Medium	1.75 Medium	2 Medium	1.95 Medium
Kandasamy et al. (2019)	1.06 Low	1.5 Low	2.2 Medium	1.59 Medium
O'Keeffe et al. (2019)	2.72 High	3 High	2.8 High	2.84 High
Donald et al. (2018)	2.50 Medium	2.75 High	2.8 High	2.68 High
McKeague et al. (2018)	2.33 Medium	2.25 Medium	1.8 Medium	2.13 Medium
Clarke et al. (2017)	2.17 Medium	1.5 Low	2.2 Medium	1.96 Medium
Jones et al. (2017)	2.78 High	2.75 High	2.4 Medium	2.64 High
Lundkvist-Houndoumadi	2.61 High	2.25 Medium	2.8 High	2.55 High

Study	WoE A: Methodological quality	WoE B: Methodological relevance	WoE C: Topic relevance	WoE D: Overall rating
& Thastum (2017)				
Shahnavaz et al. (2015)	2.28 Medium	2.75 High	2.4 Medium	2.48 Medium
Bru et al. (2013)	2.72 High	2 Medium	1.8 Medium	2.17 Medium
Donnellan et al. (2013)	2.78 High	2.5 Medium	2.6 High	2.63 High

Note. WoE ratings are described as 'High' for scores > 2.5, 'Medium' for scores > 1.5 and ≤ 2.5, and 'Low' for scores ≤ 1.5.

2.3.4 Mapping the field

Details of participants and procedures in the included studies are provided in Table 2.5. A key of acronyms is provided at the base of the table.

Table 2.5

Key Information about Participants and Procedures

Study and Location	Intervention	Aims and Context	Participants	Method	Key Themes (From *n* Participants)
Myburgh et al. (2021) South Africa (Western Cape)	I am BRAVE (Myburgh, Loxton, et al., 2021) - brief, manualised group CBT based on Coping Cat (Kendall & Hedtke, 2006). Eight 45-minute sessions.	Aimed to evaluate the preliminary effectiveness of the programme amongst vulnerable children within a semi-rural, disadvantaged farmworker community context.	N = 21 (10 female). Aged 9-12 ($\bar{x}$ = 10.38, SD = 1.02). Participants all resided in the Western Cape and spoke Afrikaans. Participants had elevated anxiety levels, according to the SCAS. Participants recruited through an NGO offering local services to families experiencing poverty.	<u>Data collection</u>: SSIs conducted in focus groups. Explored learning from intervention, changes in experience of anxiety, and whether intervention components were still used. Conducted 3 months post-treatment. <u>Data analysis</u>: Deductive and inductive content analysis. Theory-based codes were used initially before themes were formulated inductively to contextualise original codes. Some responses quantified. <u>Epistemological position</u>: Pragmatist. Data categorised into a pre-existing matrix but process involved researcher interpretation.	1. Perceived intervention utility. 2. Perceived acquisition of core CBT knowledge. 3. Perceived acquisition of core CBT components of change. 4. Perceived utility of exposure. 5. Generalisation of core intervention components of change.

Study and Location	Intervention	Aims and Context	Participants	Method	Key Themes (From *n* Participants)
Taylor et al. (2021) England (Berkshire and Oxford CAMHS)	Individual CBT tailored for SAD (Leigh & Clark, 2016). Fourteen weekly 1.5-hour sessions.	Aimed to explore experiences of CBT for SAD delivered in CAMHS.	N = 12 (6 adolescents (5 female), 6 parents). Adolescents aged 15-18 ($\bar{x}$ = 15.67). Participants had a diagnosis of SAD. No data were provided on ethnicity. Participants sampled from Leigh & Clark (2016).	Data collection: SSIs. Topic guides developed by researchers and 2 experts-by-experience. Explored participants' understanding of problems, expectations of therapy, hopes for change, and experience of therapy. Conducted post-therapy. Data analysis: IPA. Data from participant groups were coded separately before comparative analysis. Epistemological position: Constructivist / interpretive.	1. Endorsing the treatment. 2. Finding therapy to be collaborative and active; challenging but helpful. 3. Navigating change in a complex setting.
Howells et al. (2020) England (Norfolk)	CBT-based, non-diagnostic group workshops, 'Psychology of Emotions' (Howells, 2018). Six sessions. Delivered by PWPs,	Aimed to explore the effectiveness of the 'Psychology of Emotions' workshops.	Sample size cannot be determined. 212 feedback forms were received across six sessions. 350 people attended at least one session, 48 people attended all six ($\bar{x}$ = 1.89, SD = 2.13). Aged 16-25 (for those who attended at least one session, $\bar{x}$ = 19.9, SD = 2.79).	Data collection: Anonymous feedback forms provided at the end of each session. Explored likes and dislikes about the intervention. Data analysis: Framework method, from the family of qualitative content analysis (Gale et al., 2013). The justification was to identify descriptive themes in a	*What did you like?* 1. Delivery and structure (57). 2. Psycho-education (54). 3. Positive impact (30).

Study and Location	Intervention	Aims and Context	Participants	Method	Key Themes (From *n* Participants)
	supervised by CPs.		No specific inclusion criteria but all participants had emotional difficulties. 92.6% of those who recorded ethnicity were White British. Self-selecting sample, based on filling out feedback forms.	large dataset with a transparent, rigorous method. Epistemological position: Constructivist / interpretive.	4. Group context (41). 5. Facilitators (50). *What could be improved?* 1. Group pragmatics (24). 2. Session content (20). 3. Style of delivery (43).
Jones et al. (2020) England	Individual CBT tailored for individuals at risk of bipolar disorder. Up to 26 sessions. Delivered by therapists.	Aimed to explore the acceptability of the trial intervention and participants' experiences more broadly. Part of an RCT of CBT versus TAU (undefined).	N = 21. 13 (8 female) received CBT. 8 (5 female) received TAU. Aged 17-26 ($\bar{x}$ = 20.86). All participants were at risk of bipolar disorder, through early displays of symptoms. 16 participants were White British, 3 White Other, 1	Data collection: SSIs. Explored trial involvement and experiences of therapy. Conducted post-treatment by service-user researchers, with the hope of reducing power imbalances and enabling participants to speak openly. Data analysis: TA. Coding was inductive. Research team had varied	1. Relevance of study and intervention (acceptability of trial processes and value of the trial therapy). 2. Feeling understood and valued (in assessments and CBT sessions).

Study and Location	Intervention	Aims and Context	Participants	Method	Key Themes (From *n* Participants)
			Mixed Block Caribbean, and 1 Mixed White / Black African. Purposively sampled from a larger feasibility trial study.	experiences including service users (lead researchers), a clinical psychologist, a qualitative methodologist, and a carer who was also a GP. <u>Epistemological position</u>: Constructivist (critical realist).	3. Adaptability and flexibility (of research assistants and therapists).
Krause et al. (2020) England (North London)	CBT (up to 20 sessions over 30 weeks), BPI or STPP. 9, 9, and 16 adolescents respectively received each treatment.	Aimed to systematically map outcomes described by adolescents, parents, and therapists following treatment in the trial study. Compared these to a review of outcomes reported by 92 treatment efficacy and effectiveness studies (Krause et al., 2019).	N = 68 (34 adolescents (21 female), 34 parents). Adolescents aged 12-19 ($\bar{x}$ = 16.2, SD = 1.5). Participants had a diagnosis of unipolar Major Depressive Disorder with moderate to severe functional impairment. No data were provided on ethnicity. Purposively sampled from the IMPACT-ME study (Midgley et al., 2014).	<u>Data collection</u>: SSIs. Used 'The Experience of Therapy Interview' (Midgley et al., 2011a) to explore current feelings, changes as a result of treatment, experience of therapy, and significant turning points. Conducted immediately post-therapy. <u>Data analysis</u>: Deductive CA. Taxonomy of treatment outcome applied as an a priori coding frame. Justification was to systematically condense a large dataset into a conceptual framework.	Outcome domains (% adolescents discussed): 1. Symptoms (82%). 2. Self-management (71%). 3. Functioning (56%). 4. Personal growth (68%). 5. Relationships (62%).

Study and Location	Intervention	Aims and Context	Participants	Method	Key Themes (From *n* Participants)
				Epistemological position: Pragmatist. CA rooted in a positivist paradigm. Participant narratives considered socially constructed.	6. Youth wellbeing (27%). 7. Parental support and wellbeing (9%).
Loucas et al. (2020) England (Inner London)	CBT-based, group, one-day, manualised 'Discover' workshops. Telephone follow-up. Delivered by CPs.	Aimed to explore the feasibility, acceptability and outcomes of Discover. Employed an RCT design with Discover vs control (TAU).	Overall sample size cannot be determined. 14 responded to CSQs, 11 responded to interviews. 17 were in the intervention condition, 7 in the control condition. Aged 15-18. Participants were on a CAMHS waiting list for specialist treatment, referred for elevated anxiety or depression. Detailed data are provided on ethnicity, summarised as: White British (7), Black (3), and Mixed (7). Self-selecting sample from the intervention condition.	Data collection: SSIs. Explored recruitment/ assessment, intervention content, and intervention impact. Conducted immediately post-therapy. Open-ended CSQs. Data analysis: TA. Epistemological position: Not discussed by researchers.	1. Being acknowledged. 2. Valuing the group experience. 3. Developing improved ways of coping. 4. Improvement suggestions.

Study and Location	Intervention	Aims and Context	Participants	Method	Key Themes (From *n* Participants)
Wilmots et al. (2020) England (North London)	CBT. 8-21 sessions attended (x̄ = 15.6, SD = 6.11). Delivered by psychologists.	Aimed to explore facilitators and barriers to a positive therapeutic relationship for adolescents with moderate-to-severe depression who had good outcomes from CBT.	N = 5 (all female). Aged 14-18 (x̄ = 16.84, SD = 1.58). Previously diagnosed with depression but had a successful treatment outcome, no longer meeting diagnostic criteria for major depressive disorder on K-SADS (Kaufman et al., 1997). No data were provided on ethnicity. Purposively sampled from the IMPACT-ME study (Midgley et al., 2014).	Data collection: SSIs. Used 'The Experience of Therapy Interview' (Midgley et al., 2011a) to explore hopes, difficulties, and expectations of therapy; how they experienced therapeutic change; and facilitators and barriers to positive treatment outcomes. Conducted immediately post-therapy. Data analysis: IPA. The justification was to give voice to participants whilst allowing researchers to identify shared experiences across participants. Epistemological position: Constructivist / interpretive.	1. Feeling accepted and understood (5). 2. Facilitating change (4). 3. Shared decision-making (3).
Claus et al. (2019) Germany	CBT-based, group intervention for children and parents, 'Raising Healthy Children'. 12	Aimed to explore positives and negatives about the intervention and how participants had transferred learning to their everyday lives.	N = 40 (22 children, 11 female; 18 adults, 8 female) Aged 9-17 (x̄ = 13.09, SD = 2.41). Participants were at-risk for depression, due to at least	Data collection: SSIs and a focus group. Explored what participants had learned from therapy, how the family discussed depression, and facilitators / barriers to successful outcomes. SSIs conducted 4-13 months	1. General acceptability. 2. Motivation for participating. 3. Talking about depression.

Study and Location	Intervention	Aims and Context	Participants	Method	Key Themes (From *n* Participants)
	sessions, 2 hours each. Preventative intervention for children of parents with a history of depression. Delivered by trainee psychiatrists, psychologists and doctoral students.		one of their parents having experienced a depressive episode. No data were provided on ethnicity. Self-selecting sample from 80 total participants involved in the intervention.	post-therapy. Focus groups conducted immediately post-therapy. Data analysis: Deductive qualitative CA (Elo & Kyngäs, 2008). Epistemological position: Pragmatist. Data categorised into a pre-existing matrix but process involved researcher interpretation.	4. Children's knowledge of depression. 5. Children's coping with stress. 6. Parenting skills. 7. Implementation in everyday life. 8. Logistics
Cunningham et al. (2019) USA (Midwest)	TEACH, a CBT-based intervention tailored for children with lupus. Delivered by psychologists.	Aimed to assess feasibility, acceptability, and impact of the intervention.	N = 18 (17 female). Aged 13-21 ($\bar{x}$ = 16.89, SD = 2.27). Participants all had childhood-onset lupus and experienced clinical levels of depression. 11 participants were Caucasian, 3 African American, 2 Asian American, 1 mixed, and 1 Hispanic / Latino.	Data collection: SSIs. Explored feasibility, acceptability, content and format of the intervention. Conducted immediately post-therapy. Data analysis: TA. Epistemological position: Not discussed by researchers.	*Domain 1: Feasibility* 1. Usability of skills. 2. Barriers. *Domain 2: Acceptability* 1. Program format. 2. Therapist characteristics.

Study and Location	Intervention	Aims and Context	Participants	Method	Key Themes (From *n* Participants)
			Convenience sampled from patients at a paediatric rheumatology clinic.		3. Suggested modifications. *Domain 3: Treatment outcomes* 1. Sleep/fatigue 2. Mood 3. Pain 4. Self-management 5. Self-efficacy
Kandasamy et al. (2019) India (Child and adolescent psychiatry clinic)	CBT manual. 4-8 sessions. Delivered by the first author.	Aimed to explore children's perspectives on their mental health difficulties, their impact on socio-academic functioning, and the treatment process.	N = 30 (14 female). Aged 6-16 Various anxiety disorders, determined by a screener questionnaire and a neuropsychiatric interview. No data were provided on ethnicity. Convenience sampled.	Data collection: SSIs. Explored nature of mental health difficulties and experiences of the treatment process. Conducted at baseline and 12 weeks post-therapy. Data analysis: TA. Epistemological position: Not discussed by researchers.	1. Achievement. 2. Interpersonal difficulties. 3. Self-esteem. 4. Self-efficacy. These were found across illness experience, illness impact, and treatment impact.

Study and Location	Intervention	Aims and Context	Participants	Method	Key Themes (From *n* Participants)
O'Keeffe et al. (2019) England (North London)	CBT, BPI or STPP. 9, 9, and 14 participants respectively received each treatment. All key themes were represented by CBT participants. Unclear who delivered the interventions.	Aimed to explore the reasons why depressed adolescents dropped out of therapy, and to categorise these from a theoretical perspective.	N = 99. 32 were 'dropout cases' (23 female). 67 completed treatment and were included for statistical comparison (not described below). Aged 11-17 (x̄ = 15.84, SD = 1.87). Clinical levels of depression and anxiety. 15 participants were 'White British', 16 were 'any other ethnic background', and one was unknown. Sampled from the IMPACT-ME study (Midgley et al., 2014).	Data collection: SSIs. Used 'The Experience of Therapy Interview' and 'Thinking Back About Therapy Interview' (Midgley et al., 2011a, 2011b). Conducted immediately post-therapy and one year post-therapy. Data analysis: Ideal type analysis. The justification was to compare cases to form categories, or 'ideals', of dropout. Themes were listed and summaries constructed for each case, before cases were systematically compared to form categories. Epistemological position: Constructivist / interpretive.	1. Dissatisfied: therapy failed to meet their needs (18, 3 CBT). 2. Got-what-they-needed: they felt better before the end of treatment (10, 4 CBT). 3. Troubled: it was not the right time to engage in therapy (4, 2 CBT).
Donald et al. (2018) Australia (urban mental health service)	CBT (6-12 sessions, 2 participants). 'Eclectic' therapy (12	Aimed to explore how clients and therapists perceive therapeutic change and what factors facilitate change.	N = 3 (2 female). Aged 17-19 (x̄ = 17.67, SD = 1.15).	Data collection: SSIs. Focussed on experiences of therapeutic change, not the nature of mental health. Conducted immediately post-therapy.	1. Facing problems alone (3). 2. How the therapeutic space was used (2).

Study and Location	Intervention	Aims and Context	Participants	Method	Key Themes (From *n* Participants)
	sessions, 1 participant). Delivered by CPs.		One participant had anxiety, one had anxiety and depression, one had trauma. No data were provided on ethnicity. Self-selecting sample.	<u>Data analysis</u>: IPA. The justification was its focus on lived experiences and methodological flexibility. <u>Epistemological position</u>: Constructivist (critical realist).	3. Change characteristics (2). 4. Partial changes (3). 5. The role of context in change (2). 6. Growing into the new self (3).
McKeague et al. (2018) England (inner London)	CBT-based, group, one-day, manualised 'Discover' workshops. Telephone follow-up. Delivered by CPs.	Aimed to explore feasibility and acceptability of the intervention as well as barriers to participation.	N = 24. Two subsamples: intervention attenders (15, 12 female) and non-attenders (9, 5 female). Aged 16-19 ($\bar{x}$ = 17.52). Participants wanted to receive help for emotional difficulties and self-referred to the intervention. They were not screened for anxiety or depression. 10 participants were Black African, 3 Black Caribbean, 6 White British, 5 other.	<u>Data collection</u>: SSIs. For attenders, explored recruitment process, intervention experiences, impact, and feasibility. Conducted 4 months post-intervention. For non-attenders, explored barriers to participation. Conducted as soon as possible. <u>Data analysis</u>: TA. Justification was to give voice to participants, exploring commonalities and variations.	*Experiences of participating* 1. Understanding and managing stress. 2. Preference for engaging and interactive content. 3. Importance of an individualised approach. *Delivery in the school setting*

Study and Location	Intervention	Aims and Context	Participants	Method	Key Themes (From *n* Participants)
			Attenders were purposively sampled from a larger RCT. Non-attenders were sampled on a rolling basis when they decided not to participate.	Epistemological position: Researchers stated analysis was 'not conducted from a particular theoretical standpoint'.	1. Attending a workshop at school 2. Group format 3. Barriers to attending
Clarke et al. (2017) England (South-East)	Group-based, manualised CBT, 'Exploring Feelings: CBT to Manage Anxiety' (Attwood, 2004).	Aimed to explore the process of change and maintaining factors of anxiety. Employed an RCT design with intervention vs control.	N = 28 children (all male). N = 9 parents. Aged 11-14 ($\bar{x}$ = 12.75, SD = .78). All participants had autism and high levels of anxiety. 27 participants were White British, 1 was Chinese. Convenience sampled from six schools that agreed to participate and identified 37 eligible children, 28 of whose parents gave consent.	Data collection: SSIs. With children, explored emotions, recent difficult events, and coping strategies. With parents, explored autism; children's emotions and behaviours. Data analysis: TA. Themes emerged from the data. Epistemological position: Not discussed by researchers.	*Children* 1. Thought changes influence behaviour (4). 2. Learning to process complex emotion (8). 3. Pressure to conform to social norms (3). 4. Influence of environment and social context on therapeutic engagement (3). *Parents*

Study and Location	Intervention	Aims and Context	Participants	Method	Key Themes (From *n* Participants)
					1. Child's anxiety is dynamic
					2. Context maintains behaviour
					3. Learning to manage behaviour (4).
					4. Social stigma
					5. Challenging social / emotional needs (7).
					6. Home-school tensions
					7. Social difficulties
					8. Right to be different (4).
					9. Inadequate communication about school-based interventions (6).

Study and Location	Intervention	Aims and Context	Participants	Method	Key Themes (From *n* Participants)
Jones et al. (2017) England (London, CAMHS)	Individual CBT (8 participants) or Integrative Therapy (2). Delivered by CPs, CBT therapists, or CAMHS practitioners.	Aimed to explore adolescents' therapy engagement experiences, facilitators and barriers.	N = 10 (7 female, 1 female-male transgender). Aged 16-18 (x̄ = 16.9, SD = .74). Mental health needs were not explicitly stated but included clinical levels of anxiety and depression. 4 participants were White British, 2 White European, 2 Black British, 1 Latin American, and 1 British Asian. Convenience sampled. Clinicians identified suitable participants from their caseload and passed on details to the researchers.	<u>Data collection</u>: SSIs. Explored experiences of service; facilitators and barriers to attendance. Researchers consulted other adolescents to ensure appropriateness of schedules. <u>Data analysis</u>: IPA. Themes were developed from data alongside interviewers' notes, through an emergent, iterative process of abstraction, being revised throughout the entire research process. <u>Epistemological position</u>: Constructivist / interpretive.	1. Engagement begins at help seeking. 2. Strength of inner resolve. 3. Evolution of the self. 4. In the clinic room.
Lundkvist-Houndoumadi and Thastum (2017) Denmark (Training and	Manualised group CBT, 10 weekly 2-hour sessions, for youth and parents. 1-	Aimed to examine non-response to CBT among youths with anxiety disorders.	N = 15 children (9 female). At least N = 15 parents (families of each child) Aged 10-17 (x̄ = 13.5, SD = 2).	<u>Data collection</u>: SSIs. Conducted with youths and their parents to explore experiences of therapy and views on non-response. Conducted 3 months post-treatment.	1. Youths were not involved in therapy work (14). 2. Manualised group format posed challenges (10).

Study and Location	Intervention	Aims and Context	Participants	Method	Key Themes (From *n* Participants)
research clinic at Aarhaus University)	hour booster 3 months post-treatment. Cool Kids (7-12) and Chilled Adolescents (13-17) manuals, translated into Danish. Delivered by psychologists.		Participants were identified as non-responders to the intervention. They all had social anxiety disorder or anxiety with comorbid mood disorders. Participants were of Danish ethnicity. 106 youths experienced the intervention; 24 were deemed non-responders. Of these, 15 were sampled because they had clinical characteristics deemed representative of non-responders (see above).	Data analysis: IPA. The justification was to understand participants' experiences. Codes were created inductively from the material rather than theory. Epistemological position: Constructivist / interpretive.	
Shahnavaz et al. (2015) Sweden (department of paediatric dentistry at Karolinska Institutet)	Individual CBT, 4-15 sessions, for youth and parents. Delivered by CPs.	Aimed to explore how children with dental anxiety and their parents experience CBT.	N = 12 children (7 female). N = 12 parents (7 female). Aged 9-19 ($\bar{x}$ = 13). Participants all fulfilled criteria for specific phobia (blood-injection-injury phobia), relating to dental anxiety. No data were provided on ethnicity.	Data collection: SSIs. Conducted with children and parents separately to explore thoughts about CBT and perceived outcomes. Conducted 2-14 months post-treatment ($\bar{x}$ = 9). Data analysis: TA. The justification was the generation and	Perspective shift (overarching theme). 1. Mastery. 2. Safety. 3. Reduced fear.

Study and Location	Intervention	Aims and Context	Participants	Method	Key Themes (From *n* Participants)
			Participants were sampled from a group of 17 children attending the Karolinska Institutet; all those who agreed to participate were included in this study.	understanding of themes within data. Epistemological position: Constructivist / interpretive.	
Bru et al. (2013) Norway	Group, manualised CBT, similar to the Coping With Depression Course (Cuijpers et al., 2009). Eight sessions and two follow-up sessions.	Aimed to explore experience of specific CBT components. Part of a larger RCT evaluating intervention effectiveness.	N = 9 (7 female). Aged 17-20 (x̄ = 18.4). Participants had subclinical depression or mild to moderate major depressive disorder. No data were provided on ethnicity. Convenience sampled from four courses from the larger RCT. 30 people were approached, 12 initially consented.	Data collection: SSIs. Explored perceptions of CBT and intervention-specific components. Conducted immediately post-intervention or just before the final follow-up session. Data analysis: Theoretical TA, using a priori theory. Initially, categories were deductively imposed before sub-themes inductively emerged. The justification was to allow participants' narratives to speak for themselves. Epistemological position: Subjectivist – aimed to allow participants' narratives to	1. Education about depression. 2. Education about relations between thoughts, feelings, and behaviour. 3. Thought identification. 4. Cognitive restructuring. 5. Relaxation training. 6. Visualisation. 7. Pleasurable activities.

Study and Location	Intervention	Aims and Context	Participants	Method	Key Themes (From *n* Participants)
				speak for themselves and avoid interpretation.	8. Social relationships.

9. Homework. |
| Donnellan et al. (2013)

England (North-West CAMHS) | Individual CBT. Delivered by CPs. | Aimed to explore how youth perceive and make sense of their experiences of CBT. | N = 3 (all female).

Aged 12-16 (x̄ = 15).

2 participants had anxiety, 1 participant had low mood and engaged in self-harm.

No data were provided on ethnicity.

Purposively sampled by researchers from youth attending the CAMHS clinic. | Data collection: SSIs. Explored content and perceptions of CBT. Prior to the study, appropriateness of the schedule was assessed with other service users.

Data analysis: IPA. Justification was to enable exploration of participants' real-life experiences.

Epistemological position: Constructivist / interpretive. | 1. Conceptualising CBT – impacts on change and progression.

2. Process of engagement and its outcomes.

3. Developing a therapeutic relationship – a model for real life.

4. Structures of therapeutic delivery. |

Note. BPI – Brief Psychosocial Intervention, CA – Content Analysis, CAMHS – Child and Adolescent Mental Health Service, CP – Clinical Psychologist, CSQ – Client Satisfaction Questionnaire, IMPACT-ME - Improving Mood through Psychoanalytic and Cognitive-Behavioural Therapy - My Experience, IPA – Interpretative Phenomenological Analysis, K-SADS – Kiddie Schedule for Affective Disorders and Schizophrenia, NGO – Non-Governmental Organisation, PWP – Psychological Wellbeing Practitioner, RCT – Randomised Controlled Trial, SAD – Social Anxiety Disorder, SCAS – Spence Children's Anxiety Scale, SSI – Semi-Structured Interview, STPP – Short-Term Psychoanalytic Psychotherapy, TA – Thematic Analysis, TAU – Treatment as Usual, TEACH – Treatment and Education Approach for Childhood-onset Lupus.

2.3.5 Participants

In total, 762 participants contributed data to the reviewed studies. Of these, 668 were CYP, ranging from age 6 to 25 years old. Interviews were conducted with 304 CYP whilst 364 filled out forms. From available data, gender representation was roughly equal with 55% female participants (161/293). Of studies that conducted interviews, there was variation in sample size, from 3 to 68. Howells et al. (2020) utilised feedback forms and had a maximum of 350 participants, although it was not stated how many completed forms. Six studies (C. Clarke et al., 2017; Claus et al., 2019; Krause et al., 2020; Lundkvist-Houndoumadi & Thastum, 2017; Shahnavaz et al., 2015; Taylor et al., 2021) also interviewed around 94 parents.

Eleven studies took place in England and one took place in Norway, Sweden, Denmark, Germany, Australia, India, South Africa, and the USA. There was considerable heterogeneity in cultural background among participants, potentially allowing for cross-cultural analysis (Triandis, 1999). The fact that most studies took place in England is helpful when considering practice implications, since participants were all part of UK mental health care systems, so their experiences are more likely to be representative of other CYP with anxiety or depression (Frederickson, 2002).

A key consideration for WoE B was sampling strategy. Seven studies were given a low rating because researchers involved in delivering interventions selected participants to evaluate the intervention. This created a potentially coercive power dynamic for at least two reasons. First, researchers could shape interview agendas and word questions to place their intervention in a positive light; second, participants may have felt unable to provide honest responses due to effects of social desirability bias (Anyan, 2013). Six studies were given a high rating because researchers were not involved in participants' therapy and did not intend to evaluate specific interventions, so participants would likely not have felt researchers had an agenda (Anyan, 2013).

Regarding mental health difficulties experienced by participants, seven studies were given high WoE C ratings because they provided clear evidence of clinical levels of anxiety or depression. This was important because participants with serious difficulties were likely to have had the greatest degree of experience with mental health support, experienced the broadest range of therapeutic outcomes, and be most invested in spending time considering the facilitators and barriers to positive outcomes (Rennie, 1992). Four studies were given low ratings because participants were described as experiencing heightened risk for difficulties or vague 'emotional difficulties', so their views may have been less rich and informed. The remaining eight studies were given medium ratings because researchers did not explain the nature of participants' difficulties with sufficient detail to establish their severity.

In two studies participants had additional medical or neurodevelopmental conditions: childhood-onset lupus (Cunningham et al., 2019) or autism (C. Clarke et al., 2017). The implications of these studies may be less relevant to other populations, since participants' medical or neurodevelopmental condition (in addition to their anxiety or depression) likely influenced their views (Sze & Wood, 2008).

2.3.6 Data collection and analysis

Regarding data collection, 18 studies used semi-structured interviews (SSIs). Loucas et al. (2020) also used open-ended client satisfaction questionnaires while Claus et al. (2019) also used a focus group. Howells et al. (2020) were the only researchers not to use SSIs, employing anonymous feedback forms instead. This method led to a low WoE B rating because it was unlikely to facilitate rich data collection and did not allow for follow-up questions based on participant responses (Barker et al., 2016). Seven studies were given high ratings for conducting SSIs less than a month post-intervention, because this would likely mean participants' recollections were more accurate; eleven studies conducted SSIs later and were given medium ratings.

Regarding interview content, six studies were given high ratings because they contained open and non-leading questions with scope for follow-up questions, likely leading to the richest and most honest responses (Ritchie et al., 2013). Four studies were given low ratings because interviews were aimed at evaluating specific interventions and contained loaded questions such as 'what was good about intervention *x*?', limiting the depth of conversation and possibly making participants feel unable to be honest (Robson, 2002).

Regarding data analysis, eight studies employed thematic analysis (Braun & Clarke, 2006) and six studies employed interpretative phenomenological analysis (Smith et al., 2009). Howells et al. (2020) employed the framework method (Gale et al., 2013); Claus et al. (2019), Krause et al. (2020), and Myburgh et al. (2021) employed deductive qualitative content analysis (Elo & Kyngäs, 2008); and O'Keeffe et al. (2019) employed ideal type analysis (Weber, 1949). Data analysis strategy was not directly assessed for WoE because it was not felt that strategies could be objectively rated for quality (Spencer et al., 2003). Most studies categorised responses into themes. The exceptions were O'Keeffe et al. (2019), whose ideal type analysis resulted in categories of participants based on the reasons they dropped out of therapy, and Krause et al. (2020), whose content analysis resulted in categories of outcomes experienced by proportions of adolescents post-therapy. It was possible to translate these formats and extract themes for the thematic synthesis.

Regarding analytical procedures, seven studies were given low WoE A and B ratings because they reported the accounts of 'most' or 'many' participants, with little attention paid to diversity of views or context, limiting the richness of data (Braun & Clarke, 2013). Seven studies were given high ratings because they captured diversity of views and included contextual information about participants' lives outside the therapeutic space, lending nuance and depth (Braun & Clarke, 2013). This facilitated analysis of

systemic facilitators and barriers to positive outcomes, such as resolution of stressful life circumstances and support networks.

Regarding theoretical approach to data analysis, 10 studies were given high WoE C ratings because they took an inductive approach, allowing the data to guide thematic development without reference to a priori frameworks (D. Thomas, 2006). Four studies (Cunningham et al., 2019; Howells et al., 2019; Kandasamy et al., 2019; Loucas et al., 2019) were given low ratings because they took a deductive approach, basing thematic analysis on a priori frameworks. Three of these were also given low ratings for 'sampling', 'analytical procedures', and 'interview content'. This indicated a pattern of low ratings for studies that aimed to evaluate specific interventions, leading to potentially biased sampling, restrictive interviews, a pre-defined analysis strategy, and decontextualized findings. Moreover, these studies were given low WoE A ratings for appraisal questions 11-14 and 16, indicating generically poor analysis, reporting, reflexivity, and neutrality. The remaining five studies employed both deductive and inductive elements and were given medium ratings.

Epistemological position did not form a direct part of WoE judgments. Whilst few studies discussed this explicitly, the researcher was typically able to determine the most likely position based on methodological description. For four studies this was not possible due to insufficient detail (C. Clarke et al., 2017; Cunningham et al., 2019; Kandasamy et al., 2019; Loucas et al., 2019). Ten studies took a constructivist position, holding that participants' meanings needed to be interpreted by researchers. Two of these specifically took a critical realist position (Donald et al., 2018; W. Jones et al., 2020). Three studies took a pragmatist position, combining deductive analysis using theoretical frameworks with researcher interpretation (Claus et al., 2019; Krause et al., 2020; Myburgh, Muris, et al., 2021). McKeague et al. (2018) approached analysis from no particular theoretical standpoint and Bru et al. (2013) took a

subjectivist approach, privileging participants' descriptions above researcher interpretations.

Regarding data reported, five studies were given high WoE C ratings for providing roughly equal discussion of facilitators and barriers to positive outcomes. Although this criterion is idiosyncratic to this review, it could be argued these studies best reflect the reality of mental health care, given the finding that around 50% of people may not have positive outcomes from CBT (Loerinc et al., 2015). Negative views of CBT are as valid, and clinically useful, as positive views, so it is helpful for qualitative studies to illustrate breadth of experience (Shedler, 2018). Seven studies were given medium ratings for providing the majority of discussion about either facilitators or barriers. Seven studies were given low ratings because the majority of discussion concerned the nature of positive outcomes with little detail about the CBT process.

Regarding evidence for practice, eight studies provided clinical and theoretical implications of their findings and were given high WoE B ratings. The concept of generalisation – or transferability – is controversial in qualitative research (Lewis et al., 2003). Some researchers eschew the concept, considering the emphasis on detail and contextualisation to be incompatible with the notion of applying findings to a wider population or differing contexts (Yin, 2009). Others, including the author, argue this attitude does a disservice to the potential value of qualitative research for informing evidence-based practice, particularly when it concerns opinions on an intervention, such as CBT (Larsson, 2009). This WoE rating relates to *representational generalisation*, the question of whether research findings can be generalised to the populations from which samples are drawn (Lewis et al., 2003), and *theoretical generalisation*, the question of whether theoretical principles can be drawn from studies. The rating does not relate to *inferential generalisation*, the question of whether findings extend to other populations, settings, and contexts beyond those studied. Clinical and theoretical implications were considered generalizable to

populations of children and young people with anxiety and depression. Implications were not considered generalizable to adult populations or those with primarily externalising mental health difficulties. Only Kandasamy et al. (2019) failed to describe clinical or theoretical implications and were given a low rating.

2.3.7 Intervention

Eleven studies included participants who had experienced individual or family CBT with a fully-trained therapist for at least six sessions and were given high WoE C ratings. These criteria were valued because it is likely participants with in-depth, extended experiences of CBT would have the most rounded and rich perspectives (Rennie, 1992). The remaining eight studies included participants who had experienced group CBT and were given medium ratings, since it is likely participants had less in-depth understanding of CBT and less-developed therapeutic relationships (Norton & Kazantzis, 2016). Nonetheless, participants in these studies had unique perspectives on the group format and its advantages and disadvantages, which were valuable given that group CBT is a common and economical means of providing mental health support. While research on group CBT is less extensive and generally of poor quality, a review of group CBT for adults with depression showed no evidence of difference in positive outcomes between group and individual CBT at short-, medium-, or long-term follow-up (Huntley et al., 2012).

2.4 Analysis

2.4.1 Thematic synthesis

A thematic synthesis was conducted, based on the guidelines of Thomas and Harden (2008). A summary of the process is provided in Figure 2.2. The 'Findings' and 'Discussion' sections of each study were copied verbatim into NVivo 2020. For the article by Krause et al. (2020), online supplementary material was accessed because it contained illustrative quotes for themes outlined in the main text.

The first stage of analysis involved line-by-line, explorative coding. Where possible, direct quotes from participants were privileged in the coding process. Occasionally researchers only provided summary information about the views of multiple participants or presented their own interpretations of participants' views without direct quotes. In such cases, it was pragmatically assumed that primary researchers had accurately interpreted participants' responses and these elements of text were coded. A complete coding approach was taken, where the same data could be coded in multiple ways (Braun & Clarke, 2013). Codes were researcher-derived, rather than data-derived, going beyond participants' language and beginning the process of data interpretation (Braun & Clarke, 2013). Three categories were created, based on the two RQs, to order the coding process: conceptualisation of positive outcomes, facilitators to positive outcomes, and barriers to positive outcomes. The researcher read each study for a second time, adding codes and combining codes that were conceptually similar. In total, 168 codes were defined including 34 conceptualisations of positive outcomes, 57 facilitators, and 49 barriers. The remaining 28 codes were considered not to be of analytical interest because they were pre-therapy conceptualisations, neutral comments about therapy, suggestions for practice from study authors, or views expressed only by therapists or parents and not by CYP. Parents' views were coded if codes had already been defined based on CYP's views. A table detailing codes and total references in each study and a table detailing the full list of codes are provided in Appendix D.

The second stage of analysis involved defining descriptive themes. The intention was to remain interpretively close to primary studies. The two RQs were considered separately. A theme was defined if it captured a meaningful pattern across multiple codes (Braun & Clarke, 2013). This was a reflexive, recursive process where the researcher continued to define themes until all codes were meaningfully represented by a theme. Themes were visualised in maps (Figures 2.3 and 2.4). The dotted lines

show conceptual relationships. In Figure 2.3, the relationships show two themes around internal, cognitive/emotional outcomes; and three themes around external, behavioural outcomes. In Figure 2.4, there are two relationships between person and intervention variables. There is also a broader relationship between four themes relating to experiences within the therapeutic space and a single theme relating to experiences outside.

Codes and themes were tabulated to show the number of studies in which participants referenced codes and the total number of references across all studies (Tables 2.6 and 2.7). Codes were ordered primarily by number of studies and secondarily by number of references to illustrate the relative importance of codes in relation to RQs. Epistemologically, this decision was based on the *consensus criterion* of truth, whereby beliefs gain 'truth' if they are shared by multiple people (Hamlyn, 1970). An alternative to quantitative ranking of qualitative data would follow the theoretical perspective of pluralism, where every person's perspective has unique, equal validity and the researcher does not privilege any perspective above any other (Barker et al., 2016). The diversity of findings is represented in Tables 2.6 and 2.7; it shows that measuring 'positive outcomes' from psychotherapy is not as straightforward as much quantitative research makes it appear.

The third stage of analysis involved defining analytic themes. The intention was to generate new interpretive insight. This stage is potentially controversial as it involves subjective inference from the researcher (J. Thomas & Harden, 2008). However, it is also a crucial way for thematic syntheses to add value to previous research (Thorne et al., 2004). The researcher had received several days' CBT training and had used CBT once in practice prior to analysis. It was important to remain mindful of how these experiences could shape interpretation of data. The researcher acted reflexively through bracketing; keeping personal opinions, assumptions, and experiences separate from those expressed by CYP (Fischer, 2009). Occasionally, this created

internal conflict as the researcher disagreed with opinions expressed in studies; in such cases, the researcher tried to mindfully acknowledge the experience and set it aside, privileging participants' views.

Descriptive themes (Figures 2.3 and 2.4) were considered jointly when the researcher was defining analytical themes (Figure 2.5). Given the intention of this review to provide insight for CBT practitioners, the researcher intended to draw out practice recommendations. The process of deriving analytical themes from descriptive themes was not standardised but based on the researcher's interpretation of what would be most helpful for CBT practitioners. It was not the case that each analytical theme had a certain number of descriptive themes or codes that supported it, although analytical themes were all well supported by the data. A brief outline of how two analytical themes were derived is provided in Appendix O. There were no standardised criteria for the number of analytical themes defined. The researcher aimed to balance providing a comprehensive reflection of the data with a manageable number of takeaway implications for practitioners. Analytical themes form the headings in the discussion. Quotes from primary studies were chosen to illustrate themes and are provided verbatim in the discussion; an attempt was made to provide a representative range across studies.

Figure 2.2

Overview of Thematic Synthesis
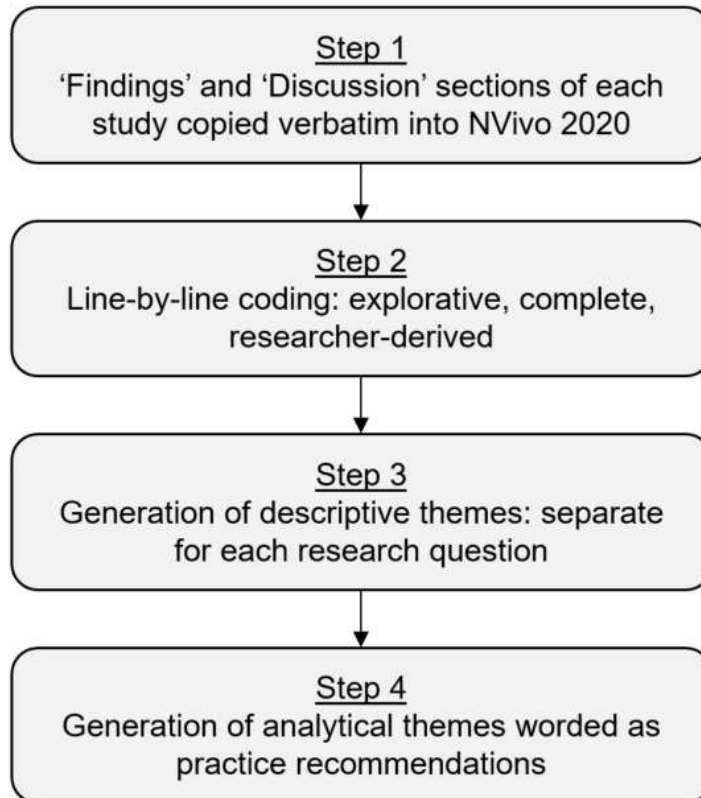
Figure 2.3

Thematic Map of Positive CBT Outcomes According to CYP
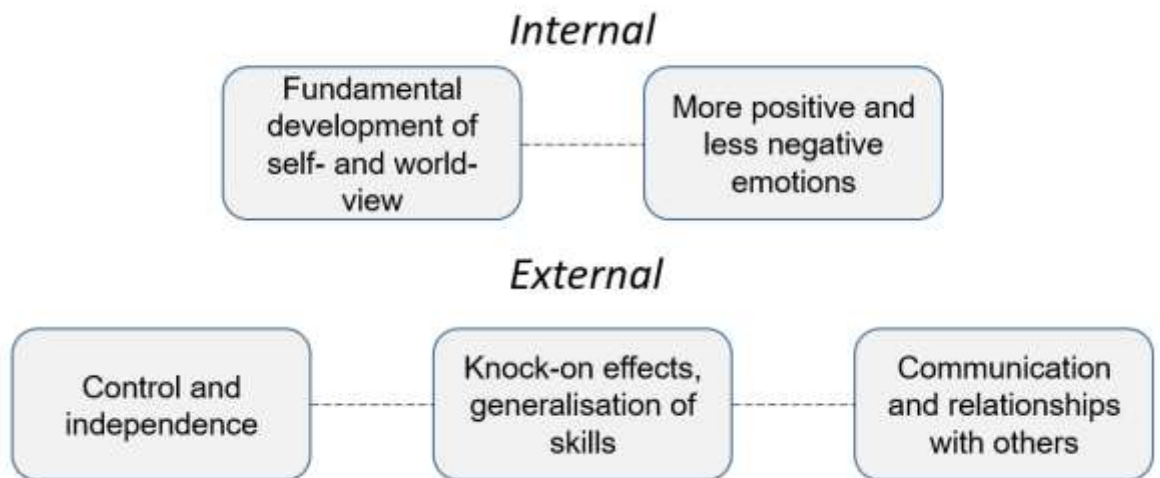
Figure 2.4

Thematic Map of Facilitators and Barriers to Positive CBT Outcomes According to CYP
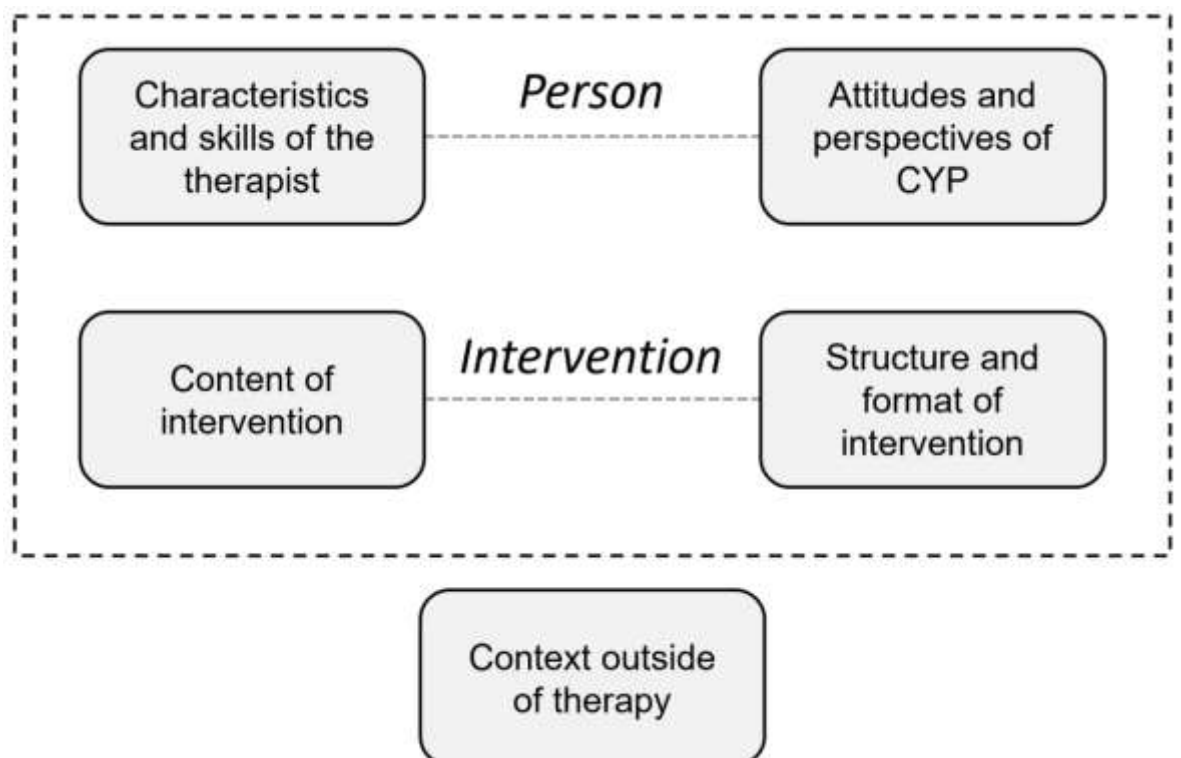
Figure 2.5

Map of Analytical Themes, Worded as Practice Recommendations
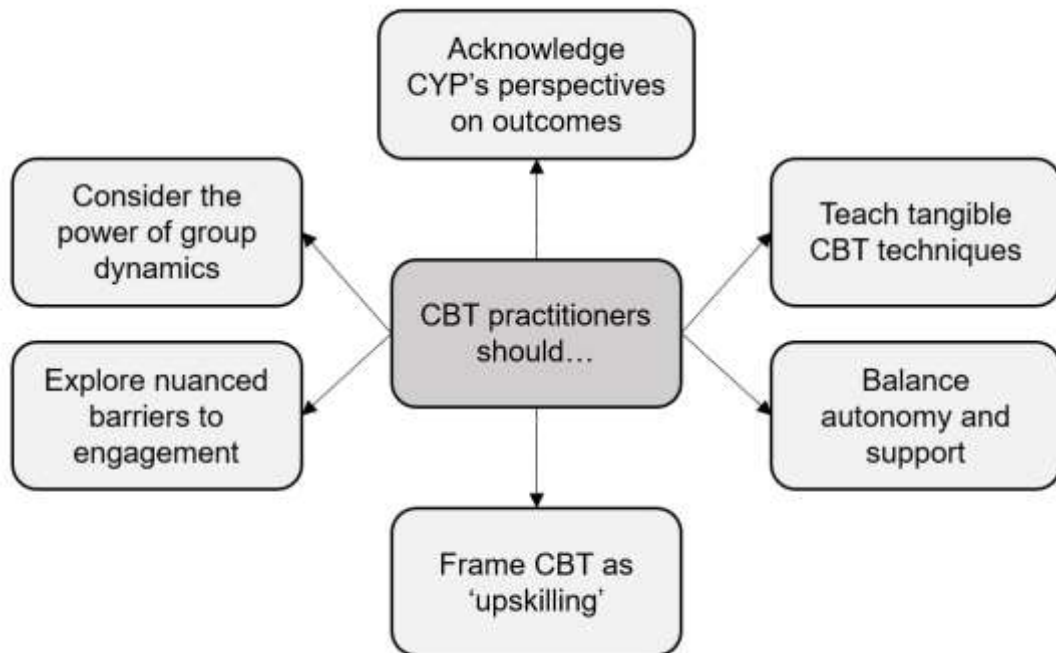
Table 2.6

Positive CBT Outcomes According to CYP

Positive outcome	Studies	References
Control and independence	17	165
Increased self-control	12	48
Better coping strategies	10	37
Greater independence	10	20
Emotional regulation skills	8	32
Increased self-confidence	8	21
Taking initiative	4	4
Standing up for self	1	3
Fundamental development of self- and world-view	17	89
Perspective shift	14	42
Greater understanding of emotions and mental health	12	17
Future orientation	7	10
Self-development	5	10
Return to 'self before mental health issues'	4	8
Normalisation of mental health issues	2	2
Knock-on effects, generalisation of skills	17	77
Generalised learning to develop life skills	9	15
Improved educational functioning	8	15
More logical thinking or behaviours	6	14
Reduction or absence of everyday struggles	6	9
Reduced negative behaviours	5	7
Improved executive functioning	5	11
Being physically more active	3	3
Greater ability to leave the house	1	2
Improved financial management	1	1
More positive and less negative emotions	13	46
Reduced negative emotions	9	26
Increased self-esteem	5	6
Happiness	4	9
Feeling safe	1	5
Communication and relationships with others	10	56
Improved social functioning	6	17
Family – better communication	6	10
Better able to open up	5	10
Better able to understand and help others	5	10
Family – more understanding of each other	2	4
Family – better system management	1	4
Family – benefitting others' wellbeing	1	1
More open to seeking help	1	1

Table 2.7

Facilitators and Barriers to Positive CBT Outcomes According to CYP

Facilitators	Studies	References	Barriers	Studies	References
Therapist characteristics	15	151	Therapist characteristics	10	46
Enabling CYP to feel understood and heard	11	36	Communicating patronisingly or with developmental inappropriateness	5	9
Being someone for CYP to talk to	8	18	Not enabling CYP to be honest	5	6
Being responsive, flexible, personalising therapy	7	19	Being unresponsive, inflexible, not personalising therapy	3	8
Giving CYP some control over therapy	7	12	Being overly formal	3	6
Enabling CYP to feel safe	7	10	Being inauthentic	3	5
Being kind, warm, friendly	4	8	Being unkind, cold, unfriendly	2	3
Being authentic	4	6	Not allowing CYP to feel sad	1	3
Enabling CYP to be honest	4	5	Not facilitating CYP's autonomy	1	2
Providing CYP the opportunity to express everything	3	5	Directing CYP with authority	1	2
Not judging CYP	3	5	Not taking the lead in therapy sessions	1	1
Scaffolding CYP's independence	3	3	Making CYP feel it's their own problem to solve	1	1
Modelling techniques to CYP	3	3			
Communicating non-patronisingly, with developmental appropriateness	2	9			
Developing familiarity and trust with CYP	2	6			
Possessing expertise which is respected by CYP	2	3			
Directing CYP with authority	2	3			
Being separate from CYP's normal life	1	1			
CYP characteristics	14	104	CYP characteristics	15	114
Acting 'for their own good', even when it's difficult	8	27	Difficulty implementing CBT techniques	5	19

Facilitators	Studies	References	Barriers	Studies	References
Seeing tangible evidence of change and monitoring progress	8	23	Not perceiving therapy as helpful	4	15
Being engaged	5	12	Lack of engagement	4	8
Being motivated	4	18	Negative preconceptions of therapy	4	7
Being self-aware	4	13	Feeling mental health difficulties are innate	4	4
Recognising therapy as helpful	3	9	Having shame or guilt about mental health	3	12
Feeling therapy is enjoyable	2	2	Difficulty understanding CBT content	3	7
			Mental health symptoms impeding engagement	3	7
			Not ready for therapy	3	4
			Difficulty committing time and effort	3	4
			Having expectations of therapy violated	3	3
			Forgetting useful learning from therapy	3	3
			Not recognising own mental health problems	2	2
			Disagreeing with CBT content from own experience	2	2
			Therapy a reminder of negativity	2	2
			Lack of motivation	1	6
			Therapy as anxiety or fear provoking	1	4
			Difficulty accepting CBT content as true	1	4
Intervention content	18	181	Intervention content	11	31
CBT techniques	18	140	Focus on unhelpful techniques	8	14
- Cognitive restructuring	11	25	Homework	4	10
- Emotion management	10	29	Repetitive or nothing new	4	8
- Relaxation exercises	8	17	Cliché examples	2	3
- Psychoeducation	8	14	Goal setting issues	2	3
- Graded exposure	7	14			
- Goal setting	5	5			

Facilitators	Studies	References	Barriers	Studies	References
- Problem solving	4	7			
- Visualisation	4	5			
- Behavioural experiments	3	10			
- Organisational skills	3	3			
- Organising pleasurable activities	2	4			
- Attention training	2	3			
- Thought diaries	2	2			
- Social skills	1	1			
- Mindfulness	1	1			
Being actively involved in CBT sessions	6	17			
Homework	3	7			
Easy to understand	3	6			
Variety of techniques and activities	2	7			
Examples providing context	1	2			
Recognised CBT content from experience	1	2			
Intervention format	10	44	Intervention format	7	32
Group format	5	23	Group format	6	17
- Sharing experiences	5	12	- Not personalised	6	9
- Engaging with others	3	5	- Unable to open up	1	3
- Less pressure to talk	2	3	- Others not understanding	1	2
- Small size	1	2	- Feeling judged	1	2
- Positive peer pressure	1	1	- Emotional leakage	1	1
Appropriate pacing	4	10	Insufficient duration of therapy	4	7
Follow up communication	2	7	Physical environment being uncomfortable	3	4
Routine of therapy	2	2	Workshop overly long	2	4
Physical environment being comfortable	1	1			

Facilitators	Studies	References	Barriers	Studies	References
Knowing there is a pre-defined end-point to therapy	1	1			
Systemic context	5	12	Systemic context	11	34
Strong support network outside therapy	2	2	Lack of time to fully engage in therapy	4	10
Resolution of stressful life circumstances	2	2	Uninvolved in decision to access therapy	3	7
Receiving preliminary support whilst on wait-list	1	5	Practical issues outside therapy	3	3
Sense of duty to others to engage in therapy	1	3	Parent or teacher lacking support from therapist to implement additional support	2	8
			Disruptive life circumstances	2	3
			Difficulties accessing service	2	2
			Missing out on schoolwork as a result of attending therapy	1	1

2.4.2 Discussion

Findings relating to RQ1 (how CYP conceptualise 'positive outcomes' from CBT) are summarised in Figure 2.3 and elaborated in Table 2.6. There were five overarching themes, which were used as centralised headings in Table 2.6. Underneath these headings are individual codes relating to each theme. These codes are provided for transparency (so readers can understand how the researcher decided on the themes) and to illustrate the diversity of ways CYP conceptualise 'positive outcomes'.

Findings relating to RQ2 (facilitators and barriers to 'positive outcomes' from CBT) are summarised in Figure 2.4 and elaborated in Table 2.7. There were five overarching themes, which were used as centralised headings in Table 2.7. Underneath these headings are individual codes relating to each theme. Codes for each theme were categorised as either 'facilitators' or 'barriers' based on researcher interpretation. Some codes were unique to the 'facilitator' or 'barrier' column, whereas other codes were seen in a positive form as 'facilitators' and in a negative form as 'barriers'.

The remainder of the discussion is structured by the analytical themes outlined in Figure 2.5. Italicised phrases refer to codes from Tables 2.6 and 2.7. Codes are supported by quotations drawn directly from reviewed studies. These are used as evidence to support the implications described in the analytical themes.

2.4.2.1 Acknowledge CYP's perspectives on outcomes

Two themes related primarily to outcomes and changes experienced *internally* by CYP in cognitive and emotional domains. 'More positive and less negative emotions' covered outcomes that most closely resembled those measured by RCTs. Many experienced *reduced negative emotions*, using language such as "less stressed", "less afraid", and "more relaxed"; few mentioned anxiety or depression directly. Few expressed directly experiencing more positive emotions but, of those that did, most used the term *happiness*, "I feel like I'm more happy, a lot happier than what I was

before I started" (Cunningham et al., 2019). This suggests implications for the language typically used by researchers in outcome measures. Clinical terms may hold little relevance for CYP, or CYP may prefer euphemisms such as "less stressed", given the chance to express their own voice.

The theme 'Fundamental development of self- and world-view' represented cognitive and identity-related outcomes, the most frequently mentioned of which was *perspective shift*. For example, "I understood that much depends on how you look at situations. And I think that has changed a lot about how I view things" (Bru et al., 2013) and "it makes me think that I have only ever been pushed around on the playground a couple if [*sic*] times and I think those were by accident. So it helps me stop being worried by it all the time" (C. Clarke et al., 2017). The starkness of these descriptions of outcomes from CBT contrasts with the interval scales typically used to quantify degrees of symptom reduction. While most participants experienced future-oriented perspective shift, some described *returning to 'self before mental health issues'*, such as "back to the person I was before" (Wilmots et al., 2019). For many, the personalised perspective shift was accompanied by a more academic *greater understanding of emotions and mental health*. Some referenced the CBT model, "becoming aware of how it works; a situation, an interpretation and then a feeling" (Bru et al., 2013). Others referenced the perspective-understanding link, "it gives you a better understanding of what you're going through… as well as… a different way of thinking" (Loucas et al., 2019). Others indicated *normalisation of mental health difficulties*, "depression is curable and that people still, you know, are normal" (Claus et al., 2019).

The other three themes related to outcomes and changes experienced *externally* by CYP in behavioural and social domains. 'Control and independence' showed how participants linked cognitive developments with behavioural changes, "You dealt with

the fear, got it in perspective; you could control the situation yourself" (Shahnavaz et al., 2015) and:

> Now I'm able to understand my problems and why I'm suffering like this. I'm able to overcome things and to suggest myself solutions for these problems. Before, I used to depend on parents now I can do it myself. Whenever the symptoms occur, I'm able to manage them. (Kandasamy et al., 2019)

Such insights suggest maturity, since they acknowledge that negative emotions ("fear" and "symptoms") may still occur but CYP are now able to get them "in perspective" and "control the situation". These are domain-general skills, likely to aid CYP across different contexts and systems in their lives. The emphasis on independence may be particularly salient during adolescence, a developmental period of reduced reliance on adult caregivers and greater risk-taking in exploring a wider social environment (Spear, 2013).

The theme 'Knock-on effects, generalisation of skills' represented indirect behavioural outcomes, such as *improved educational functioning*, "giving exams without fear" (Kandasamy et al., 2019); *improved financial management*, "being more careful with finances" (W. Jones et al., 2020); and *being physically more active*, "I was activated and became in better shape... there was less time to think when I was active" (Bru et al., 2013). The theme 'Communication and relationships with others' represented similarly indirect outcomes in the social domain, including *improved social functioning*, "I spend much more time together with other people" (Bru et al., 2013), and *better family system management*, "Some adolescents adjusted their roles within the family system by learning to impose boundaries between their needs and those of family members" (Krause et al., 2020). Several outcomes related specifically to improved communication of emotions such as *better able to open up*, *more open to seeking help*, and *better able to understand and help others*. This last outcome shows that CYP developed empathy and felt empowered to pass on their learning, "I help my dad

82

when he is stressed. When he comes home in the evening, I teach him how to relax instead of smoking" (Myburgh et al., 2021), and:

> I feel like I become more sympathetic as well towards situations because I can understand them more so if anybody else is in that situation, I can be like 'ok, I've been through that' you know, what can I do to help them. (Wilmots et al., 2020)

It seems CBT contributed indirectly to health-related outcomes, social skills, and life skills. This may have occurred through cognitive development or reduction in emotional distress, which removed barriers that had been holding CYP back. In addition, some CYP felt they could actively help and educate others, suggesting positive outcomes for people who had never received CBT. Based on how primary studies reported findings, it was unclear whether the same participants articulated both specific and general positive outcomes, and whether these linked to participants' goals at the start of therapy or whether they were unexpected.

Overall, CYP experienced a broad range of positive outcomes from CBT across cognitive, emotional, behavioural, and social realms, contrasting with the standardised measures typically used in research and practice. This variety reflects the findings of Neelakantan et al. (2019) and Krause et al. (2020), one of the studies reviewed for this synthesis. Krause et al.'s participants reported a variety of emotional symptoms including reductions in self-harm and suicidality, but the authors did not report any quotes so they were not included in this review. It is possible practitioners may be reluctant or struggle to measure additional outcomes as they may require additional administrative efforts, may be subjective to individuals, and CYP may not be aware of indirect outcomes until therapy is completed (James et al., 2015). However, practitioners and researchers should acknowledge that CYP may not share their conceptualisations of 'positive outcomes', particularly regarding the language used and the variety of forms. One reason for the variety of outcomes identified in this

review is that CYP may find it easier, or assign more importance, to tangible outcomes and techniques, discussed next.

2.4.2.2 Teach tangible CBT techniques

The most frequently mentioned facilitator to positive outcomes was *CBT techniques*. This fits with the practical focus of positive outcomes, suggesting CYP value teaching of skills they can employ in their everyday lives. It is also supported by the codes *seeing tangible evidence of change and monitoring progress* and *being actively involved*, such as "It [a progress chart] was quite useful cos you could see – you could compare the different things – what I'd done each week to see what I was progressing in and what I wasn't" (Taylor et al., 2021). This suggests a positive reinforcement cycle, where CYP are taught useful techniques, employ these techniques, see that they work, and engage more in therapy, "the more she told me about how I can manage my low moods, my anxiety, and sometimes my OCD [obsessive compulsive disorder], it made me want to come here more" (S. Jones et al., 2017).

In terms of specific techniques, *cognitive restructuring* and *psychoeducation* link with *perspective shift* and *greater understanding of emotions and mental health* as key cognitive outcomes. Emotional control techniques, particularly *emotion management* and *relaxation exercises*, were frequently mentioned. It was rare for participants to directly identify techniques they found unhelpful; more often the *focus on unhelpful techniques* involved wishing more time had been spent on the most helpful techniques. Some participants were particularly utilitarian, "Rose and Max spoke about how 'just talking… didn't really solve anything', and expressed the need to be actively working to reduce the impact of symptomology" (S. Jones et al., 2017).

One widely-reported caveat around the preference for various, tangible CBT techniques is that CYP had *difficulty implementing CBT techniques*, "It's easy to say something different to yourself there and then, but I don't know how well it's going to

work in the long term… It's not difficult to find [positive] thoughts, but it's difficult to use them" (Bru et al., 2013) and "If I'm out with friend [*sic*], I probably wouldn't want to do [the coping skills] in front of them" (Cunningham et al., 2019), noting the significance of peer judgment for adolescents. Therapists should be mindful of complicating factors that only exist outside the therapeutic space and work with CYP to plan in advance how they might problem-solve implementation difficulties.

The prominence attributed to tangible CBT techniques by CYP sits somewhat counter to research findings that the quality of the therapeutic relationship is a better predictor of outcomes than therapeutic techniques (Lambert & Ogles, 2004; Orlinsky et al., 2004). The well-known 'Intervention Pie Chart' suggests 'technique and model factors' account for around half the variance in therapeutic change compared with 'the therapeutic relationship' (Lambert, 1992). The prominent focus on techniques found by this review may partly have a developmental explanation, since adolescents are typically more sensitive to immediate rewards than adults (Spear, 2013). Methodological factors are also relevant, as it is not possible for a qualitative review to assign causality to factors identified, so therapeutic techniques may be prominent in CYP's minds but not necessarily the most important factor for bringing about change. Indeed, many CYP identified factors related to the therapeutic relationship, discussed next.

2.4.2.3 Balance autonomy and support

A key facilitator for participants experiencing individual CBT was being given *control over therapy*, "Maddison [CBT service-user] valued being given the opportunity by her therapist to exert control over her treatment course, which promoted engagement" (Wilmots et al., 2019) and a therapist who could be *responsive, flexible, personalising therapy*, "It was [a] more personalised approach I guess. And like we could figure out a way… where it wasn't working for me" (Donald et al., 2018). These points around control and personalisation link with the importance of *greater independence* as an

outcome, emphasising that CYP value agency and collaboration during the therapeutic process. The theme of 'keeping control' over engagement in and pace of counselling services was identified by participants engaging in face-to-face, telephone, and text-message-based services, suggesting it is a key factor across various therapeutic modalities (Gibson et al., 2016). Further support comes from the few participants who experienced therapists who were *unresponsive, inflexible, not personalising therapy*, "He would be like listening, but not listening if you get what I mean... it was like he was tryin' to force me to say something that I din wanna [*sic*] say" (Wilmots et al., 2019). These points highlight the importance of Socratic questioning, a collaborative approach in which therapists guide CYP to explore their thoughts and reach their own conclusions, rather than taking an expert role and withholding control (Padesky, 1993; Stallard, 2021).

Quantitative process research supports the importance placed on therapist flexibility. Podell et al. (2013) found a small, but significant, correlation ($r = -.16$, $p < .05$) between therapist style (collaborative and empathic) and self-reported anxiety. Chu and Kendall (2009) found therapist flexibility (adapting treatment to CYP's needs and interests) correlated significantly ($r = .25$, $p = .05$) with child engagement in later CBT sessions, which in turn predicted improvements in anxiety symptoms post-treatment. The most common reason for flexibility was changing activities to match CYP's *interests*; changing activities to match CYP's *suggestions* was less common. It would be helpful for future qualitative research to explore the nuances of how CYP perceive therapist flexibility, such as whether they feel they could make suggestions to alter the course of therapy or whether the therapist was perceptive of their interests and integrated these into activities.

While these codes support the value of autonomy for CYP, another set of codes exhibit the value of adult support. Foremost among these were *enabling child to feel understood and heard* and *being someone for the child to talk to*. The first code

suggests it was helpful for many CYP simply to talk, while the second underlines the importance of the therapist actively listening. For example, "She seemed like a person you could speak to anything about, she had that aura about her" (S. Jones et al., 2017) and "I felt like [the therapist] actually understood where I was coming from which was amazing... it's so nice to have someone to listen to that" (Cunningham et al., 2019). Both quotes contain an element of awe, suggesting the therapist possessed skills which CYP could not articulate. 'Being listened to' was identified as a prominent theme in a qualitative review of adolescents' opinions of what makes a good medical professional (Freake et al., 2007), suggesting it is important to CYP when discussing their physical, as well as mental, health. In addition to therapists understanding, it was important to be *authentic*, "I thought she was genuinely maybe concerned" (S. Jones et al., 2017) and "[My therapist] wanted to help. Not judgmental or anything. You know, like a nice person. So it was a good relationship." (O'Keeffe et al., 2019). These issues suggest some dependence on a skilled adult listener and a need for emotional acceptance, but also highlight the role of the adult in facilitating CYP's voices.

There appears to be a balance between needing an adult and desiring autonomy, mirroring adolescence more widely as a transition from adult dependence to finding independence (McElhaney et al., 2009). This was articulated by one participant:

> I feel like in general when you're young you kind of feel like 'oh I'm independent, I don't need adults'... I feel like, if you, when you speak to an adult it just feels like they're authority and they're going to tell you off kind of thing so it's nice when someone is friendly with you and not talking down on you. (S. Jones et al., 2017)

In light of this, the element of awe noted above may indicate surprise at encountering an adult who does not aim to exert control, unlike parents or teachers. This is supported by the opposing codes *communicating non-patronisingly* and *communicating patronisingly*. Negative comments included being made to feel "a bit

like a child" and "you're talking to me like I'm five" (S. Jones et al., 2017), while positive comments included "more focus on teenagers" (Howells et al., 2019), and "understand everything from the perspective of young people because in a different age people view things differently and sometimes… an issue might be minor for adults but for young people it's big" (S. Jones et al., 2017). Feeling understood and heard relates not just to adolescents' own words about their lives but to their developmental status. The quotes above suggest that adolescents do not wish to be treated like children but also that they have "issues" which are more salient for teenagers than they would be for adults. It could be a tricky balance for therapists to respect adolescents' maturity and avoid patronising them whilst ensuring they take seriously issues which may seem trivial to adults.

2.4.2.4 Frame CBT as 'upskilling'

The balance between autonomy and support is informed by Vygotsky's zone of proximal development and its pedagogical counterpart, scaffolding (Bruner, 1985; Vygotsky, 1962). The therapist needs to provide enough support to ensure CYP feel heard, but not so much that they feel patronised, while promoting autonomy and independence so CYP are better able to cope in everyday life. The individualised, dynamic nature of this process is captured by the code *appropriate pacing*, "participants... valued being given space to share information at their own pace" (Wilmots et al., 2019). Some participants metaphorically described a process of *scaffolding independence*, "It's like riding a bike, she was kind of like my safety pedals like the actual pedals you get and I guess they're kind of coming off now and I've got to ride my bike on my own now" (W. Jones et al., 2020).

This rounded, pedagogical view of CBT fits with the way many participants discussed positive CBT outcomes consisting of interwoven cognitive, behavioural, and emotional elements. With a change in perspective and greater self-understanding comes an increased ability to regulate emotions and control behavioural responses

when difficult situations arise. Viewed like this, CBT is a practical process of upskilling people to solve future problems independently rather than a treatment solely addressing emotional symptomatology. This may have implications for how therapists present CBT to CYP, since *negative preconceptions of therapy* can be barriers:

> it sounds like if you say to someone that you're going to like behavioural therapy or like whatever it sounds a bit weird at first like not something that really a teenager would want to go to… I always thought that somewhere like that was where you go when you're going mad. (Donnellan et al., 2013)

Concerns around stigma have been reported by CYP in other qualitative reviews, such as reluctance to share personal information and struggling to accept they might benefit from help (Lynch et al., 2020; McCashin et al., 2019). Presenting CBT as a pedagogical tool that can build independence and lead to a broad range of outcomes relevant to improved quality of life may help CYP who struggle to engage in or even consider CBT, discussed next.

2.4.2.5 Explore nuanced barriers to engagement

In line with the findings of Murphy and Hutton (2018), successful therapeutic outcomes appeared to hinge on CYP as well as therapist characteristics. CYP identified considerably more therapist characteristics as facilitators compared to child characteristics. It may be that CYP see the locus of change in therapy having more to do with a skilled therapist than action on their own part. However, one key facilitator was for CYP to *act 'for their own good', even when it's difficult,* "[I] psyched [myself] up and thought this is going to be a good thing so don't get scared otherwise you won't end up coming" (S. Jones et al., 2017), and:

> there was [*sic*] a few cases where I really didn't want to talk about it but… we had to really nit pick it because we needed to get to the like root of the

problems, so I did say the stuff but a lot of me didn't want to say because obviously it's like really personal stuff. (Donnellan et al., 2013)

These participants suggest therapy is anxiety-provoking but can bring about gains that make the anxiety worthwhile; accepting this fact was key to their engagement.

Other CYP appeared unable to clear this mental hurdle, *not perceiving therapy as helpful*, "He always has his guards up. According to him, no one can help him… On our way here he told us: 'I told you this will not lead to anything' (Mother)" (Lundkvist-Houndoumadi & Thastum, 2017) and "I don't think I talked that much, I gave quite small answers coz as I say part of me didn't really wanna be there and my heart wasn't really in it, erm, I was rather sceptical" (Donnellan et al., 2013). These quotes suggest different perspectives, the first 'I am un-helpable (the problem is with me)' and the second 'therapy isn't helpful (the problem is with therapy)'. There were 18 barrier codes identified in relation to child characteristics, many of which were mentioned infrequently, suggesting it may be hard to predict why CYP are not engaging or making progress. Research suggests up to two thirds of people may feel ambivalent about change prior to engaging in CBT (Westra & Dozois, 2006). This figure may be higher among CYP since they do not typically refer themselves for support (Stallard, 2021). Given the central importance of CYP feeling understood and heard, it is imperative for therapists to clarify why CYP are reluctant to engage, to ensure CYP's concerns are addressed appropriately and they are not led to feel misunderstood and further disengage. One structural element that may impede or facilitate engagement is whether CBT is conducted on an individual or group basis, discussed next.

2.4.2.6 Consider the power of group dynamics

The importance of personalisation for CYP engagement is underscored by the code of group therapy being *not personalised*, "helping young people that are feeling stressed, the best thing to do would be talk to them about their individual circumstance

if they're willing to tell you their personal lives" (McKeague et al., 2018). While the group format can restrict personalisation, it can facilitate *sharing experiences* and *engaging with others*, "It made me feel better… to know… there are other people going through the same thing" and "I found it helpful… because there was other people of my age… with different ways of coping… it helped because I took in how they coped with their stress" (Loucas et al., 2019). The group format provided emotional reassurance and peer learning; meeting others their age may have helped reduce stigma. Furthermore, a valued degree of control may be provided to CYP experiencing group CBT through *variety of techniques and activities*, "The fact that they gave us a lot of different approaches… not all of them suited me but there were definitely some that did" (Loucas et al., 2019). Within groups, it may be easier for CYP to learn about a range of techniques (from therapists and each other) and choose what works best for them, rather than feeling pressure to try what an adult is recommending in a one-on-one setting.

The countering perspectives of not enough personalisation and sharing with others pose a practical dilemma for the group format. This may be addressed by having small group sizes or asking CYP if they feel the need for more personalised support then offering individual CBT. Therapists should also consider the nature of CYP's difficulties before recommending group therapy; the remaining four barrier codes under *group format* were referenced exclusively from Lundkvist-Houndoumadi and Thastum (2017), whose participants had social anxiety. For these CYP, the presence of others reinforced their difficulties as they were *unable to open up* and *felt judged*.

2.4.3 Practice recommendations

In making recommendations for practice, this review is following the principle of representational generalisation, whereby qualitative findings can be tentatively extended to the populations from which samples are drawn (Lewis et al., 2003). Many of the reviewed studies took a similar approach of drawing out practice

91

recommendations from qualitative data (e.g. S. Jones et al., 2020), suggesting this is accepted practice.

Some sample characteristics of reviewed studies were heterogeneous. Studies were conducted across five continents across the age range of 6-25 years and participants in two studies had additional medical or neurodevelopmental conditions. Other sample characteristics were homogeneous. All participants had primarily internal mental health difficulties and had experienced CBT. Arguably, within this homogeneity, there was variability since the nature of anxiety or low mood can differ substantially and CBT can be delivered in myriad ways. As such, the findings of this review are not necessarily applicable to every CBT practitioner working with CYP experiencing anxiety or depression. However, the fact that there was substantial consensus among participants of different ages and roughly equal gender distribution, living in different countries, undergoing CBT with different practitioners, suggests certain themes are representative of many CYP's experiences. In this way, the synthesis process has added to the potential generalisability of findings from individual qualitative studies. The following recommendations for practice are made for CBT practitioners working with CYP experiencing anxiety or depression. This includes EPs, the majority of whom use CBT-based approaches, deliver CBT directly, or advise other professionals who use CBT (Atkinson et al., 2011; Greig et al., 2019).

Practitioners should consider setting goals and measuring outcomes in euphemistic terms, mirroring the language used by CYP, such as 'stressed' rather than 'anxious'. Standardised instruments typically use clinical terminology but this may not reflect CYP's lived experiences; CYP may feel uncomfortable if they are asked to complete standardised questionnaires employing such language. It would potentially contribute to a sense of being heard and respected for CYP, as well as providing more accurate responses, if the language of CBT outcome measures better reflected CYP's own conceptualisations.

Practitioners should recognise the value placed on tangible CBT techniques by adolescents. It is not clear that certain techniques are particularly helpful or unhelpful, but having actions to take and seeing tangible evidence of change facilitates CYP's engagement in therapy and helps them towards positive outcomes.

Practitioners should balance encouraging CYP autonomy and providing responsive support. Possessing control over therapeutic decisions and working towards independent management of difficulties is desirable to many CYP, but so is the feeling of being heard and understood by an empathetic adult, who responds to their personal situation and respects their developmental stage.

Practitioners should consider framing CBT as a process of upskilling CYP, leading to a broad range of outcomes that are relevant to their everyday lives. Presenting this perspective to CYP who are potentially engaging, or interested, in therapy may help to address negative preconceptions and stigma.

Practitioners should acknowledge the breadth of reasons why CYP find it difficult to engage in CBT or achieve positive outcomes in relation to CYP characteristics. CYP have a nuanced variety of perspectives on how their situation is hindering them; therapists should spend time exploring this. The process of discussing individuals' barriers may in itself facilitate engagement, as it would indicate to CYP that they are being understood and heard, which was a key facilitator identified by this review.

Practitioners should be aware that group therapy dynamics pose a dilemma as personalisation may be limited but sharing experiences with peers can be emotionally reassuring and pedagogically useful. The solution may be to ensure CYP are aware that, if personalisation is an issue, this could be addressed through individual therapy, as it may be an indicator of more entrenched difficulties.

2.4.4 Limitations

In conveying diversity in response to the RQs, the discussion was unable to consider all codes. This runs counter to the tenets of richness and contextualisation that are central to qualitative methodology and epistemological pluralism (Barker et al., 2016). However, it is difficult to see a way of addressing this issue that is non-reductive; if broader codes had been defined, diversity would have been less apparent. This speaks to the issue of data saturation in qualitative research, which becomes even greater when vast amounts of data from primary studies are combined in the review process (Saunders et al., 2018). From a utilitarian perspective, given this review focussed on an intervention, the purpose was primarily to inform practice, which meant distilling complexity into practical conclusions that can be acted upon.

Relatedly, by listing codes according to their prevalence, this review could be accused of marginalising participants whose views were not widely shared. Given that individualisation was repeatedly identified as a facilitator for positive outcomes, understanding CYP's idiosyncratic views is a key responsibility for therapists; it would be inexcusable to dismiss a view because it seemed atypical. Yet, the logic of championing individualisation renders impossible the task of comprehensively representing all participants' views. The salient point is the therapeutic skill of personalising delivery, which is of clear value to many CYP, and acknowledging that it will require time and effort to understand precisely why CYP are not making progress, since reasons are unlikely to be predictable based on general experience and the dangers of misunderstanding reasons are stark.

2.4.5 Research recommendations

Across all three WoE criteria, studies which employed qualitative methods to evaluate specific interventions received lower scores. Future research should carefully consider the implications of power dynamics in such designs. Interviewers should not have prior involvement in interventions, interview schedules should not pose leading

questions, and researchers should not employ a priori evaluative frameworks that over-simplify participants' experiences into positives and negatives. This would provide more robust evidence and researchers would receive more honest feedback on interventions, helping them make future design decisions.

Studies exploring how CYP conceptualise positive outcomes to CBT should explore whether the same participants identify specific outcomes (e.g. meeting up more with friends) and general outcomes (e.g. perspective shift). Some CYP may only identify specific outcomes and therapists might support them to see how CBT could inform their lives more broadly. Furthermore, it would be helpful to explore whether positive outcomes link with goals set at the beginning of therapy or whether the process of CBT leads to unexpected outcomes. This comparative logic might be applied more broadly, with qualitative studies interviewing participants at multiple points before, during, and after therapy to explore the process of change in greater detail. The majority of studies in this review only collected data from participants after they had finished the intervention.

Some codes had relatively thin data; future research could explore whether this is because they are not important to CBT, whether they are taken for granted, or some other reason. Questions could be asked about whether CYP value a variety of CBT techniques in individual therapy, as they do in group therapy. Greater attention could be paid to facilitators and barriers in the systemic context, since this is theoretically of great importance (Bronfenbrenner, 1979) but was infrequently mentioned by participants. Few CYP explicitly mentioned clinical terms for mental health difficulties (e.g. anxiety, depression), preferring euphemisms such as 'stressed'. Future research could explore whether clinical language in pre-/post-measures is actively uncomfortable and whether CYP would prefer psychological measures to better reflect their own conceptualisations of mental health difficulties. A future qualitative

review could explore what practitioners consider to be facilitators and barriers to positive CBT outcomes and compare these to the current review.

Finally, it is notable that no codes were identified in relation to confidentiality, despite this being among the most important themes in previous reviews (Freake et al., 2007; Lynch et al., 2020). This could be due to differences in researcher interpretation of the concept, since this review identified codes around safety and trust. However, confidentiality is distinct and was mentioned only twice by participants in the reviewed studies, in relation to concerns that the school setting may limit confidentiality and in the context of personal data collection for a research study. The reasons for this discrepancy are unclear, so future research should address confidentiality directly as a potential facilitator or barrier to positive CBT outcomes.

2.4.6 Conclusion

This review aimed to explore how CYP with anxiety and depression conceptualise 'positive outcomes' from CBT and what they consider to be facilitators and barriers to such outcomes. Regarding RQ1, as anticipated, a broader variety of direct and indirect outcomes were identified as meaningful by CYP compared with the typical standardised but reductive outcomes reported in RCTs (Krause et al., 2019, 2020). Moreover, CYP used different language to describe outcomes that would typically be measured by researchers and practitioners – rather than 'reduced anxiety or depression', CYP typically described feeling 'happier' and 'less stressed'. Regarding RQ2, facilitators and barriers were identified relating to characteristics of people involved in the therapeutic relationship (therapist and CYP), the nature of the intervention (content and structure), and the systemic context outside therapy. It was not the intention of this review to assess the relative importance of these factors in contributing to positive outcomes, although data were provided on the prevalence of codes and themes to suggest what was shared between study contexts and might be transferable to other contexts. The primary aims of the review were to explore the

perspectives of CYP with experience receiving CBT to extend prevailing research trends, in which standardised measures and practitioners' voices dominate, and to prompt practitioners and researchers to reflect on their practice.

2.5 References

Anyan, F. (2013). The influence of power shifts in data collection and analysis stages: A focus on qualitative research interview. *Qualitative Report, 18*(18), 1–9.

Atkinson, C., Bragg, J., Squires, G., Muscutt, J., & Wasilewski, D. (2011). Educational psychologists and therapeutic interventions: Preliminary findings from a UK-wide survey. *DECP Debate, 140*.

Attwood, T. (2004). *Exploring feelings: Cognitive behaviour therapy to manage anxiety*. Future Horizons.

Barker, C., Pistrang, N., & Elliott, R. R. (2016). *Research methods in clinical psychology: An introduction for students and practitioners* (3rd ed.). Wiley-Blackwell.

Beck. (1970). Cognitive therapy: Nature and relation to behavior therapy. *Behavior Therapy, 1*(2), 184–200. https://doi.org/10.1016/S0005-7894(70)80030-2

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. Sage.

Britten, N. (2010). Qualitative research and the take-up of evidence-based practice. *Journal of Research in Nursing, 15*(6), 537–544. https://doi.org/10.1177/1744987110380611

Bronfenbrenner, U. (1979). Contexts of child rearing: Problems and prospects. *American Psychologist, 34*(10). https://doi.org/10.1037/0003-066X.34.10.844

Bru, L., Solholm, R., & Idsoe, T. (2013). Participants' experiences of an early cognitive behavioral intervention for adolescents with symptoms of depression. *Emotional and Behavioural Difficulties, 18*(1), 24–43. https://doi.org/10.1080/13632752.2012.675138

Bruner, J. (1985). Vygotsky: A historical and conceptual perspective. In *Culture communication and cognition: Vygotskian perspectives*. https://doi.org/10.1080/02103702.1981.10821841

Chu, B. C., & Kendall, P. C. (2009). Therapist responsiveness to child engagement: Flexibility within manual-based CBT for anxious youth. *Journal of Clinical Psychology, 65*(7), 736–754. https://doi.org/10.1002/jclp.20582

Clarke, C., Hill, V., & Charman, T. (2017). School based cognitive behavioural therapy targeting anxiety in children with autistic spectrum disorder: A quasi-experimental randomised controlled trail incorporating a mixed methods approach. *Journal of Autism and Developmental Disorders, 47*(12), 3883–3895. https://doi.org/10.1007/s10803-016-2801-x

Clarke, M., & Williamson, P. (2015). Core outcome sets and trial registries. *Trials, 16*(1). https://doi.org/10.1186/s13063-015-0738-6

Claus, N., Marzano, L., Loechner, J., Starman, K., Voggt, A., Loy, F., Wermuth, I., Haemmerle, S., Engelmann, L., Bley, M., Schulte-Koerne, G., & Platt, B. (2019). Qualitative evaluation of a preventive intervention for the offspring of parents with a history of depression. *BMC Psychiatry, 19*(1), 1–14.

https://doi.org/10.1186/s12888-019-2273-6

Cooke, A., Smith, D., & Booth, A. (2012). Beyond PICO: The SPIDER tool for qualitative evidence synthesis. *Qualitative Health Research*, *22*(10), 1435–1443. https://doi.org/10.1177/1049732312452938

Cuijpers, P., Muñoz, R. F., Clarke, G. N., & Lewinsohn, P. M. (2009). Psychoeducational treatment and prevention of depression: The "coping with depression" course thirty years later. *Clinical Psychology Review*, *29*(5), 449–458. https://doi.org/10.1016/j.cpr.2009.04.005

Cunningham, N. R., Fussner, L. M., Moorman, E., Avar Aydin, P. O., Brunner, H. I., & Kashikar-Zuck, S. (2019). Development and pilot testing of the treatment and education approach for childhood-onset lupus (TEACH): A cognitive behavioral treatment. *Pediatric Rheumatology*, *17*(1). https://doi.org/10.1186/s12969-019-0307-8

de Haan, A. M., Boon, A. E., de Jong, J. T. V. M., Hoeve, M., & Vermeiren, R. R. J. M. (2013). A meta-analytic review on treatment dropout in child and adolescent outpatient mental health care. *Clinical Psychology Review, 33*(5), 698–711. https://doi.org/10.1016/j.cpr.2013.04.005

Donald, I. N., Carey, T. A., & Rickwood, D. J. (2018). Therapeutic change in young people—A qualitative investigation of client and therapist perspectives. *Counselling and Psychotherapy Research*, *18*(4), 402–411. https://doi.org/10.1002/capr.12191

Donnellan, D., Murray, C., & Harrison, J. (2013). An investigation into adolescents' experience of cognitive behavioural therapy within a child and adolescent mental health service. *Clinical Child Psychology and Psychiatry*, *18*(2), 199–213. https://doi.org/10.1177/1359104512447032

Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing*, *62*(1), 107–115. https://doi.org/10.1111/j.1365-2648.2007.04569.x

Fischer, C. T. (2009). Bracketing in qualitative research: Conceptual and practical matters. *Psychotherapy Research*, *19*(4–5), 583–590. https://doi.org/10.1080/10503300902798375

Freake, H., Barley, V., & Kent, G. (2007). Adolescents' views of helping professionals: A review of the literature. *Journal of Adolescence*, *30*(4), 639–653. https://doi.org/10.1016/j.adolescence.2006.06.001

Frederickson, N. (2002). Evidence-based practice and educational psychology. *Educational and Child Psychology*, *19*(3), 96–111.

Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology*, *13*(1), 1–8. https://doi.org/10.1186/1471-2288-13-117

Gibson, K., Cartwright, C., Kerrisk, K., Campbell, J., & Seymour, F. (2016). What young people want: A qualitative study of adolescents' priorities for engagement across psychological services. *Journal of Child and Family Studies*, *25*(4), 1057–1065. https://doi.org/10.1007/s10826-015-0292-6

Gough, D. (2007). Weight of evidence: A framework for the appraisal of the quality and relevance of evidence. *Research Papers in Education*, *22*(2), 213–228. https://doi.org/10.1080/02671520701296189

Greig, A., MacKay, T., & Ginter, L. (2019). Supporting the mental health of children and young people: A survey of Scottish educational psychology services. *Educational Psychology in Practice*, *35*(3), 257–270. https://doi.org/10.1080/02667363.2019.1573720

Hamlyn, D. W. (1970). *The theory of knowledge*. Doubleday Anchor.

Hofmann, S. G., Asnaani, A., Vonk, I. J. J., Sawyer, A. T., & Fang, A. (2012). The efficacy of cognitive behavioral therapy: A review of meta-analyses. *Cognitive Therapy and Research*, *36*(5), 427–440. https://doi.org/10.1007/s10608-012-9476-1

Howells, L. (2018). *Cognitive behavioural therapy for adolescents and young adults: An emotion regulation approach*. Routledge.

Howells, L., Rose, A., Gee, B., Clarke, T., Carroll, B., Harbrow, S., Oliver, C., & Wilson, J. (2019). Evaluation of a non-diagnostic "Psychology of Emotions" group intervention within a UK youth IAPT service: A mixed-methods approach. *Behavioural and Cognitive Psychotherapy*, *48*(2), 129–141. https://doi.org/10.1017/S1352465819000407

Huntley, A. L., Araya, R., & Salisbury, C. (2012). Group psychological therapies for depression in the community: Systematic review and meta-analysis. *British Journal of Psychiatry*, *200*(3), 184–190. https://doi.org/10.1192/bjp.bp.111.092049

James, K., Elgie, S., Adams, J., Henderson, T., & Salkovskis, P. (2015). Session-by-session outcome monitoring in CAMHS: Clinicians' beliefs. *Cognitive Behaviour Therapist*, *8*. https://doi.org/10.1017/S1754470X15000653

Jones, S., Hassett, A., & Sclare, I. (2017). Experiences of engaging with mental health services in 16- to 18-year-olds: An interpretative phenomenological analysis. *SAGE Open*, *7*(3). https://doi.org/10.1177/2158244017719113

Jones, W., Peters, S., Byrne, R. E., Shiers, D., Law, H., & Parker, S. (2020). "It felt very special, it felt customised to me": A qualitative investigation of the experiences of participating in a clinical trial of CBT for young people at risk of bipolar disorder. *Psychology and Psychotherapy: Theory, Research and Practice*, 1–18. https://doi.org/10.1111/papt.12313

Kandasamy, P., Girimaji, S. C., Seshadri, S. P., Srinath, S., & Kommu, J. V. S. (2019). Interventions for childhood anxiety disorders - What works best from a child's perspective: A qualitative study. *Indian Journal of Psychological Medicine*, *41*(3), 235–239. https://doi.org/10.4103/IJPSYM.IJPSYM_509_18

Kaufman, J., Birmaher, B., Brent, D., Rao, U., Flynn, C., Moreci, P., Williamson, D., & Ryan, N. (1997). Schedule for affective disorders and schizophrenia for school-age children-present and lifetime version (K-SADS-PL): Initial reliability and validity data. *Journal of the American Academy of Child and Adolescent Psychiatry*, *36*(7), 980–988. https://doi.org/10.1097/00004583-199707000-00021

Kendall, P. C., & Hedtke, K. (2006). *Cognitive-behavioral therapy for anxious children: Therapist manual*. Workbook Publishing.

Krause, K. R., Bear, H. A., Edbrooke-Childs, J., & Wolpert, M. (2019). What outcomes count? A review of outcomes measured for adolescent depression between 2007 and 2017. *Journal of the American Academy of Child and Adolescent Psychiatry*, *58*(1), 61–71. https://doi.org/10.1016/j.jaac.2018.07.893

Krause, K. R., Midgley, N., Edbrooke-Childs, J., & Wolpert, M. (2020). A comprehensive mapping of outcomes following psychotherapy for adolescent depression: The perspectives of young people, their parents and therapists. *European Child and Adolescent Psychiatry*. https://doi.org/10.1007/s00787-020-01648-8

Lambert, M. J. (1992). Psychotherapy outcome research: Implications for integrative and eclectic therapists. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration*. Basic Books.

Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 139–193). Wiley.

Larsson, S. (2009). A pluralist view of generalization in qualitative research. *International Journal of Research and Method in Education*, *32*(1), 25–38. https://doi.org/10.1080/17437270902759931

Leigh, E., & Clark, D. M. (2016). Cognitive therapy for social anxiety disorder in adolescents: A development case series. *Behavioural and Cognitive Psychotherapy*, *44*(1), 1–17. https://doi.org/10.1017/S1352465815000715

Lewis, J., Ritchie, J., & Ormston, R. (2003). Generalising from qualitative research. In *Qualitative research practice: A guide for social science students and researchers* (pp. 347–362). Sage.

Loerinc, A. G., Meuret, A. E., Twohig, M. P., Rosenfield, D., Bluett, E. J., & Craske, M. G. (2015). Response rates for CBT for anxiety disorders: Need for standardized criteria. *Clinical Psychology Review*, *42*, 72–82. https://doi.org/10.1016/j.cpr.2015.08.004

Loucas, C. E., Sclare, I., Stahl, D., & Michelson, D. (2019). Feasibility randomized controlled trial of a one-day CBT workshop ('DISCOVER') for 15- to 18-year-olds with anxiety and/or depression in clinic settings. *Behavioural and Cognitive Psychotherapy*, 142–159. https://doi.org/10.1017/S1352465819000286

Lundkvist-Houndoumadi, I., & Thastum, M. (2017). Anxious children and adolescents non-responding to CBT: Clinical predictors and families' experiences of therapy. *Clinical Psychology and Psychotherapy*, *24*(1), 82–93. https://doi.org/10.1002/cpp.1982

Lynch, L., Moorhead, A., Long, M., & Hawthorne-Steele, I. (2020). What type of helping relationship do young people need? Engaging and maintaining young people in mental health care: A narrative review. *Youth and Society*, 1–24. https://doi.org/10.1177/0044118X20902786

Masic, I., Miokovic, M., & Muhamedagic, B. (2008). Evidence based medicine: New approaches and challenges. *Acta Informatica Medica*, *16*(4), 219. https://doi.org/10.5455/aim.2008.16.219-225

McCashin, D., Coyle, D., & O'Reilly, G. (2019). Qualitative synthesis of young people's experiences with technology-assisted cognitive behavioral therapy: Systematic review. *Journal of Medical Internet Research*, *21*(11). https://doi.org/10.2196/13540

McElhaney, K. B., Allen, J. P., Stephenson, J. C., & Hare, A. L. (2009). Attachment and autonomy during adolescence. In *Handbook of adolescent psychology: Individual bases of adolescent development* (pp. 358–403). Wiley and Sons.

McKeague, L., Morant, N., Blackshaw, E., & Brown, J. S. L. (2018). Exploring the

feasibility and acceptability of a school-based self-referral intervention for emotional difficulties in older adolescents: Qualitative perspectives from students and school staff. *Child and Adolescent Mental Health*, *23*(3), 198–205. https://doi.org/10.1111/camh.12234

Midgley, N., Ansaldo, F., Parkinson, S., Holmes, J., Stapley, E., & Target, M. (2011a). *Experience of therapy interview*. Anna Freud Centre.

Midgley, N., Ansaldo, F., Parkinson, S., Holmes, J., Stapley, E., & Target, M. (2011b). *Thinking back about therapy interview*. Anna Freud Centre.

Midgley, N., Ansaldo, F., & Target, M. (2014). The meaningful assessment of therapy outcomes: Incorporating a qualitative study into a randomized controlled trial evaluating the treatment of adolescent depression. *Psychotherapy*, *51*(1), 128–137. https://doi.org/10.1037/a0034179

Murphy, R., & Hutton, P. (2018). Practitioner review: Therapist variability, patient-reported therapeutic alliance, and clinical outcomes in adolescents undergoing mental health treatment – A systematic review and meta-analysis. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, *59*(1), 5–19. https://doi.org/10.1111/jcpp.12767

Myburgh, N., Loxton, H., & Engels, R. C. M. E. (2021). Cross-cultural adaptation of an anxiety measure in a disadvantaged South African community context: Methodological processes and findings. *Transcultural Psychiatry*. https://doi.org/10.1177/13634615211011850

Myburgh, N., Muris, P., & Loxton, H. (2021). Promoting braveness in children: A pilot study on the effects of a brief, intensive CBT-based anxiety prevention programme conducted in the South African context. *Child Care in Practice*, 1–23. https://doi.org/10.1080/13575279.2021.1902785

Neelakantan, L., Hetrick, S., & Michelson, D. (2019). Users' experiences of trauma-focused cognitive behavioural therapy for children and adolescents: A systematic review and metasynthesis of qualitative research. *European Child and Adolescent Psychiatry*, *28*(7), 877–897. https://doi.org/10.1007/s00787-018-1150-z

Norton, P. J., & Kazantzis, N. (2016). Dynamic relationships of therapist alliance and group cohesion in transdiagnostic group CBT for anxiety disorders. *Journal of Consulting and Clinical Psychology*, *84*(2), 146–155. https://doi.org/10.1037/ccp0000062

O'Keeffe, S., Martin, P., Target, M., & Midgley, N. (2019). "I just stopped going": A mixed methods investigation into types of therapy dropout in adolescents with depression. *Frontiers in Psychology*, *10*, 1–14. https://doi.org/10.3389/fpsyg.2019.00075

Orlinsky, D. E., & Howard, K. I. (1986). Process and outcome in psychotherapy. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behaviour change* (pp. 311–385). Wiley and Sons.

Orlinsky, D. E., Ronnestad, M. H., & Willutzki, U. (2004). Fifty years of psychotherapy process-outcome research: Continuity and change. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 307–389). Wiley.

Padesky, C. A. (1993). Socratic questioning: Changing minds or guiding discovery. *A Keynote Address Delivered at the European Congress of Behavioural and*

Cognitive Therapies, London [Conference Presentation].

Podell, J. L., Kendall, P. C., Gosch, E. A., Compton, S. N., March, J. S., Albano Anne-Marie, A. M., Rynn, M. A., Walkup, J. T., Sherrill, J. T., Ginsburg, G. S., Keeton, C. P., Birmaher, B., & Piacentini, J. C. (2013). Therapist factors and outcomes in CBT for anxiety in youth. *Professional Psychology: Research and Practice*, *44*(2), 89–98. https://doi.org/10.1037/a0031700

Rapley, H. A., & Loades, M. E. (2019). A systematic review exploring therapist competence, adherence, and therapy outcomes in individual CBT for children and young people. *Psychotherapy Research*, *29*(8), 1010–1019. https://doi.org/10.1080/10503307.2018.1464681

Rennie, D. L. (1992). Qualitative analysis of the client's experience of psychotherapy: The unfolding of reflexivity. In *Psychotherapy process research: Paradigmatic and narrative approaches* (pp. 211–233). Sage.

Ritchie, J., Lewis, J., Nicholls, C. M., & Ormston, R. (Eds.). (2013). *Qualitative research practice: A guide for social science students and researchers*. Sage.

Robson, C. (2002). *Real world research* (2nd ed.). Blackwell Publishing.

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., Burroughs, H., & Jinks, C. (2018). Saturation in qualitative research: Exploring its conceptualization and operationalization. *Quality and Quantity*, *52*(4), 1893–1907. https://doi.org/10.1007/s11135-017-0574-8

Shahnavaz, S., Rutley, S., Larsson, K., & Dahllöf, G. (2015). Children and parents' experiences of cognitive behavioral therapy for dental anxiety: A qualitative study. *International Journal of Paediatric Dentistry*, *25*(5), 317–326. https://doi.org/10.1111/ipd.12181

Shedler, J. (2018). Where is the evidence for "evidence-based" therapy? *Psychiatric Clinics of North America*, *41*(2), 319–329. https://doi.org/10.1016/j.psc.2018.02.001

Sigurvinsdóttir, A. L., Jensínudóttir, K. B., Baldvinsdóttir, K. D., Smárason, O., & Skarphedinsson, G. (2020). Effectiveness of cognitive behavioral therapy (CBT) for child and adolescent anxiety disorders across different CBT modalities and comparisons: A systematic review and meta-analysis. *Nordic Journal of Psychiatry*, *74*(3), 168–180. https://doi.org/10.1080/08039488.2019.1686653

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological anlaysis: Theory, method and research*. SAGE Publications Ltd.

Spear, L. P. (2013). Adolescent neurodevelopment. *Journal of Adolescent Health*, *52*(2 SUPPL.2), S7–S13. https://doi.org/10.1016/j.jadohealth.2012.05.006

Spencer, L., Ritchie, J., Lewis, J., & Dillon, L. (2003). Quality in qualitative evaluation: A framework for assessing research evidence. In *National Centre for Social Research*.

Stallard, P. (2018). *Think good - feel good: A cognitive behavioural therapy workbook for children and young people* (2nd ed.). John Wiley & Sons, Ltd.

Stallard, P. (2021). *A clinician's guide to CBT for children to young adults* (2nd ed.). John Wiley & Sons, Ltd.

Sze, K. M., & Wood, J. J. (2008). Enhancing CBT for the treatment of autism spectrum disorders and concurrent anxiety. *Behavioural and Cognitive Psychotherapy*,

36(4), 403–409. https://doi.org/10.1017/S1352465808004384

Taylor, L., Creswell, C., Pearcey, S., Brooks, E., Leigh, E., Stallard, P., Waite, P., Clark, D. M., Stephens, G., & Larkin, M. (2021). Delivering cognitive therapy for adolescent social anxiety disorder in NHS CAMHS: A qualitative analysis of the experiences of young people, their parents and clinicians-in-training. *Behavioural and Cognitive Psychotherapy*, 398–412. https://doi.org/10.1017/S1352465821000047

Thomas, D. (2006). A general inductive approach for analyzing qualitative evaluation data. *American Journal of Evaluation*, *27*(2), 237–246. https://doi.org/10.1177/1098214005283748

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology*, *8*, 1–10. https://doi.org/10.1186/1471-2288-8-45

Thorne, S., Jensen, L., Kearney, M. H., Noblit, G., & Sandelowski, M. (2004). Qualitative metasynthesis: Reflections on methodological orientation and ideological agenda. *Qualitative Health Research*, *14*(10), 1342–1365. https://doi.org/10.1177/1049732304269888

Triandis, H. C. (1999). *Cross-cultural psychology*.

Vygotsky, L. (1962). *Thought and language*.

Wampold, B. E., Minami, T., Tierney, S. C., Baskin, T. W., & Bhati, K. S. (2005). The placebo is powerful: Estimating placebo effects in medicine and psychotherapy from randomized clinical trials. *Journal of Clinical Psychology*, *61*(7), 835–854. https://doi.org/10.1002/jclp.20129

Weber, M. (1949). Objectivity in social science and social policy. In E. A. Shils & H. A. Finch (Eds.), *The methodology of the social sciences* (pp. 50–112). Palgrave Macmillan.

Westra, H. A., & Dozois, D. J. A. (2006). Preparing clients for cognitive behavioral therapy: A randomized pilot study of motivational interviewing for anxiety. *Cognitive Therapy and Research*, *30*(4), 481–498. https://doi.org/10.1007/s10608-006-9016-y

Wilmots, E., Midgley, N., Thackeray, L., Reynolds, S., & Loades, M. (2019). The therapeutic relationship in Cognitive Behaviour Therapy with depressed adolescents: A qualitative study of good-outcome cases. *Psychology and Psychotherapy: Theory, Research and Practice*, 276–291. https://doi.org/10.1111/papt.12232

Yin, R. K. (2009). *Case study research design and methods* (4th ed.). Sage.

Chapter 3: Empirical Paper

'It's Hard Not to Use It': The Value of a Workbook for Practitioners Delivering Cognitive-Behavioural Therapy to Children and Young People

3.1 Abstract

Experimental research establishing the efficacy and effectiveness of CBT typically uses manualised protocols to ensure practitioners deliver the same treatment to all participants (Kiesler, 1994). However, practitioners have mixed views about the value of manuals, with some preferring to work based on professional judgment (Addis & Krasnow, 2000). Implementation science examines factors affecting intervention uptake, pragmatically considering how to achieve positive outcomes in real-world conditions (Bauer & Kirchner, 2020). This approach is relevant to the field of CBT, where there is an implementation gap between research and practice (Kelly, 2016). The current study examined how practitioners use a non-manualised CBT workbook (Think Good – Feel Good, TGFG) when working with CYP (Stallard, 2002). A convergent mixed-methods design was employed, with an online survey producing qualitative and quantitative data from 238 respondents and semi-structured interviews with six practitioners (Creswell & Clark, 2017). Data were analysed separately using content and statistical analysis (surveys) and thematic analysis (interviews) before being integrated using a joint display (Braun & Clarke, 2013; Krippendorff, 2018). Key findings were that growing practitioner confidence facilitates flexible workbook usage; practitioners pragmatically combine therapeutic modalities; cognitive resources from workbooks are the most used; both CYP and practitioners have views around manualization; workbook resources can explain content and build therapeutic alliance; and there are risks and benefits to the increased accessibility to CBT provided by workbooks. Recommendations for practice, recommendations for future research, and limitations are discussed.

3.2 Introduction

3.2.1 Evidence-based practice

Originating in medical professions, evidence-based practice (EBP) describes that the combination of practitioner expertise (individuals' judgment and knowledge) and research evidence leads to the most effective outcomes for patients (Sackett et al., 1996). This has been implemented in psychological professions, with additional consideration given to preferences and backgrounds of 'patients' (American Psychological Association, 2006). For an intervention to be evidence-based (EBI), efficacy trials must be undertaken (Bauer et al., 2015). These occur in highly-controlled settings to establish causal relationships between interventions and outcomes, prioritising internal validity (Barker et al., 2016).

The logic of EBP involves rigorously testing interventions then teaching practitioners to use them. In practice, there are challenges associated with implementing EBIs, which have been conceptualised as the 'implementation gap' (Kelly, 2016). One means of bridging this gap is conducting effectiveness trials, which control variables and measure outcomes but occur in natural settings and prioritise external validity (Gartlehner et al., 2006). Efficacy trials ask '*can* this work in ideal conditions?'; effectiveness trials ask '*will* this work in real-world conditions?' (Shaw & Pecsi, 2021).

The role of EPs has been described as scientist-practitioner (Lane & Corrie, 2006) or applied scientist (Barker et al., 2016), integrating scientific knowledge and principles into practice in the vein of EBP (Fallon et al., 2010). However, not all EPs see their role this way, perhaps because they lack confidence with research or perhaps because EBP contradicts their values of being guided by experience and reflection (Fox, 2003).

3.2.2 Implementation science

Even if there is evidence that an intervention works in practice, there is no guarantee it will routinely be delivered by practitioners. Studies have estimated it may take up to 17 years for innovative research to become routine practice (Morris et al., 2011). Implementation science aims to identify and address facilitators and barriers to intervention usage in practice (Bauer & Kirchner, 2020). It considers acceptability of interventions to providers and recipients, skills and knowledge of providers, and organisational context demands (Forman & Barakat, 2011).

The model of clinical readiness levels (CRL) provides a means of judging the extent to which an intervention is supported by efficacy, effectiveness, and implementation evidence (Shaw & Pecsi, 2021). CRL could be a useful tool for scientist-practitioners but it relies on infrastructure that does not necessarily exist. Many journal articles are locked behind paywalls, inaccessible to practitioners (Shaw & Pecsi, 2021). Even if research is accessible, practitioners must evaluate a minefield of factors affecting validity and reliability including publication bias, underpowered studies, p-hacking, and the fact that 50-70% of results may not be reproduced under experimental replication (D'Intino et al., 2018; Open Science Collaboration, 2015). In this context, it is little wonder many EPs prefer to trust their gut (Fox, 2003).

3.2.3 Fidelity and flexibility

Well-evidenced or not, many interventions exist and are widely used by EPs to achieve positive outcomes for CYP (Fallon et al., 2010). In recent years, there have been calls for increased intervention for CYP with mental health difficulties (Department of Health and Department of Education, 2017). CBT has one of the strongest evidence bases for supporting CYP with common difficulties such as anxiety and low mood (David-Ferdon & Kaslow, 2008; Sigurvinsdóttir et al., 2020). Much CBT research uses manuals: standardised guidelines about the theory, sequencing, content, and procedures of sessions (Kiesler, 1994; Marshall, 2009). While

manualization is favoured methodologically for maximising internal validity, another way of delivering CBT is formulation-based, where practitioners make decisions based on experience and judgment (Nezu, 2020). In a survey of 125 UK-based professionals treating eating disorders, 16% 'rarely' or 'never' used manuals whilst 51% 'often' or 'always' used manuals, suggesting manuals are widely used in practice (Waller et al., 2013).

The issue of manualization provokes strong opinions among practitioners, going beyond treatment effectiveness and prompting reflection on professional identity (Addis & Krasnow, 2000). Opponents typically resent the loss of flexibility and diminished importance of professional expertise, claiming manuals restrict practitioners' ability to respond to idiosyncratic situations (Drisko & Grady, 2019; Shedler, 2018). Proponents suggest manuals are informative, supportive, and accessible, meaning professionals can be easily and widely trained to deliver effective interventions (Singla et al., 2018). A review comparing manualised with non-manualised forms of the same psychotherapy found two studies supporting non-manual superiority and four studies showing no difference (Truijens et al., 2019).

These studies broadly saw manualization as a dialectic: either practitioners followed manuals with fidelity or followed their judgment with flexibility. Most practitioners report modifying manuals (Durlak & DuPre, 2008) which may be wise because, in a review of 47 studies, manual fidelity was not consistently associated with effectiveness (Truijens et al., 2019). Kendall and Beidas (2007) argue for a compromise, 'flexibility within fidelity'. This suggests, for example, that practitioners working with anxious CYP should always undertake exposure tasks during certain sessions, but the nature of exposure should address the individual's anxiety, as judged by the practitioner. Chorpita et al. (2005) describe a continuous manualization scale, suggesting all facets of manuals could be varied to differing degrees. Keeping in mind the ultimate objective of improving outcomes for CYP, the important issues are identifying which treatment

components are crucial, which can or should be adapted, and how this should be done (Durlak & DuPre, 2008).

3.2.4 Workbooks

Workbooks occupy an interesting position in the fidelity-flexibility debate. They typically describe themselves as non-prescriptive collections of materials to help practitioners adapt psychological approaches or interventions (including CBT) for specific circumstances. One example of a CBT workbook is Think Good – Feel Good (TGFG) (Stallard, 2002, 2018a). It is available to the public and widely-used by EPs; a survey of Principal EPs in Scotland found that, of 21 services in which EPs delivered CBT interventions, TGFG was used in 12 services (57%). TGFG contains background material on CBT, psychoeducational material, and worksheets to explore key concepts. It is accompanied by a Clinician's Guide (CG) focussing on the CBT process (Stallard, 2005, 2021). TGFG chapters introduce thoughts, feelings, and behaviours before looking at controlling and changing each area.

To the researcher's knowledge, there is currently no peer-reviewed research exploring usage or effectiveness of TGFG or other CBT workbooks. Two unpublished dissertations involved delivering standardised programmes based on TGFG materials to 4th-6th grade children with anxiety (Erhardt, 2019) and year 5 classes (Brightmore, 2016). Both studies found equivocal results and had statistical weaknesses such as failing to establish stable baselines and undertaking several uncorrected tests. Furthermore, by idiosyncratically designing standardised programmes, these studies limited their external validity. Practitioners could not easily replicate such programmes and are discouraged from doing so by TGFG.

3.2.5 The current study

When EPs and other practitioners use or recommend interventions, they frequently face dilemmas around whether there is strong evidence of effectiveness and how interventions will be implemented in specific circumstances. CBT is a widely used and

potentially beneficial intervention that can be delivered in myriad ways. The concept of the workbook as a set of resources and guiding principles is under-explored in the research literature but potentially useful for practitioners looking to combine the benefits of evidence-based practice with flexibility. The current study focusses on TGFG as an example of a widely-used workbook, considering how the format helps practitioners and how the format compares with other modes of delivery. This study aims to explore the views of practitioners, provide insight for those designing interventions, and inform theoretical discussions around intervention delivery.

There are two research questions (RQs):

- How do practitioners typically use TGFG?
- What is helpful about supplementary resources for practitioners providing mental health support?

3.3 Method

3.3.1 Overview

This study used a two-phase, convergent mixed-methods design (Creswell & Clark, 2017; Jick, 1979). The researcher collected quantitative and qualitative data simultaneously; analysed the data separately; then integrated the analyses to compare the results, explore points of convergence and divergence, and gain more in-depth answers to the RQs (Creswell & Clark, 2017; Morse, 1991). Phase one consisted of an online survey with closed and open questions, producing quantitative and qualitative data. A fixed, cross-sectional design was used, with a self-report survey administered once. Phase two consisted of online semi-structured interviews, producing qualitative data.

The reason for conducting a survey was to collect data from many participants, to explore how TGFG is *typically* used and the *breadth* of usage. The reason for conducting interviews was to gain detailed perspectives on how TGFG is used and

allow sensitive consideration of personal issues related to working as a mental health practitioner. The benefits of an online survey are that it is easy for the researcher to distribute widely, anonymous, and quick for participants to respond. The drawbacks are that it is inflexible and does not facilitate nuanced responses. Interviews complemented the survey, providing richness about a few practitioners' experiences alongside surface-level information about many practitioners' experiences.

This study took a theoretical perspective of pragmatism (Creswell & Clark, 2017). This perspective holds that knowledge is important so far as it is useful and practical for human endeavour (Barker et al., 2016; Moon & Blackman, 2014). Epistemologically, pragmatism is informed by constructionism, which holds that knowledge is created through individuals' interpretations of experiences and surroundings (Moon & Blackman, 2014). Methodologically, pragmatism embraces pluralism as data collection methods are chosen for their ability to provide useful information rather than ideological reasons and can be used in combination. A summary of the researcher's philosophical considerations is provided in Figure 3.1.

Figure 3.1

Philosophical Considerations and Research Procedures
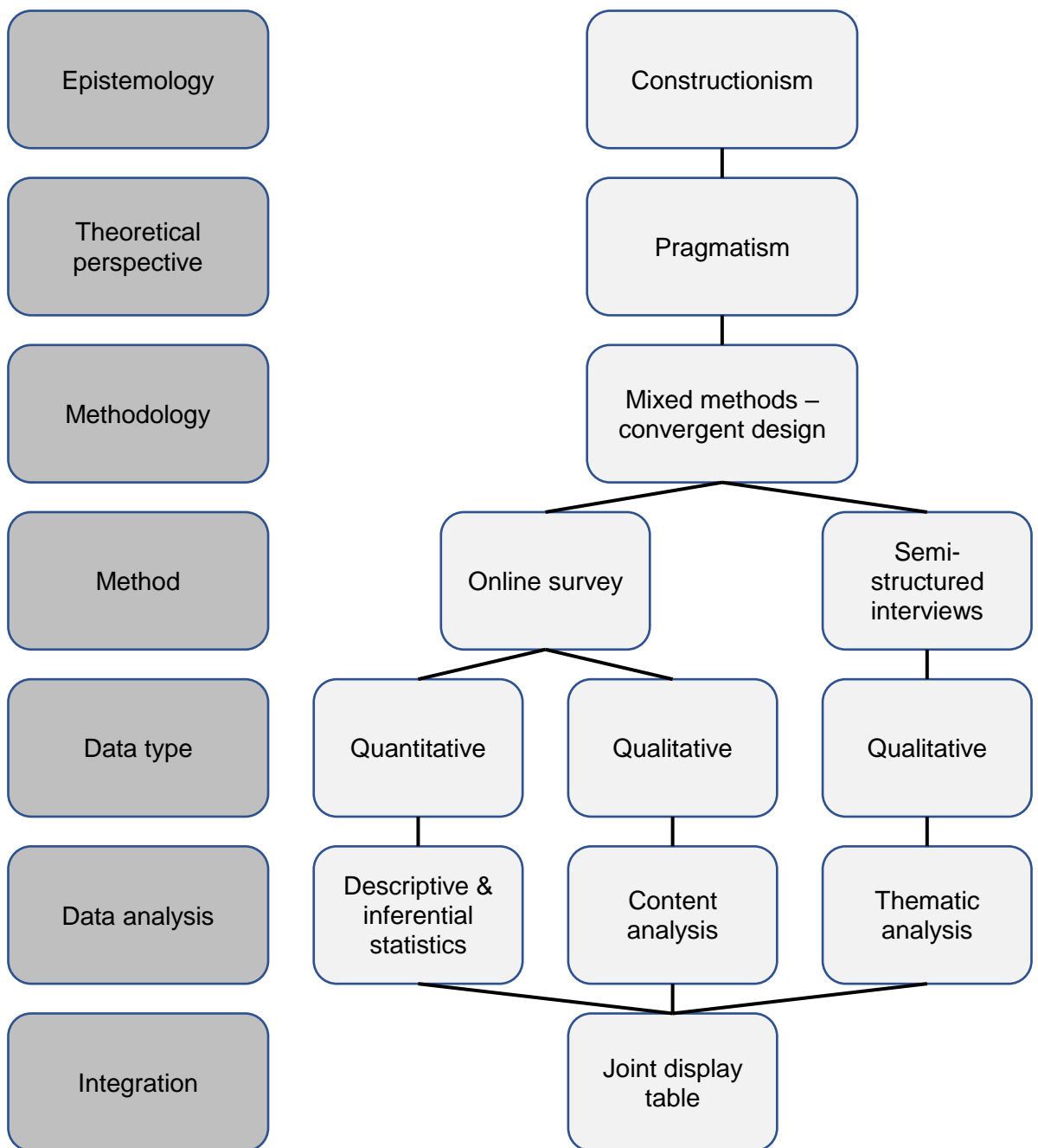
3.3.2 Survey phase

3.3.2.1 Participants

A purposive sampling strategy was pursued (Robson, 2002). The researcher used subjective judgment to make the survey available to those who may have used TGFG. Recruitment targeted psychological professionals since they were likely to have experience, training, and insight on the matters of interest. Participants were primarily recruited through responding to emails containing the survey hyperlink. Emails were sent to programme directors of educational and clinical psychology doctoral training courses in the UK and Ireland, principal EPs of local authority services in the UK and Ireland, programme directors of education mental health practitioner and child wellbeing practitioner courses, and EPNET (a public forum for EPs). In addition, the survey was distributed through word of mouth, personal contacts, and social media. Appendix E lists where the survey was shared.

Following distribution, the researcher was reliant on participants' willingness to take part and ability to access technology. This may have led to volunteer bias among the sample (Barker et al., 2016). It is possible practitioners were more likely to participate if they had strong views about TGFG, had used TGFG recently, had more free time, or were confident navigating online surveys.

The sample population was practitioners with experience using TGFG to support CYP. The inclusion criterion was that participants had previously used TGFG with CYP aged 5-18, verified by an eligibility question in the survey.

A priori power analysis was conducted with G*Power software to determine the minimum number of participants (Faul et al., 2007). The test family was χ^2 and the statistical test was goodness-of-fit for contingency tables. The parameters set were a medium effect size, significance level of .05, and power of .8. Degrees of freedom

were calculated for the most complex contingency table as 15. The minimum desired sample size was 210 participants.

Of 271 organisations contacted, 69 (25.5%) confirmed sharing the survey. There were 1790 visits to the initial information page (the same individuals may have accessed the survey several times). There were 1402 (78.3%) instances of respondents not navigating further and twenty-six instances of navigating to, but not answering, the eligibility question. Forty-one respondents were screened out by the eligibility question. Of 362 individuals who self-identified as eligible, 238 submitted responses. This gives a response rate of 13.3% from visits to the initial information page and a completion rate of 65.7% from individuals who self-identified as eligible. Participants were anonymous but demographic information was collected (Table 3.1).

Table 3.1

Demographics of Survey Participants

Characteristic	Option	Frequency	Percentage
Years of experience working in CYP's mental health	<1	6	2.5
	1-2	22	9.3
	3-5	64	27.1
	6-10	60	25.4
	11+	84	35.6
Level of training before first using TGFG[a]	Self-taught by reading the workbook / clinician's guide	102	43
	General CBT training, not specific to TGFG	169	71.3
	Training specifically about TGFG	7	3
	None of the above[b]	22	9.3
Country working in children's mental health[c]	United Kingdom	109	47
	England	78	33.6
	Scotland	19	8.2
	Northern Ireland	6	2.6
	Wales	5	2.2
	Ireland	5	2.2
	Australia	2	0.9

Characteristic	Option	Frequency	Percentage
	Gibraltar	1	0.4
	United States of America	1	0.4

[a] Participants could respond to multiple options on this question.

[b] The survey had an 'other' option; the researcher re-coded any responses that were clearly described by existing options before re-coding remaining responses to 'none of the above'.

[c] This was an open question; responses reflect how participants chose to identify their country of work.

3.3.2.2 Procedure

The survey was designed using Jisc Online Surveys. This platform is hosted on UCL infrastructure and does not require third party data processing (Information Commissioner's Office, 2019). A pilot survey was created and sent to two trainee EPs. Minor alterations were made based on their feedback. The survey became live on 9 November 2020 and closed on 24 June 2021. The survey was self-administered by participants on behalf of their individual perspective (Robson, 2002) and took 5-10 minutes to complete. See Appendix F for the full survey.

The survey opened with a welcome page explaining the study, eligibility, and data processing. There followed a mandatory eligibility question to ensure participants had previously used TGFG. The main survey contained 16 questions in five sections: The support you provide, The CYP with whom you work, Your use of the TGFG workbook, Your opinions on TGFG, and About you. There was a notice offering the opportunity for participation in interviews before a thank you notice. Participants provided consent for data collection by clicking 'submit' at the end of the survey. Three question types were used: single choice between multiple options, multiple choice between multiple options, and open text response. 'Other' responses were permitted where the options were not exhaustive and to avoid presenting too many options.

User experience was considered (Barker et al., 2016; Robson, 2002). This was important ethically, to ensure participants felt comfortable; and empirically, to motivate

participants to complete the survey and provide honest, detailed data. The opening questions had multiple options or sought short responses, with later questions seeking longer responses, to help participants settle (Dillman et al., 2014). The topics addressed by questions went from descriptive, seeking data on when TGFG is used, to evaluative, seeking data on how TGFG is used, to personal, seeking opinions on why TGFG is useful. Demographic questions, which could be sensitive, came at the end to avoid feelings of intrusiveness at the beginning and signal that the survey was closing (Harvard University, 2007). Questions were divided into sections to show how questions were related and provide a feeling of staged progression through the survey. All questions were optional so could be skipped.

Item wording was considered (Barker et al., 2016). Questions were short, avoided emotive language and jargon, avoided leading participants towards certain responses, and addressed specific issues (Bradburn et al., 2004). This was important to ensure construct validity, that data were being collected on the concepts intended (Barker et al., 2016).

3.3.2.3 Analysis

Quantitative data were analysed using descriptive and inferential statistics. For multiple-choice questions, frequency counts and percentages were calculated using Microsoft Excel. Inferential statistical analyses were conducted using IBM SPSS Statistics Versions 27 and 28.

Chi-square (χ^2) tests were conducted to compare responses. To meet the assumption of independence, only questions with single forced-choice responses were analysed: Questions 2, 3, 8, 9, 15, and 16. Data from Question 16 (Q16) were originally multiple choice but were edited to create a variable that could be analysed. Data from participants who *only* selected 'self-taught' or 'general CBT training' were re-coded to a single variable. All other data were disregarded.

Conceptual justifications were made for each comparison to minimise the number of tests conducted and the possibility of Type 1 errors (Field, 2013). Q15 and Q16 were compared to the other four questions because it was hypothesised that practitioner experience and training levels would affect workbook usage. Q8 and Q9 were compared because it was hypothesised that practitioners who read from the workbook directly in sessions would be more likely to use worksheets. To meet the assumption of all expected counts in the contingency tables being above 5, it was necessary to combine some responses (Table 3.2). In larger contingency tables, all expected counts should be above 1 and no more than 20% should be below 5 (Field, 2013). Where omnibus chi-square tests were significant, post-hoc explorations were conducted by analysing standardised residuals (z), the standardised difference between observed and expected values in each cell of the contingency table (Sharpe, 2015). Standardised residual values of +/- 2 were considered statistically significant. Cramér's V (φ_c) effect sizes, ranging from 0-1, were reported, as measures of association between categorical variables.

Table 3.2

Data Alterations Made to Satisfy the Assumptions of Chi-Square Tests

Question	Original responses	Combined category	Statistical consequences[a]
2	'Groups', 'Both individuals and groups'	'People who use TGFG with groups at least some of the time'	No expected counts below 5
3	10-12, 13-15, 16+	10+	6.3% expected counts below 5, none below 1
8	'I read directly from the workbook, sharing it with the child', 'I read directly from the workbook but don't share it with the child'	'I read directly from the workbook'	No expected counts below 5

9	'I give the child printed worksheets to complete for homework', 'I do not make use of the worksheets'	'I do not use worksheets in sessions directly'	12.5% expected counts below 5, none below 1
15	<1, 1-2	0-2	N/A

[a] These are in the contingency table of each question with Q15

Qualitative data were analysed using content analysis, a method of quantifying qualitative data (Krippendorff, 2018). Content analysis involves calculating frequencies of categories within qualitative data. This method was chosen because the survey produced a large amount of referential data without much detail or contextualisation. Furthermore, the aim was to understand how practitioners *typically* use TGFG, which requires quantitative data showing proportions. Given the geographic representation and large sample size achieved, it was hoped quantitative findings could be generalised to UK-based mental health practitioners. The data analysis process is outlined in Table 3.3 (see Appendix M for annotated screenshots). Data alterations were made before analysis (Appendix G) (Robson, 2002).

When conducting content analysis, it is crucial to define how data is unitized (Krippendorff, 2004). A unit is an individual element that can be distinguished from other elements and counted. Two ways of defining units were employed: categorical and thematic distinctions. For Q10 and Q11, a deductive coding process was followed, the focus was on manifest content of responses (Potter & Levine-Donnerstein, 1999), and categorical distinctions were made based on lists of worksheets and chapters in TGFG (Krippendorff, 2004). Participants responded to these questions variously: worksheet titles, page numbers, descriptive references to specific worksheets, and descriptive comments about worksheets generally. The two editions of TGFG have different worksheets, chapters, and page numbers. This complicated the coding process because it was not always clear which edition participants used. The researcher assumed participants used the first edition, unless otherwise stated, since the second edition was released recently (2018), although this

may have led to coding inaccuracies. For the remaining survey questions, and general descriptive responses to Q10 and Q11, an inductive coding process was followed, the focus was on latent patterns in responses (Potter & Levine-Donnerstein, 1999), and thematic distinctions were made based on the researcher's judgment (Krippendorff, 2004). Categorical distinctions are simpler and more reliable because they are based on pre-existing exhaustive lists but thematic distinctions are potentially more analytically meaningful.

Table 3.3

Content Analysis Process

Phase	Process description
1. Familiarisation with data	• Responses copied verbatim into the left-hand column of tables in Word (except Q14, which was analysed using NVivo due to the quantity and detail of responses) • Read through responses and noted points of interest
2. Coding	• For each response, either created a new code or coded to a pre-existing code, indicating this in the right-hand table column • Where appropriate, re-coded responses to original categories • Each survey question had its own table and set of codes • Individual responses coded in multiple ways if appropriate • Responses marked as 'irrelevant' if they did not pertain to the question, or 'unclear' if they could not be confidently categorised, and not analysed
3. Frequency counting	• Frequency count of each code made using Excel

3.3.3 Interview phase

3.3.3.1 Participants

A purposive sampling strategy was pursued (Robson, 2002). Emails were sent to EPNET and a survey page advertised the opportunity for interview participation. This

was added after the approval of an ethics amendment on 17 February 2021, meaning 176 respondents did not see the page.

It was neither necessary, nor prohibited, for participants to have responded to the survey before or after the interview. There were two inclusion criteria:

1. The practitioner had received formal training in CBT
2. The practitioner had experience using TGFG with individuals or groups of CYP aged 5-18

Interested individuals were sent an Information Sheet (Appendix H) outlining what involvement would entail. Individuals were encouraged to ask questions and seek clarifications. They were asked to read and sign a Consent Form (Appendix I). Participants kept copies of these.

Six individuals were interviewed. Demographic data, collected through a form (Appendix J), are displayed in Table 3.4. Five interviewees were White British, one was White British and Asian, four were female, and all were either TEPs or EPs. Interviewees ranged in age from 31 to 66, in EP experience from 2 to 22 years, and in TGFG experience from 2-3 uses to 11+ uses. Interviewees had experience with a range of versions of TGFG; the only resource not used by any participant was the second edition of the CG (Stallard, 2021).

The decision to halt recruitment was practical and theoretical. Practically, the volume of data was appropriate for the time restrictions on the researcher. Theoretically, the decision related to saturation, the point at which further data collection is unnecessary as it would be unlikely to result in important new ideas (Guest et al., 2006; Saunders et al., 2018). Guest et al. (2006) analysed 60 interviews and found 94% of high-frequency themes could be identified within the first six interviews and that saturation was achieved within 12 interviews. In this study, after six interviews, major ideas were recurring and many had been expressed in survey responses.

Table 3.4

Demographics of Interview Participants

	Age	Gender identity	Ethnicity	Years' experience	Most recent role[a]	CBT training and experience	Times used TGFG	Versions of TGFG used[b]
1	32	Female	White British	2.5	TEP	Brief training as TEP, taught CBT as A level psychology teacher	2-3	TGFG (2018), TGFB
2	33	Male	White British	6	EP	Substantial training as TEP	6-10	TGFG (2002), TGFG (2018)
3	66	Female	White British	22	EP	12 full days' training through local authority	11+	TGFG (2002)
4	31	Female	White British	2.5	EHWP, TEP	Masters level mental health training	11+	CG (2005)
5	44	Female	White British	15	EP	Brief training as TEP, training through local authority	6-10	TGFG (2002), CG (2005)
6	31	Male	White and Asian	2	TEP	Substantial training as TEP	2-3	TGFG (2018), TGFB

[a] EHWP – Emotional health and wellbeing practitioner; EP – Educational psychologist; TEP – Trainee educational psychologist

[b] CG (2005) – A Clinician's Guide to Think Good – Feel Good (2005); TGFB – Thinking Good – Feeling Better Workbook (2018) (Stallard, 2018b); TGFG (2002) – Think Good – Feel Good Workbook, 1st Edition (2002); TGFG (2018) – Think Good – Feel Good Workbook, 2nd Edition (2018)

3.3.3.2 Procedure

A pilot interview was conducted with a personal contact who was a clinical psychologist and TGFG user. Minor alterations were made based on her feedback.

Interviews were conducted using Microsoft Teams. Interviews were recorded and transcripts were produced automatically by Teams. These were edited prior to data analysis. Identifying data were replaced with pseudonyms.

Interviews were guided by a semi-structured schedule (Appendix K) to provide a consistent framework alongside enabling flexibility based on participants' responses (Robson, 2002). Interviews began with an introductory statement before a question about professional experience, five open-ended questions, a summary question about the main reason for using TGFG, and an opportunity to say anything additional. The main questions were posed to every participant. Follow-up probes were used to further explore issues raised or enquire about issues not raised (Turner, 2010; Zeisel, 1984). The guiding principles behind the schedule were to expand upon survey findings and explore more sensitive topics, namely practitioner identity and comparison with other CBT delivery methods.

Interviewee experience and comfort were considered. The introductory statement and opening question aimed to settle and inform interviewees. Participants could choose not to answer any question without giving a reason. Tact and sensitivity were employed by the interviewer, particularly when posing personal questions around identity and confidence. Interview length was constrained to one hour to respect participants' time and avoid fatigue.

3.3.3.3 Analysis

Data were analysed using thematic analysis (Braun & Clarke, 2006). Thematic analysis is theoretically and methodologically flexible. It involves analysing textual data to identify meaningful ideas (codes) and patterns that connect codes (themes).

An adapted six-phase process of thematic analysis was employed (Table 3.5) (Braun & Clarke, 2006).

There were three analysis stages. The first was informal, noting comments whilst reading transcripts. The second was coding, using NVivo (see Appendix M for annotated screenshots). A 'code' was defined as a distinct piece of meaningful information relevant to the RQs (Braun & Clarke, 2013). Researcher-derived coding was used, going beyond the language of participants and labelling codes based partially on researcher interpretation but remaining close to the manifest content of responses (Braun & Clarke, 2013; Ely et al., 1998). A complete coding approach was taken, identifying everything of interest within the dataset (Braun & Clarke, 2013). The third stage was identifying themes. A 'theme' was defined as a prominent pattern that connected several codes and could be identified across multiple (but not necessarily all) participants' responses (Braun & Clarke, 2013). This involved a high degree of researcher interpretation. Themes were structured laterally, with causal and associative links as perceived by participants, and hierarchically, with sub-themes that captured distinct but related components (Braun & Clarke, 2013).

Table 3.5

Thematic Analysis Process

Phase	Process description
1. Familiarisation with data	• Transcripts produced automatically by Teams and copied verbatim into Word • Transcripts edited for accuracy and legibility • Noted points of interest and patterns during transcription editing process using Word 'comments' • Read through transcripts again, noting further points of interest
2. Generating initial codes	• Edited transcripts copied verbatim into NVivo • Complete, researcher-derived coding of each transcript • Extracts coded in multiple ways if appropriate, with no limit to the number of codes for an individual extract • Ongoing process of refining, combining, adding, and re-labelling codes

Phase	Process description
3. Searching for themes	• Identified ideas that connected several codes
4. Reviewing themes	• Initial thematic map drafted on paper then on PowerPoint • Considered associative and perceived causal connections between themes, as articulated by participants
5. Defining and naming themes	• Gave representative labels to themes and sub-themes • Categorised codes under themes – not every code was categorised as it was important to be concise • Checked themes and sub-themes against codes and transcripts for validity and representativeness
6. Producing the report	• Systematically read through data on all codes to choose a selection of the most important codes in relation to the RQs • Chose representative extracts to illustrate themes and allow readers to evaluate the researcher's reasoning • Wrote 'Results' section reporting key ideas and extracts • Wrote 'Discussion' section, thinking analytically about the implications of the results and linking them to the wider literature

3.3.4 Integration

Integration, where qualitative and quantitative datasets interface, is one of the defining features of a mixed methods study (O'Cathain et al., 2007). Within this study's convergent design, datasets were analysed and reported separately before comparisons were made across datasets. The intention was to provide new insight that would not arise from either dataset alone (Creswell & Clark, 2017). A joint display table was constructed, setting survey and interview results side-by-side (Guetterman et al., 2015). The table was ordered by topics of importance to RQs. Meta-inferences were made about whether results showed confirmation (agreement or consistency), discordance (disagreement or inconsistency), or expansion (interviews clarified or extended survey data) (Teddlie & Tashakkori, 2009).

3.3.5 Reflection

Given the lack of previous research on TGFG, this study took an exploratory approach, meaning the researcher played an active role in designing data collection measures (Stebbins, 2001). The researcher's choices in linguistic phrasing, ordering, and design of questions influenced how participants thought about the issues raised. The researcher's experiences and perspectives influenced data analysis; other researchers may have reached different conclusions based on the same data (Kvale, 1994). The researcher had three and a half days' CBT training and a small amount of experience using TGFG. The researcher had quantitative and qualitative methods training but no experience using qualitative or mixed methods in primary research. The researcher was continually learning and reflecting on theoretical and methodological decisions. The researcher was part of the same profession as all interviewees and many survey respondents. Shared professional experiences helped build rapport during interviews and may have made participants feel more comfortable. It is possible the researcher and participants had implicit understandings of aspects of practice that were not explored as fully as they could have been.

Measures were taken to enhance credibility (ensuring research addresses its intended aims) and trustworthiness (ensuring research is documented systematically) (Bazeley, 2013; Braun & Clarke, 2013). The researcher kept diary notes on developing thinking and reasoning behind decision-making, which informed the writing up process. Transcripts were produced by computer software and edited for accuracy. The researcher engaged in self-reflection while conducting thematic analysis; refining, revising, and checking codes and themes against transcripts. This was to avoid altering the meaning and context of participants' language and to ensure themes accurately and comprehensively reflected the data (Bazeley, 2013; Braun & Clarke, 2013). The mixed methods methodology allowed for triangulation of findings

from surveys and interviews, lending credibility to those which were confirmed and prompting consideration of those showing discordance or expansion.

3.4 Results

3.4.1 Survey phase

The large number of survey responses suggests a representative view was gained of how practitioners, particularly EPs, use TGFG. These data are valuable given the paucity of existing research about CBT workbooks, providing a bottom-up perspective to compare against recommendations from controlled trials. Full survey results are provided in Appendix L.

3.4.1.1 Content analysis

The researcher intended the survey to be as accessible as possible, so little guidance was provided on how to respond to open questions. One consequence of this was that the format and content of responses, and the conditions under which participants responded, varied greatly. A brief discussion of this variety will be provided before the results of the content analysis are presented alongside descriptive statistics, ordered by survey headings.

Questions 6-9, 12, 13, and 16 had 'Other' response options. Whilst Q12 had three 'Other' responses, Q7 had 74. This suggests the response options provided by the researcher for certain questions were reductive, meaning the data may be misrepresentative. Participants may have selected more options if they had been provided, even if they didn't explain them as 'Other' responses.

Length and detail of responses varied. For Q10, one participant listed 15 worksheets whilst some participants listed one, described types of worksheet, or listed page numbers. This suggests some participants responded to the survey from memory whilst others likely had TGFG in front of them for reference. The alternative to having

an open question would have been listing over 70 worksheets as options, but this would likely have alienated participants through being overly long. This illustrates the difficulty of balancing the collection of a comprehensive dataset with keeping participants engaged.

3.4.1.2 Descriptive statistics

3.4.1.2.1 The support you provide

Most participants used TGFG exclusively with individuals (75.11%). Very few used TGFG exclusively with groups (3.38%). The rest used it with both individuals and groups (21.52%). The most common average number of TGFG sessions was 4-6 (46.64%), with a sizable proportion using 1-3 (20.59%) or 7-9 (19.3%), fewer using 10-12 (10.9%) or 13-15 (2.5%), and none using 16+.

3.4.1.2.2 The CYP with whom you work

The youngest age of CYP with whom TGFG was used was $M = 9.01$ ($SD = 2.26$) with a range of 5-16. The average age was $M = 11.26$ ($SD = 2.03$) with a range of 7-17. Almost all participants used TGFG for CYP with anxiety (96.2%). Participants also used TGFG for CYP with behaviours that challenge (64.1%), depression / low mood (60.8%), emotionally-based school avoidance (39.2%), attachment difficulties (32.9%), difficulties with attention / hyperactivity (27.4%), and bullying / social exclusion (24.9%). Of participants who selected 'Other', nine further responses were coded, indicating practitioners used TGFG to address a wide range of difficulties. When deciding whether TGFG was an appropriate intervention, most participants indicated it depended on the nature of CYP's difficulties (87.4%), many indicated it depended on the severity of difficulties (41.2%), and few always used TGFG for all difficulties (1.3%). Of 'Other' responses, 28 participants indicated their decision would depend on CYP's level of understanding / language. Other common responses were that it would depend on the practitioner's judgment, CYP's motivation, and practical constraints such as time.

3.4.1.2.3 Your use of the TGFG workbook

Most participants did not read directly from the workbook during sessions, instead using it as a prompt / reminder (40.7%) or planning aide (36.4%). Of those who read directly from the workbook, most shared it with the child (17.4%) rather than keeping it to themselves (0.4%). Most participants used printed worksheets during sessions (79.7%). Some used them for homework (6.4%). Some did not use worksheets (7.2%). Worksheets that engaged CYP's attention included 'What thinking errors do you make?' (33 references), 'The magic circle' / 'The negative trap' (20), and 'Thought / Feelings thermometer' (17). Common descriptive responses included that CYP were engaged by worksheets with visuals (11), worksheets involving drawing (6), and practical / concrete worksheets (3). Specific chapters participants found helpful included 'Thinking Errors' (46), 'Thoughts, feelings, and what you do' (27), 'Automatic thoughts' (26), and 'Balanced thinking' (20). The top six named chapters had a primarily cognitive focus.

3.4.1.2.4 Your opinions on TGFG

The most helpful aspects of TGFG were worksheets (80.2%), use as a planning aide (80.2%), introductory CBT chapters (46%), characters (43.9%), and 'Helpful tips' sections (31.6%). Despite Stallard not intending TGFG to be prescriptive, 19.8% of participants used TGFG as a 'manual' to read from. The aspects of TGFG that practitioners thought CYP found most engaging were worksheets (84.1%), characters (45.8%), and 'Helpful Tips' sections (28.2%). Only 8.4% thought CYP found reading directly from the workbook themselves engaging. Many responses to the open-ended question about TGFG usage reflected themes from interviews and are discussed in the joint display table. For example, participants combined TGFG with other approaches (20), used TGFG flexibly (19), did not follow TGFG in a manualised fashion (16), and used it to plan (15).

3.4.1.3 Inferential statistics

Table 3.6 provides a summary of chi-square tests conducted and whether they were statistically significant at the $p < .05$ level. Four out of ten tests were significant and are elaborated statistically and descriptively.

There was a significant association between years of experience and whether TGFG was used with individuals or groups, $\chi^2 (3) = 15.199$, $p = .002$, $\phi_c = .254$. Participants with 6-10 years' experience were significantly more likely to use TGFG with groups than expected ($z = 2.6$). Participants with 0-2 years' experience were less likely to use TGFG with groups at a level approaching significance ($z = -1.9$). There was not a linear relationship between years of experience and likelihood of using TGFG with groups, since participants with 11+ years' experience were less likely to use TGFG with groups ($z = -1.1$).

There was a significant association between how participants used TGFG within sessions and whether they used worksheets, $\chi^2 (2) = 9.458$, $p = .009$, $\phi_c = .21$. The great majority of respondents used the worksheets. These respondents were distributed across the Workbook groupings in line with chance expectation. Of those who didn't use the worksheets, fewer than would be expected by chance read directly from the workbook ($z = -2.2$), and more than expected by chance only used the workbook to plan ($z = 1.8$).

There was a significant association between years of experience and type of training, $\chi^2 (3) = 13.253$, $p = .004$, $\phi_c = .289$. Participants with 0-2 years' experience were significantly more likely to be self-taught than expected ($z = 2.1$). There were opposing and consistent (although non-significant) trends in the standardised residuals. For self-taught participants, standardised residuals *decreased* through years of experience, whereas for participants with CBT training, standardised residuals *increased* through years of experience. In essence, being self-taught was associated with having less experience, whilst having CBT training was associated with having more experience.

There was a significant association between how participants used TGFG within sessions and type of training, χ^2 (2) = 15.34, p < .001, ϕ_c = .315. Self-taught participants were significantly more likely to read directly from the workbook than expected (z = 2) and significantly less likely not to read directly from the workbook than expected (z = -2.3). The opposite trend was observed in the standardised residuals of participants with CBT training, although they were non-significant.

There were no significant associations between years of experience and average number of TGFG sessions, χ^2 (9) = 10.667, p = .299, how participants used TGFG within sessions, χ^2 (6) = 10.54, p = .104, or whether participants used worksheets, χ^2 (3) = 3.75, p = .29. There were no significant associations between type of training and whether TGFG was used with individuals or groups χ^2 (1) = 0.009, p = .925, average number of TGFG sessions χ^2 (3) = 2.3, p = .513, or whether participants used worksheets, χ^2 (9) = 3.886, p = .143.

Table 3.6

Summary of Chi-Square Tests Conducted and Significance Levels

Comparison 1	Comparison 2	p < .05?
Q15 – Years of experience	Q2 – Individuals / Groups	Yes
Q15 – Years of experience	Q3 – Average number of sessions	No
Q15 – Years of experience	Q8 – Workbook usage	No
Q15 – Years of experience	Q9 – Worksheet usage	No
Q15 – Years of experience	Q16 – Type of training	Yes
Q16 – Type of training	Q2 – Individuals / Groups	No
Q16 – Type of training	Q3 – Average number of sessions	No
Q16 – Type of training	Q8 – Workbook usage	Yes
Q16 – Type of training	Q9 – Worksheet usage	No
Q8 – Workbook usage	Q9 – Worksheet usage	Yes

3.4.2 Interview phase

Themes and sub-themes identified through thematic analysis are shown in Figure 3.2. The four outer themes are arranged laterally, with no intention of privileging any particular theme. There was a causal link perceived by some participants between feeling supported and gaining confidence to use TGFG more flexibly. The central theme, 'Content / rapport relationship', captured fundamental ideas about the function of supplementary resources within the therapeutic space. While not discussed as a theme, the influence of 'Educational Psychology (EP) context' was present – consciously or unconsciously – across all participants' views and experiences.

Figure 3.2

Thematic Map of Practitioners' Usage of 'Think Good – Feel Good'
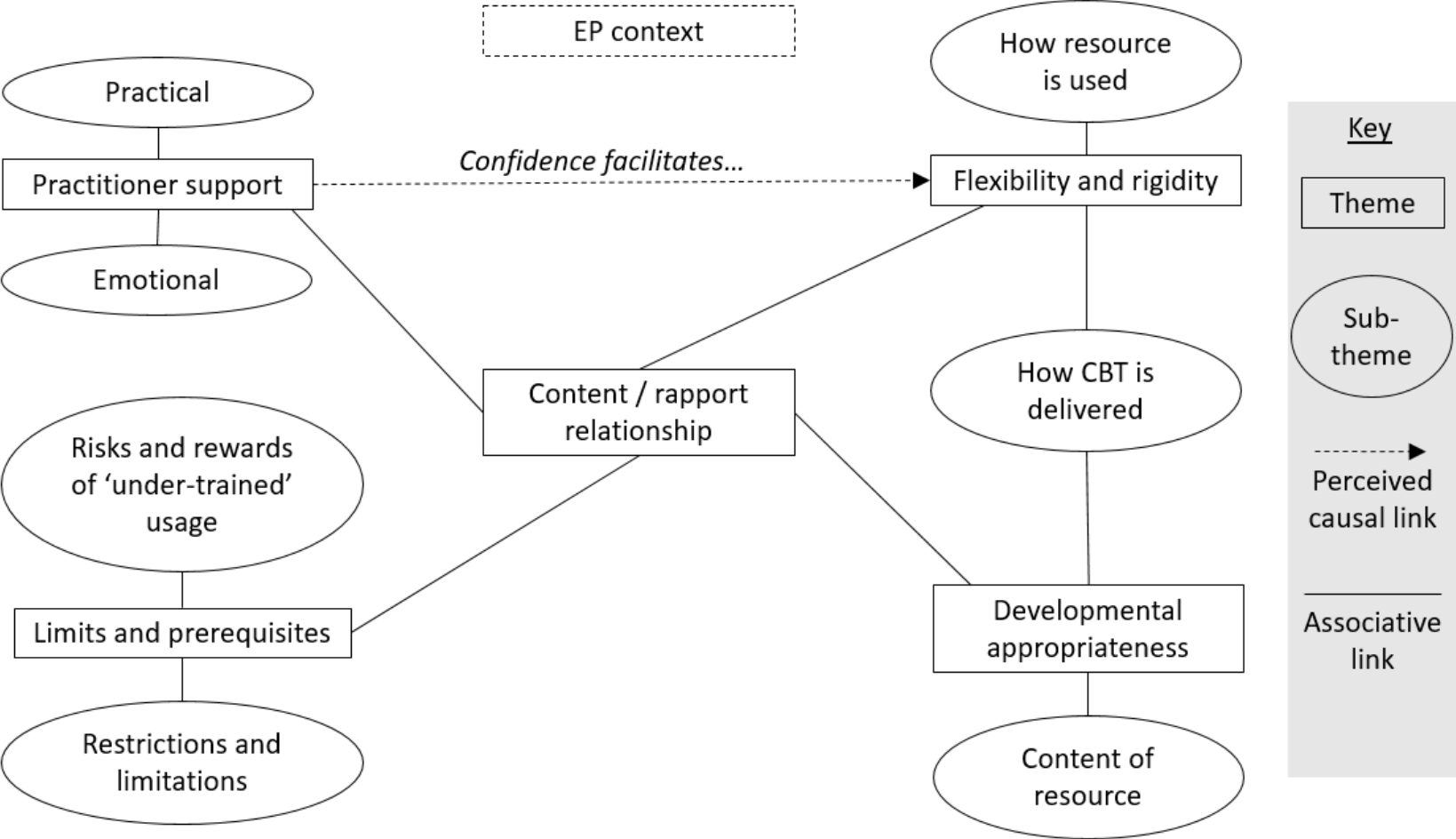
3.4.2.1 Practitioner support

This theme explored how practitioners felt practically and emotionally supported by TGFG to deliver effective services.

3.4.2.1.1 Practical

The convenience and accessibility of TGFG were highlighted. All participants used TGFG to plan sessions:

> I've used it as a kind of planning aide to look at the sort of topics and areas that it covers and then applied that to my case, my situation, thoughts about whether those topics are of use and in what order. (Participant 6 (P6))

Session plans were not necessarily taken verbatim but practitioners adapted structure and content.

Practitioners mentioned background theory, "I think the way it's explained 'cause, in the beginning of the clinician's book, you've got all of the theory and evidence behind why he's adapting or how he's adapting it for children" (P4). All participants had prior CBT training, but used TGFG to remind them of key principles. Participants referred to TGFG as a "reference tool" (P2) or:

> a quick revision manual… It's the confidence of I haven't got to plough through all my CBT notes and all the thick tomes of books, I can just pick this up and have a quick look and see what might be useful. (P3)

Sections of TGFG addressing cognitive elements were particularly helpful. These were considered difficult to explain but crucial for developing understanding:

> you can find a lot of psychoeducation online... But the bit about CBT, I think, is hardest for the clinician and the child is the cognitive element… I think that any kind of really concrete prompts that help you with that, like they have in these books, are really useful. (P5)

TGFG worksheets helped make abstract ideas more tangible, an attribute not easily found in other resources.

Tangibility was helpful for reminding practitioners what had been covered during CBT, "I use the worksheets because it records stuff and therefore I don't have to remember it… for when I write my reports" (P5). The recording attribute of worksheets was helpful within the therapeutic relationship, "we set up like a little folder together… I come to the next session we review what we did in the previous session and our learning and try to build on it" (P5). Worksheets were used as evidence of progress.

Parts of TGFG were used for other professional purposes. Some worksheets were seen as self-contained and useful to non-psychologists, "in a consultation if something came up I may have provided a particular resource. So for example, the thought diary" (P2). Another function was to assess CYP's understanding and motivation for engaging in CBT:

> I might take the odd little bits out of TGFG just to see if they're ready really for following through with some sort of intervention, that's something they might engage with too, by how they engage with a couple of initial worksheets. (P5)

3.4.2.1.2 Emotional

TGFG helped practitioners feel confident in their ability to deliver CBT, particularly less experienced practitioners, "It also gives you a sense of security, knowing that you aren't just making things up, as someone who's not a fully qualified CBT practitioner" (P6). This "sense of security" was linked with the perception that, by following TGFG content, "what you're doing is evidence-informed" (P4). Participants felt confident about the developmental appropriateness of content, "it's reassurance as well that actually this will be appropriate for someone... This is well researched to be helpful for this age group" (P1). For P6, reassurance and evidence base were connected with professional accountability:

You know that if later on you're questioned, 'then why did you do this?', you can go back to those resources and say… 'look, I was following this program. It suggested this. I know that there's evidence behind the program'.

Two participants read aloud verbatim passages. This was to ensure explanations were communicated accurately, "I read those [Thinking Errors] directly so that I'm sure I've got them right for the child" (P3) and because the book explains things well, "I might say 'I'm just going to read this bit out of the book, 'cause this bit's really important and I can't teach you this bit any better than what it says here'" (P5). Reading directly from TGFG was the exception rather than the rule, but reading aloud may emphasise the importance of particular passages, supporting the pedagogical process.

Most participants felt that, over time, their usage of TGFG changed:

at the beginning I used it a lot more in a very structured way and it definitely supported my feelings of confidence and competence... It comes with experience and it comes with the more you use the materials, the more you get to know them, the more you can be flexible with them, because you've got the confidence and those feelings of competence to be able to do that. (P5)

"Structured" workbook usage was associated with low levels of experience and confidence, perhaps because this provided "security". Over time, with growing confidence, practitioners saw "flexible" usage as more effective or desirable.

3.4.2.2 Flexibility and rigidity

This theme explored perceptions of how TGFG could, or should, be used flexibly; how practitioners adapted content; and how TGFG can be combined with other approaches. The first sub-theme concerned higher-level views about manualization. The second sub-theme concerned specific views about working effectively with CYP.

3.4.2.2.1 How resource is used

There were positive and negative opinions about using resources like TGFG rigidly (covering all the content in order in a manualised way). Most negatively, P4 suggested "You might as well just be a robot" if you're following a manual, whilst P6 suggested "I have a view that manualized interventions like that are for slightly lesser skilled professionals". As TEPs, these practitioners felt they should use their training and experience to improve the resource by adapting it, "I just think if you have the ability to make it more personalized and more applicable to that particular person's life, then that should happen" (P6). These opinions were personal for P4:

> I think it would take away something from my identity a bit. And also I probably have a belief that that manualized approach isn't as useful, so then it wouldn't be as useful because I'm like being horrible about it from the beginning.

P4 referenced a self-reinforcing cycle, whereby negative "beliefs" about manualization, based partly on her identity as a skilled professional, could negatively influence her practice. P1 felt more positive:

> not that I think there would be anything wrong with following it rigidly, if you had a great relationship the child's probably going to go with you, but whatever you do for the young person to sort of go with you and want it, you have to have formed a relationship somehow.

The question of manualization was secondary to establishing a strong therapeutic relationship. Others highlighted that rigidly following a structure could "help people feel more confident" (P2) and described that "You can be sure that you're doing the right thing, whatever the right thing is that the book prescribes, and you work through it" (P6). These suggest the book is authoritative and provides certainty to practitioners by "prescribing" how to deliver therapy.

Some participants wondered what the "right thing" might be with TGFG, "I don't know how much it encourages that flexibility. I just tend to be quite flexible with my approaches. But whether the book itself advocates that or not, I'm not sure" (P1), and "it gives you the permission to be creative" (P4). TGFG can "encourage" or "give permission to" practitioners to practice "flexibly" or "creatively". The decision of whether to work in a manualized way might be influenced by practitioners' personalities, "people are very different in general I think to the extent to which they like to be exactingly follow[ing] things and the extent to which they like to improvise. So it's a bit of a personality thing" (P1). This links to P4's point about her identity influencing her practice. Taking the middle ground, P2 commented, "the combination of having a structure of activities, but yeah, being able to equally use them quite creatively. That's what works for me".

One way participants used TGFG "creatively" was by combining it with other approaches, describing TGFG as "one strand among other strands, but because it's got so many good child-friendly ideas, it's probably the thickest strand" (P3). Practitioners incorporated other approaches such as solution-focused therapy (P1), personal construct psychology (P3), or acceptance and commitment therapy (P5). Other approaches might help "to get an idea across or to tease an idea out from a child" (P3). Despite this multiplicity, TGFG was seen as the "thickest strand" because:

> It's so kind of flexible, you know, like it's hard not to use it from my perspective. And you know, maybe to be fair, that's also a sign of my like level of experience and competence that I go to TGFG. You know, maybe if I knew more about CBT, I'd have, you know a broader range of tools. (P2)

This returns to the issue of professional competence, with P2 suggesting he lacked knowledge of alternatives and possibly felt reliant, "it's hard not to use it", attributing TGFG's ubiquity in his practice to its "flexibility".

3.4.2.2.2 How CBT is delivered

Participants discussed personalising CBT to individual needs, skills, and preferences. This could happen reactively, during sessions, "being able to adapt quite quickly on your feet, and think, well, that isn't working, let's switch to this" (P3). Reactive flexibility could be missed if "you're ploughing through it bit by bit" (P3) in a manualised fashion, as following the content may take precedence over monitoring CYP's engagement and understanding. P3 found the range of resources in TGFG helpful if she needed to change direction during sessions, "there's enough in the book that you can pick and choose and work with a child on the one that you think is actually resonating with them". P5 would "formatively assess as I go along… I might change what I'm doing the following week and take a bit more of a teaching element or put a few more practical activities in it". The decision of whether to follow a structured approach might be influenced by CYP's preferences:

> I think when you meet them and you realise this is someone that loves structure then it's a good idea to go for a more structured and manualized approach, so I think you can adapt it based on their learning style… I'm not saying that manualized is bad but I think not all children are going to engage with that. (P4)

P5 expressed a similar sentiment, "Some children need the worksheets… Sometimes they're very happy just chatting", suggesting worksheets facilitate involvement in CBT for CYP who find "just chatting" difficult.

Practitioners adapted TGFG, personalising content, "the more specific examples are to them, it doesn't have to be there exactly, but it could be something they're interested in or something they've mentioned about what they like to do" (P4), and format by creating "a board game version of CBT… adding some rewards and competition" (P4). Adaptations improved the experience for CYP by engaging their attention and appealing to interactive, game-like elements to make the experience fun. Other

practitioners felt it was *necessary* to adapt TGFG to help CYP understand, "that student's level of language necessitated that it was simplified, adapted, and personalized" (P6) and "it's the 'thinking errors'… for me there are too many to present to a child, so I tend to… pick maybe two or three of them" (P3). These observations highlight the considerable verbal skills required to engage with CBT and how a large range of material can be overwhelming and detract from learning, rather than being flexible in a helpful way.

3.4.2.3 Developmental appropriateness

This theme explored how CBT and TGFG are accessible and engaging for CYP at different developmental levels, including aspects of the therapeutic approach and TGFG content.

3.4.2.3.1 How CBT is delivered

CYP do not typically refer themselves for CBT. P1 noted an implication:

> CBT is meant to be led by the client's need and not something you've imposed. I guess it's crucial to form the goals with the young person rather than say you know 'your teacher said you need to do X, so we're going to change, do that with you'.

P1 highlighted self-motivation and leadership drive as important characteristics for CYP to have, but also mentioned working collaboratively to set "goals". P5 described how working collaboratively can empower CYP by involving them in decision-making, "I might read them [passages] out to them or might allow them to read it to themselves. I always give them a choice". P4 collaborated when writing formulations, "It's not like a map of 100 things that might go on, which you might see in an adult model, but this is the type of thing that you can use but also share with the child". Formulations were pedagogical components that should be simple so CYP could understand the links.

P4 suggested collaboration is linked with transparency:

you want to show that you're sharing that thought process and it's not all in my head and 'I'm just like a magician thinking about stuff', that you're showing everything you're doing and sharing that and it's kind of like a joint understanding.

CYP play an active role contributing to "a joint understanding" that is part of a "process" and not something fixed, dictated by the "magician" practitioner. The notion of transparency is described as demystification – by "showing everything you're doing", practitioners provide evidence for their claims and avoid hiding anything or 'tricking' CYP into believing something. Transparency applied with parents:

you're becoming a team with the parent rather than this special person that knows their child and does these special magic things with them. So I think it's good to be really transparent with the parent and then you can find out as well what things don't work as well. (P4)

P4 seemed aware of how her profession may be seen by others, as "special" or "magic", seeing this as negative because it impeded transparency. One benefit of working in a "team" was that parents could provide information about how best to work with CYP and avoid strategies that "don't work as well", contributing to intervention effectiveness.

One reason for transparency was that talking therapy could seem unusual, "for some people and for their families… working in this way at all is just not normal" (P4). Explaining CBT and listening to how families "normally talk about these things" (P4) were crucial. The novelty of CBT was seen positively, "to actually have these conversations, to even break down thoughts, feelings is quite novel to young people and then... they can quite like doing it" (P1) and "not all of them have ever had the opportunity to stop and think about that" (P2). The fast-paced, exam-focussed school

context might not leave room for reflection on personal experiences, so the opportunity to do this during CBT was valuable.

Despite the potential value of therapeutic discussions, participants considered the importance of CYP being motivated to engage. P1 highlighted how contextual framing could affect motivation, suggesting CYP might "feel like the session is some kind of punishment. You know, imagine the school's like 'you're not having detention, you're having [CBT]'" while P3 described how "one of the schools actually frogmarched children into the room". These examples suggest staff felt they knew what was best and were imposing CBT on CYP, not giving them a choice about participation and even equating it to "punishment" for breaking school rules. In contrast, P5 reported:

> I think there's also something about a young person wanting to do it and to make some changes and be motivated to help themselves and to develop some strategies… it's your choice to be here, you have to want to access this.

P5 highlighted intrinsic motivation, "choice", not just to attend sessions but to actively "access" support to "make some changes" and "help themselves". In contrast to "punishment" and "frogmarching", CYP had the option not to attend, "it's always voluntary" (P5), which paradoxically may have strengthened their resolve to attend. Another factor supporting motivation was providing background explanations of key concepts so CYP:

> know and understand why they're using their strategies and somebody is not just saying 'take a deep breath' or 'go to your calm box'... You'll typically get a 'no' off them at that point, because they have no understanding as to why they're being asked to do that. (P5)

This highlights the tension between practitioners having knowledge of potentially helpful strategies and the need to avoid positioning themselves as experts. Self-understanding precedes and justifies the benefits of behavioural strategies, "If you

don't understand yourself, I'm never quite sure really how you can make some changes" (P5). For P1, taking a strengths-based approach and "thinking about their successes" provided behavioural evidence that countered negative self-beliefs, "remembering that fear and how you overcame it", showing that future successes were achievable. P1 highlighted tensions within CYP's attitudes, "normally if someone's having emotional problems, part of them does want to change but part of them is safe in what they're doing at the moment, especially with an avoidance behaviour". This suggests "change" requires bravery and overcoming the temptation to maintain apparently benign "avoidance behaviours" that may be maintaining larger problems. P1 advocated "making the goals very, very small" to avoid overwhelming CYP and alienating them so that change seems unrealistic.

P2 described progression from general concepts to personalised examples:

> we might start off doing some work exploring the fact that thoughts, feelings, and behaviours are linked, and once we've kind of got that and been kind of applying that to life, then I might use that as a linking tool so be like 'oh so now specifically with you'.

P6 elaborated, "You do need to get to the point where it is about them. Maybe before that happens it's easier to practice CBT type skills, but almost from a third perspective". General, conceptual discussions could be less intense and form an accessible introduction to CBT before the more challenging process of reflecting on CYP's own lives. P2 felt TGFG worksheets like 'What thinking errors do you make?' supported this progression by asking which background concepts are applicable to individuals' experiences. For P5, the 'What are they thinking?' worksheets were effective:

> because it's one step removed and it's not personal to them. Sometimes doing everything that's very personal to you or thinking about you can be quite

difficult? So I do find that they tend to engage. It's almost as though they

empathize a lot more with animals than other people.

The use of animals was developmentally appropriate.

More fundamental than considerations around how CBT can best be delivered is the question of whether CYP have the requisite cognitive skills. P1 highlighted the challenges, "people can find it very, very difficult to separate thoughts and feelings", whilst P5 described a baseline competence level, "I've typically only chosen to use CBT if I know that they can understand, read the worksheets". Alternatives such as "more physical games" (P5) might be more developmentally appropriate. Participants had differing experiences regarding CYP's age. For P2, "metacognitive skills help and are generally more developed in children that are older", whilst for P3, "I have worked with one little girl who was exceptionally bright and she was five and she got it straightaway". This highlights the difference between chronological age and developmental level, suggesting assessment of the latter is more appropriate when judging suitability for CBT. Metacognitive skills are important for bridging the gap between self-awareness and self-understanding, "Lots of children don't know and understand why they think and feel the way that they do… and they want to know and understand it" (P5). Practitioners described CYP experiencing an "ah ha moment" (P2) or "lightbulb moment" (P3), a burst of insight that could be "powerful" (P2) and "rewarding" (P3). When CYP were motivated and able to understand CBT concepts, significant progress could be made, "Those are typically the children that are really fascinated and really interested by the awareness that you give them" (P5).

3.4.2.3.2 Content of resource

Participants were torn on whether it was helpful that TGFG worksheets resembled schoolwork. P5 was positive, "Children are used to worksheets anyway, in schools", whereas P6 was unsure, "I do think using videos or other forms of multimedia that

aren't worksheets is good. I think the thing with worksheets is they feel like school. CBT shouldn't feel like school in my opinion".

Participants felt homework tasks were generally not completed, "children don't always complete or fill in the diaries. It is quite hard to get them to do that part of it" (P5). Some reasons were practical, "it's not very successful if you give it out in school. Children tend to screw it up and put it in their bags, and then it's forgotten" (P3) whilst others were related to difficulties understanding, "I just needed to be a bit clearer in what the sheet was asking them to do rather than the issue being with the sheet" (P6). It could be difficult for CYP to understand tasks without scaffolding, they may lack the independent drive to engage with challenging and uncomfortable thinking, or they may not see the benefit in completing tasks. One helpful strategy could be to enlist family support, "parents will usually make sure that it's done" (P3), although this phrasing suggests completing the task is the goal, rather than developing understanding. P5 described that "Some of the young people ask for copies of them [worksheets] interestingly, they want to keep them, they want to look at them, they want to take them away". This again highlights intrinsic motivation, as CYP may consider certain worksheets particularly helpful and want to retain them, without being told to do so.

Regarding worksheet design, P1 described that images could aid understanding, "plenty of young people have reading difficulties or just generally visuals, are visual learners". P4 agreed, describing that illustrations such as "negative glasses" acted as "concrete examples", making challenging concepts feel tangible. In contrast, P2 felt visuals were "cringy… Simpsons-style cool" and felt "contemporary illustrations" would be better. However, this did not seem to bother CYP:

> a young person has never said 'this looks rubbish' or… 'you're trying to say that I'm a child' or whatever, so I've never noticed it being a barrier and I've always felt like there's been high engagement in those activities. (P2)

This highlights that practitioners' and CYP's opinions of what's important, effective, and engaging do not necessarily align.

3.4.2.4 Limits and prerequisites

This theme explored implications of the fact that TGFG is available to be used by anyone regardless of training and experience, as well as restrictions brought about by professional context and competence.

3.4.2.4.1 Risks and rewards of 'under-trained' usage

Participants described benefits of the fact that TGFG could be used by people without formal therapeutic training. One such group is people interested in CBT training, "If someone asked me now, where would I start with CBT and… I don't know what to do, I would probably say you can have a look and pick out a few things from there to start with" (P4). Resources are accessible to a novice, useful as inspiration, and could be used in a trial-and-error approach. Another such group is families and support systems, "I do think it perhaps shouldn't be a standalone, especially with younger children, putting all the responsibility on them... I think it is important to address the system around the child, as well as focusing on the child" (P1) and "I typically try to get some of the parents on board as well with the elements that I think are important to the young person, but they won't necessarily engage with" (P5). P1 suggested working individually with CYP might not bring about sufficient change as they may not have "responsibility" to govern all aspects of their lives. P5 suggested parents might be able to "engage" CYP more effectively than therapists, potentially working as co-therapists. A third such group is school staff:

> I also feel like towards the end of the book, lots of that could be done in school as well with my support. The first bit feels as though it needs more of a therapeutic input to me and then the end bit almost feels as though I could

leave those sorts of strategies and ideas and problem solving with the school.

(P5)

The role of the practitioner could be to work through the emotionally and cognitively challenging aspects of CBT but, once the child understands these, behavioural elements could be managed by school staff.

Despite these hopeful suggestions, participants also described risks and difficulties of 'under-trained' usage. P5 explained that psychologists had promoted TGFG to school staff as "structured enough for somebody to pick it up and to use it… Even if you just read it to a young person". However, in reality:

they probably didn't feel confident enough to necessarily use it in that way. Typically, even though it was sat on their shelf, they'd ask me to come in to do something along these lines and I would say, 'well, you've got the book' and they would say 'no, we'd much rather that you come in'.

This suggests a disconnect between psychologists' confidence that TGFG could be "just read" and school staff's uncertainty that a book is sufficient to run CBT. Alternatively, it may be that staff would prefer ("much rather") a psychologist to run CBT, perhaps because they perceived this would be more effective. A potential reason for reluctance was explored by P3, "it might be a bit overwhelming looking at it thinking 'Oh my God, I've got to work through all this'", suggesting TGFG might appear like a manual requiring a large time commitment. P2 noted the skills people might lack, such as "being able to navigate conversations which are emotionally charged and to contain them to allow people to process those emotions in a safe way and get some use from it", as well as systemic support, such as not "receiving supervision". Providing therapy can have an emotional impact on practitioners. Supervision is an important way to process difficult experiences but would unlikely be

available outside certain professions. P2 highlighted the potential risks to "safe" practice of practitioners lacking skills to "navigate" challenging conversations.

3.4.2.4.2 Restrictions and limitations

Participants discussed limits to using TGFG in their practice. P3 described a restriction specific to the EP context, "it's a time-consuming process and many schools don't want you to spend that much time on one child". Given the limited time typically available for EPs to work in individual schools, working therapeutically with CYP could be seen as inefficient. P5 expanded, "I think that's something we always have to be aware of as EPs that we're not a long-term therapeutic service". Some CYP may have complex, protracted difficulties that EPs would struggle to address within their working model. In contrast, P1 felt TGFG is "contained for the kind of work that EPs" do, "often quite a short-term, limited number of sessions", suggesting positive effects could be achieved within limited time. P6 highlighted that, given the range of work EPs complete, "it might be hard to find the time to plan a session, to spend a lot of time thinking about it", which could restrict time available to personalise sessions and make following the TGFG structure rigidly more appealing. P4 highlighted this link between contextual restrictions and the appeal of manualization, "some people don't have the time, the headspace, the funding, the sessions to be able to do that [work creatively], so I completely understand why it becomes quite manualized".

P3 acknowledged that "I only work with children with sort of low levels of anxiety or low levels of mental health issues who don't meet the threshold for CAMHS [Child and Adolescent Mental Health Services]... I think it's very important to stay within my professional competencies". P3 may have felt less skilled than CAMHS practitioners but she also felt her work was preventative so CYP with "low levels of mental health issues" did not "escalate" to more serious challenges and had the opportunity to address their difficulties. Regarding the Clinician's Guide (CG), P3 said "I bought the

CG and I've never read it, which is just dreadful really", implying feelings of guilt. P3 was not alone as all participants except P4 reported never having read the CG. P5 explained, "I do like the blue practical book. I do have to say the CG always seems to sit on our resource shelves in our office and you notice that people don't pick it up very often", suggesting the "practical" nature of TGFG is more appealing. In contrast, P4 had *only* used the CG, "I think I probably didn't end up going into the original blue one because lots of times services just already have sheets and activities that they've developed". In P4's view, TGFG was redundant because she already had access to sufficient resources, but she acknowledged that TGFG could be "even better for someone who's starting out" without access to other resources.

3.4.2.5 Content / rapport relationship

This theme explored fundamental ideas about the function of supplementary resources within the therapeutic space.

P1 described the value of content around setting goals and designing behavioural experiments:

> Lots of the content is worthwhile… with no content at all, just having a chat, you might be sympathetic, but you might not really move anywhere… Sometimes it does need to be a little bit more active than just this sort of like sympathetic listening.

This positions CBT as practical and progress-oriented, as opposed to static "chat" and "sympathetic listening", which might make someone feel better but would not equip them to cope better. P4 agreed:

> It's quite validating I guess for a young person to see that you are listening by writing things down together and they can see whether you've got it right or wrong 'cause you might put something down and they think 'that's definitely not what I would have said', or 'that's not what I meant'. And then you could

change it... It gives them a sense of control and agency as well over the fact that they've got a say in what you're doing. It's like more collaborative when you're focusing on the worksheet maybe than if you were just talking.

Recording conversations on worksheets allows for collaborative reflection and revision, helping practitioners and CYP reach joint understandings and avoid misinterpretations. However, there are risks of overly focussing on content:

what can happen with CBT is it becomes all about these worksheets and all about the content of what you're going to do. But I still think that your relationship with... those people like the parent, the child, whoever… that is still really important and sometimes that can be missed because you're so blinded by all this amazing information and resource and everything... there is this danger with CBT of thinking I must do this, this, this… tick it all off. (P4)

The risk of outlining steps for practitioners to follow or discreet resources to complete is that progress becomes associated with completing tasks. This could "blind" practitioners to the more complex and important, but less easily measurable, goal of establishing a relationship. P6 agreed but considered how the importance of content may change over time, "I think it's more about the relationship you have with that young person and less about the presentation of the sheet... Maybe in the first session or something like that it could be more important that they're highly engaging".

This leads to a unique function of external resources in achieving therapeutic aims:

any worksheet is quite containing for both the child and the clinician. So you've got a piece of paper between you that you're looking at with boxes around it, and it kind of focuses the session in… rather than it being like a really scary, 'what's this all about?'… 'cause working with some adult on some random thinking and talking stuff is not the easiest thing to do. (P4)

Worksheets provide an external point of joint attention so practitioner and CYP do not have to look at each other; they are tangible, "piece of paper", so may offer a familiar grounding; they are structured, "with boxes", offering clear, ordered, achievable steps; and they "focus the session" on specific things rather than open-ended discussion.

3.4.3 Integration

After reviewing survey and interview results, nine topics of pertinence to the RQs were identified. Comparisons and evaluations are presented in Table 3.7. Overall, many of the codes generated from survey Q14 (Table L19) were similar to interview themes.

Table 3.7

Joint Display of Survey Results, Interview Results, and Mixed-Methods Meta-Inferences

Topic	Survey results	Interview results	Meta-inferences
TGFG usage changing over time	*Chi-square tests with Q15 and Q16, and Q8 and Q16*: Self-taught practitioners were more likely to have less experience and to read directly from the workbook. CBT-trained practitioners were more likely to have more experience and not to read directly from the workbook. *Chi-square test with Q2 and Q15*: Practitioners with 6-10 years' experience were more likely to use TGFG with groups than expected. Practitioners with 0-2 years' experience were less likely to use TGFG with groups than expected.	*Theme*: Flexibility and rigidity *Perceived causal link*: Confidence facilitates flexible workbook usage	*Confirmation:* Interview data suggested practitioners' resource usage changed over time, becoming more flexible with confidence, knowledge, and experience. Survey data suggested practitioners who had CBT training, rather than being self-taught, were more experienced and less likely to read directly from the workbook. Survey data also suggested a trend for practitioners to use TGFG more with groups if they had more experience, although this was not a consistent linear trend. Survey data confirmed interview themes, showing that having less experience and less training was associated with reading directly from the workbook, possibly a sign of lacking confidence, avoiding flexibility, and feeling reliant on the workbook. *Discordance:* Survey data showed there were no significant differences in average number of sessions, whether practitioners read directly from TGFG, or whether practitioners used worksheets, based on experience. *Discordance:* One interviewee thought he might 'move on' from TGFG to other resources once he had more experience. Several interviewees and survey respondents saw TGFG as suitable for beginners. However, survey data suggested the most

Topic	Survey results	Interview results	Meta-inferences
	Descriptive stats from Q15: The largest group (36%) had 11+ years' experience. Only 12% had 2 or fewer years' experience (Table L20).		experienced practitioners still use TGFG, albeit potentially in different ways as suggested above.
Cognitive parts of TGFG	*Descriptive stats from Q10 and Q11:* Nine of the top ten most-used worksheets were from chapters with a cognitive focus (Table L11). The six chapters with a cognitive focus were the six most helpful for practitioners (Table L13).	*Sub-themes*: Practical support, Risks and rewards of 'under-trained' usage	*Confirmation:* Interview data suggested cognitive concepts were difficult for CYP to understand and for practitioners to explain but crucial for making therapeutic progress. This confirmed the survey results that practitioners found cognitive chapters and worksheets more helpful than those about feelings or behaviours. Interview participants noted that TGFG's resources provided concrete prompts for explaining challenging, intangible concepts.
TGFG as planning aide	*Descriptive stats from Q8, Q12, and Q14:* 80% used TGFG as a planning aide (Table L15). 36% used TGFG to plan without bringing the book into sessions (Table L9). The fourth most common response to Q14 was highlighting TGFG's use as a planning aide (Table L19).	*Sub-theme:* Practical support	*Confirmation:* All interview participants described using TGFG as a planning aide. Typically, they would adapt structure and content rather than working through chapters in the order they are presented in the book. Survey responses to Q14 used language such as 'inspiration', 'for ideas', and 'starting point', suggesting a similar approach to interviewees.

Topic	Survey results	Interview results	Meta-inferences
Flexibility of TGFG	*Descriptive stats from Q14:* Top 3 responses suggested TGFG could be combined with other approaches, should be used flexibly, and was not prescriptive (Table L19).	*Theme:* Flexibility and rigidity	*Confirmation:* Interview participants named several approaches they combined with TGFG, such as solution-focussed approaches. They often adapted resources by changing the format or incorporating individuals' interests.
	Descriptive stats from Q14: One respondent felt there was 'too much flexibility' (Table L19).		*Discordance:* Being able to 'leapfrog' through activities was seen as unhelpful because it discouraged practitioners from checking CYP's understanding before moving on. Interview participants did not mention the idea that flexibility could be negative, although many acknowledged that structure and rigidity could be helpful in some circumstances.
Reading directly from TGFG	*Descriptive stats from Q8, Q12, and Q13:* 18% read directly from TGFG in a typical session, sharing it with the child (Table L9). 20% read from TGFG as a 'manual' (Table L15). 8% thought CYP found it engaging to read directly from TGFG themselves (Table L17).	*Sub-theme:* Emotional support	*Expansion:* Interview data suggested, on the whole, practitioners preferred not to read aloud directly from TGFG, preferring to put things in their own words. From the survey, self-taught practitioners were more likely to read directly, whereas CBT-trained practitioners were less likely to read directly. Among interviewees, reading aloud was considered useful to ensure key ideas were conveyed accurately, boosting practitioners' confidence. Whilst this practice seems uncommon, it could be pedagogically useful if used sparingly, to highlight key learning.

Topic	Survey results	Interview results	Meta-inferences
	Chi-square test with Q8 and Q16: Self-taught practitioners were more likely to read directly from the workbook. CBT-trained practitioners were more likely not to read directly from the workbook.		
What is helpful for practitioners vs what is engaging for CYP	*Descriptive stats from Q12 and Q13*: 80% found worksheets helpful (Table L15) and 84% thought CYP found them engaging (Table L17). 32% found Helpful Tips sections helpful and 28% thought CYP found these engaging.	*Theme:* Developmental appropriateness	*Expansion:* Broadly speaking, survey respondents felt that what was helpful for them was also engaging for CYP. Interviewees reported they would prioritise what CYP seemed to find engaging and pursue this because this would *make* it helpful for effecting therapeutic change. One interviewee felt the process of pursuing engaging activities was subconscious and that she would use resources more if CYP had found them engaging in the past.
	20% read from TGFG as a manual but only 7% thought CYP found this engaging.		*Discordance:* Survey data showed one clear discrepancy between what was helpful vs engaging. This could impede therapeutic relationships. Motivation and engagement are key to success but may be hindered if practitioners make decisions based on their own perception of what *should* be helpful, rather than considering what CYP find helpful. Only one interviewee referenced this idea, reporting that whilst he thought TGFG visuals were patronising, CYP had never said this themselves.

Topic	Survey results	Interview results	Meta-inferences
Professional competence	*Descriptive stats from Q14 and Q16*: 20% were exclusively 'self-taught' to use TGFG, without 'general CBT training' (Table L22). Only 3% had specific training on using TGFG. Nine respondents recommended TGFG to school staff (Table L19).	*Sub-theme*: Risks and rewards of 'under-trained' usage	*Discordance:* Interview data suggested psychological training and support were necessary for effectively delivering CBT. Despite several survey respondents recommending TGFG to school staff, interviewees reported that untrained school staff were reluctant and unconfident to use TGFG. This was the case even when professionals suggested TGFG could simply be read aloud. This brings into question whether exclusively self-taught TGFG users would have sufficient therapeutic skills and knowledge.
	Descriptive stats from Q11 and Q12: Background theory chapters (1 and 2) were 'particularly helpful' for fewer than 4% (Table L13). However, when given the option, 46% indicated 'introductory chapters' were helpful (Table L15).	*Sub-themes*: Practical support, Restrictions and limitations	*Expansion:* Interview data suggested practitioners were unlikely to make use of the CG and preferred the practical nature of TGFG. When practitioners did engage with background material, this was positioned as a quick revision exercise, rather than in-depth reading. This suggests that, whilst theory / background elements of TGFG are useful for around half of TGFG users, they are not the main reason most practitioners use the resource.
Brevity of intervention	*Descriptive stats from Q3*: 67% used TGFG for 1-6 sessions (Table L2).	*Sub-theme*: Restrictions and limitations	*Expansion:* Interview data suggested the EP role may limit prolonged intervention work, since schools may wish to direct EP time towards other priorities. Also, funding restrictions mean some practitioners are required to keep to time boundaries, such as not exceeding a certain number of sessions. This

Topic	Survey results	Interview results	Meta-inferences
			clarified some of the reasons survey respondents commonly reported a small number of sessions.
Utility of worksheets	*Descriptive stats from Q9 and Q10*: 80% used worksheets in sessions and 6% gave them for homework (Table L10). A large range of worksheets were specifically named as useful (Table L11) and practitioners shared various views about what made them useful (Table L12).	*Themes*: Practical support, Developmental appropriateness, Content / rapport relationship	*Expansion:* The vast majority of survey and interview participants agreed worksheets were helpful. In response to an open survey question, 86% of worksheets in the first edition of TGFG were specifically referenced as helpful by at least one respondent, showing the huge extent and value of diversity. Survey data evaluating worksheets focussed on aspects of content such as design, topic focus, and activities. Interview data expanded to consider how worksheets function within the therapeutic relationship; adapting complex ideas to be accessible to CYP, offering the facility to record ideas tangibly so they could be discussed and reviewed, and containing emotional intensity to ease potentially challenging discussions.

3.5 Discussion

3.5.1 RQ1: How do practitioners typically use TGFG?

Answering this question first requires considering how practitioners decide whether to use TGFG when supporting CYP. There were four key criteria: type of difficulty, CYP's understanding, CYP's motivation, and systemic support. Whilst few survey respondents used TGFG for all mental health difficulties, a wide range was reported, suggesting individual expertise and judgment play a role in decision-making. 'Anxiety disorders' are over three times more prevalent among 5-19-year-olds than 'depressive disorders' (NHS, 2018) but there is strong evidence supporting CBT with both populations (David-Ferdon & Kaslow, 2008; Sigurvinsdóttir et al., 2020). It was unsurprising these difficulties were considered suitable for TGFG. Unexpectedly, two thirds of respondents used TGFG for CYP exhibiting behaviours that challenge. The evidence-base for this is weaker, with a review of 24 studies tentatively finding CBT had a small-medium effect on episodes of challenging behaviour (Ho et al., 2010). This finding may reflect the high prevalence of 'behavioural disorders' among CYP (NHS, 2018) and the fact that this challenges school staff, leading to high referral rates (Anderson, 1997). It is important for practitioners to consider the evidence-base and potentially challenge unsuitable referrals.

Regarding understanding, TGFG was most commonly used with late primary school and early secondary school age-groups. There is a significant rise in emotional difficulty prevalence during early adolescence (NHS, 2018) along with a rise in metacognitive and self-reflective skills (Veenman & Spaans, 2005), crucial for engaging in talking therapy. The 'Developmental appropriateness' theme showed how practitioners felt TGFG resources scaffolded understanding and engaged attention through visuals, accessible explanations, and concrete examples. CBT workbooks may help practitioners deliver interventions to CYP at earlier ages, when difficulties are less entrenched (DfE, 2015).

While the first two criteria were considered prerequisites, motivation was considered malleable. Key factors that could build motivation included collaboration in setting goals and choosing activities, transparency about the CBT process, using worksheets to build rapport, the novelty of having space to discuss feelings, and being aware that participation was voluntary. Many CYP themselves identify that achieving positive change requires attending persistently, despite the challenging nature of CBT (Jones et al., 2017).

Systemic support was seen as a bureaucratic bottleneck, where practitioners felt schools were reluctant for them to do extended therapeutic work because it was an inefficient use of time. A survey of how EPs conduct therapeutic interventions found that the two most common barriers were 'Limitations of service time allocation model' and 'service capacity' (Atkinson et al., 2011). In a survey of Scottish EPs, 76% of services reported that capacity in terms of time and staffing were significant barriers to therapeutic delivery (Greig et al., 2019). In the current study, over two thirds of respondents used TGFG for 1-6 sessions, at the lower end of the 5-20 CBT sessions recommended by the NHS (2019), and most undertook individual rather than group work. A study of adults with panic disorders found a consistent decrease in outcome symptom severity as a function of sessions attended, up to at least 6 sessions, which was maintained at 12-month follow-up (Craske et al., 2006). There is a tricky balance between professionals providing support broadly to enable fair access (BPS, 2018) and acknowledging that positive therapeutic outcomes take time.

Once a decision has been made to work with CYP, the question becomes: what use to make of TGFG? There was consensus that TGFG was not an intervention itself but a resource supporting therapeutic interventions.

Some evidence suggested practitioners across the spectrum of experience continued using TGFG in similar ways. In contrast to interviewee P2 feeling he relied on TGFG due to inexperience, the largest group of survey respondents had 11+ years'

experience and many still used TGFG. This suggests TGFG is of continuing relevance to experienced practitioners' work, not simply supporting inexperienced practitioners. Inferential statistics suggested that experience was not related to number of sessions, worksheet usage, or workbook usage.

Other evidence suggested 6-10 years' experience was associated with greater likelihood of working with groups, perhaps because it takes skill and experience to manage group dynamics effectively (Bion, 1961). However, the most experienced practitioners were less likely to work with groups. In the absence of follow-up data, the reasons for this non-linear relationship are unclear. Some interviewees reported that experience was related to how flexibly they used TGFG. They felt that because TGFG was evidence-based, recommended by colleagues, and gave "permission to be creative" (P4), this increased their confidence in their own judgment. Survey data suggested self-trained practitioners were more likely both to have less experience and to read directly from the workbook. This reinforces the suggestion that experience leads to greater confidence, which leads to more flexible and less manualised workbook usage. TGFG was typically used flexibly in two main ways: adapting resources and combining TGFG with other approaches.

The first form of flexibility has been previously studied, with a significant relationship found between therapist flexibility and later child engagement ($r = .25$, $p = .05$), which in turn was significantly related to positive outcomes (Chu & Kendall, 2009). Across 20 courses of CBT, 87.5% of sessions involved manual content being adapted, most commonly to match CYP's interests or abilities. Whilst many participants in the current study reported personalising resources to improve engagement, some interviewees suggested non-personalised resources also play a role. Genericness was associated with distance from personal experience, which could feel safer and easier to engage with. Interviewee P5 suggested generic worksheets could be interspersed as productive breaks from personal discussions, whilst P2 described a linear progression

from general to personal over the course of therapy. Future research could explore the permutations of the genericness-personalisation dialectic, and the role each concept plays. In some ways, it parallels the flexibility-fidelity dialectic but it focuses more on the person receiving therapy rather than the practitioner.

The second form of flexibility is illustrated by the casual phrases, "dip in and out" (P5) and "one strand among other strands" (P3). Some practitioners used TGFG resources within other CBT-based approaches whilst others created bespoke interventions by combining TGFG with other therapeutic approaches. This gives an impression of pragmatism, taking what works from TGFG and leaving what does not. This approach was the most commonly mentioned theme in response to survey Q14. However, to the researcher's knowledge, it does not have precedence in the research literature; by its nature pragmatism resists controlled study. Combination approaches exist, such as integrated psychological therapy for schizophrenia, but this is a structured program, addressing cognitive distortions, social skills and problem solving (Roder et al., 2006). From one perspective, the pragmatic approach could be accused of defying evidence-based practice in favour of practitioner judgment. From another perspective, it is taking an idiosyncratic but scientific approach to practice in the spirit of the applied scientist, testing and combining different approaches based on what works for individuals in unique circumstances (Barker et al., 2016; Fonagy et al., 2005). Future research could evaluate the effectiveness of pragmatic approaches, or how they are perceived by practitioners and CYP.

Consideration of how TGFG was used often elicited broader thoughts about manualised intervention delivery. Some interviewees dismissed manualization as robotic, an approach for less skilled professionals that did not allow for personalisation of content or moment-by-moment adaptations within sessions. Others valued TGFG's structure because it helped them feel confident when they were inexperienced, fit their personal preferences, or saved time in their busy schedules. These opinions broadly

resembled those found by Addis and Krasnow (2000), suggesting manuals remain a divisive concept two decades on. An additional consideration raised in the current study was that CYP have different preferences for structure; manualised programmes could provide certainty and safety for some but bore and alienate others. These are important considerations for implementation science, demonstrating potentially contradictory influences and avenues for future research. For example, what would be the best approach if a practitioner personally opposed to manuals worked with CYP who valued structure? In line with the opinion expressed by P4, practitioners' negative preconceptions about manuals could negatively influence intervention delivery, leading to less effective outcomes, thereby reinforcing the practitioner's original beliefs. Future qualitative research could explore CYP's attitudes towards structure and manualization and how this affects their therapeutic experience.

3.5.2 RQ2: What is helpful about supplementary resources for practitioners providing mental health support?

This question widened the scope of enquiry to consider the role of supplementary resources (such as workbooks and worksheets) within the therapeutic space. For this discussion, 'therapeutic space' is defined as an opportunity for thinking between people (Bronstein & Flanders, 1998). The survey found that nearly 2/3 practitioners brought TGFG into sessions and around 80% brought worksheets, suggesting supplementary resources are commonplace in therapeutic spaces.

Outside the direct therapeutic space, workbooks act as planning aides: structuring practitioner's thinking, reminding practitioners what to cover, providing ready-to-use resources, and inspiring creativity. These support practitioners in terms of efficiency (practicalities in preparing an intervention), understanding (education or revision of concepts), and emotion (reassurance they were doing the right thing). TGFG was seen as a trusted (evidence-based and accessible) friend to which practitioners could turn to prepare for therapeutic work, even after a long absence.

Practitioners valued supplementary resources with a cognitive focus above those with emotional or behavioural foci. The six cognition-focussed TGFG chapters were the six most used and 9/10 of the most-used worksheets came from these chapters. This could reflect that cognitive insight is at the heart of achieving change through CBT so is prioritised for consideration (Kaplan et al., 1995). Self-understanding was seen as foundational; CYP needed to understand the reasoning behind behavioural strategies to be motivated to do them. It could also reflect that cognitive concepts are difficult to explain and hard to understand (Verduyn, 2000), and are easily confused with feelings (Belsher & Wilkes, 1994), so physical resources make ideas tangible and concrete. P5 suggested therapeutic expertise was required to work on cognitive understanding but that school staff could be supported to implement behavioural strategies. This could be an argument for efficiency – targeting therapeutic resources at the early, complex stages of CBT – or a suggestion that strategies might be more successfully implemented by staff because they have longer-term relationships with CYP. This inter-professional suggestion is of relevance to EPs, who work closely with schools but have time restrictions that limit opportunities for therapeutic work. Future research could explore the effectiveness of the approach, the feasibility of managing it for EPs, and the acceptability of responsibility for school staff.

In addition to explaining cognitive concepts, another difficult aspect of CBT is building therapeutic alliance (the relationship between practitioner and CYP). Alliance is among the most important variables in achieving change and is related to positive outcomes with an average effect size of .24 (Castonguay et al., 2006). In the current study, supplementary resources were valued for explaining content and building alliance.

Regarding content explanation, it is helpful to take as an example the most-used worksheet, 'What thinking errors do you make?', a questionnaire which narrows down a generic list of thinking errors to those relevant to individuals. This trades open

discussion (particularly difficult for CYP whose metacognitive skills are developing) for systematic choices, helping practitioner and CYP focus on pertinent information, reducing cognitive load for processing novel information, and providing insight (Schnotz & Kürschner, 2007). From a strengths-based perspective, this activity facilitates consideration of ways CYP do *not* make thinking errors, enabling practitioners to challenge narratives of hopelessness or catastrophizing (Zimmerman, 2013). The worksheet has boundaries (i.e. questions to answer) so can be completed, leading to a sense of achievement which could enhance motivation and focus.

Regarding alliance building, it is helpful to consider secondary intersubjectivity, where two people pay joint attention to an object, developing shared understandings and goals whilst retaining awareness of each other's feelings, thoughts, and reactions (Bråten & Trevarthen, 1994; Tomasello et al., 2005). Writing things down means they can be seen by practitioner and CYP. This could aid transparent communication and be validating for CYP if they see something that reflects, or enhances, their self-understanding. If something inaccurate were written, it could be edited, giving CYP control and enabling them to feel heard. Practically, writing aids memory and facilitates progress reviews because you can take a physical object made at a certain time and re-examine its significance. Interviewee P6 suggested a dynamic relationship whereby content is ultimately less important but functions to build rapport. In the early stages of CBT, there may be uncertainty and anxiety about meeting someone new, so something familiar (that resembles schoolwork) and engaging could break the ice. P4 described that worksheets reduce the emotional intensity of thinking and talking about difficult experiences through containment. A supplementary resource becomes a third, non-human participant in the therapeutic space, moderating the stress of one-to-one interaction. On the other hand, worksheets might make CBT feel like an unengaging, academic exercise. Future qualitative research could explore individual differences among CYP's worksheet preferences and

whether it could be practitioners' responsibility to judge CYP's emotional state and decide whether they would benefit from something familiar or more stimulating. Prompting discussion about the relationship between content and rapport is among the most important contributions of this study, because it does not have much precedence in the literature but is relevant to enhancing CBT outcomes. Future research could systematically delineate the functions of supplementary resources and theoretical models might be developed from a basis of secondary intersubjectivity and joint attention.

Bringing the discussion to a close, a final point is considered on conflicting evidence about the level of training and confidence required to use TGFG and practice CBT. P5 reported that school staff did not feel comfortable, despite being told they could read TGFG aloud to CYP. Future research could explore CBT workbook usage by school staff, to establish whether it is happening and how resources are used, in comparison to psychologists. Among survey respondents, 20% were exclusively self-taught from TGFG and only 2% had training specifically about TGFG. For that 20%, TGFG was not an adjunct but the foundation of knowledge and practice. These respondents were more likely to have less experience working in children's mental health and more likely to read directly from the workbook during CBT sessions. CBT-trained respondents were more likely to have more experience and less likely to read directly. It could be that practitioners initially feel the TGFG workbook is sufficient to run a CBT intervention, and the ability to read aloud from it is reassuring. Practitioners may seek out training as they gain experience, leading them to feel more confident about using TGFG flexibly. Future research could further explore the interrelationship between training, confidence, and flexibility.

Some authors argue EPs possess the requisite skills to undertake CBT without additional training (Squires, 2010). In a survey of Scottish EP services, 57% felt EPs were 'well' or 'very well' equipped to deliver therapeutic interventions through initial

training whilst 62% thought this was the case through continuing professional development (Greig et al., 2019). However, some interviewees in the current study questioned how comfortable they felt calling their practice 'CBT' and were concerned about staying within professional competence, suggesting they would only work with lower-level difficulties. Some respondents felt it was crucial to read and understand the CG and not just take resources from TGFG but others reported not reading the CG, feeling it was unnecessary. A large-scale survey of EPs found that the most important facilitator to using therapeutic interventions was 'access to training', suggesting many EPs feel they need additional skills, beyond those provided in initial training, to practice effectively (Atkinson et al., 2011).

Given that TGFG is publicly available, no training is required to use it. On one hand, this encourages broad access to something potentially helpful and supports people in the myriad ways described above. On the other, it could give people false confidence that they can help someone without necessarily possessing interpersonal therapeutic skills (such as handling challenging conversations) or working within support systems (such as supervision). Official guidance from the BPS advises practitioners to seek specialist supervision when undertaking therapeutic work (Dunsmuir & Leadbetter, 2010). The availability of appropriate supervision in practice may be limited; a survey of Scottish EP services found that only 38% felt 'well' or 'very well' equipped to supervise EPs delivering therapeutic interventions (Greig et al., 2019). The findings of the current study suggest there are few doubts that a workbook can be hugely supportive in bringing about positive change from CBT. However, it also raises thorny questions about what practice should be defined as CBT and how CBT can be practised safely to promote the wellbeing of practitioners and CYP.

3.5.3 Practice recommendations

Given the sample demographics, practice recommendations are most relevant to EPs working in the UK, but may be of interest to other practitioners.

First, practitioners should consider how to negotiate referrals and design interventions effectively. Tensions may exist between the evidence-base for CBT effectiveness and pressure from schools to work with children considered disruptive or to keep interventions short. Flexibility is clearly valued but there are certain content and structural elements which may be important to maintain as foundations.

Second, practitioners should reflect on the added value brought by supplementary resources and look to maximise their implementation. Whilst there could be drawbacks relating to overuse or clashing with CYP preferences, in many cases worksheets (and other resources) can help explain content, enhance motivation, build rapport, and contain emotional intensity.

Finally, while CBT workbooks offer powerful opportunities, practitioners should be careful to avoid complacency. It could be tempting to see task completion or following a book's structure as of primary importance, but building therapeutic alliance and working with members of CYP's support systems must be considered. Moreover, practitioners who are exclusively self-taught using TGFG may consider whether further training could benefit their practice, given the complexities of delivering CBT. A simple first step would be to read the CG as well as TGFG, which offers significantly more background material.

3.5.4 Limitations

Regarding the survey, several questions (such as Q6 and Q7) elicited many 'Other' responses, suggesting the original options were reductive. If all respondents had a broader range of options to choose from, rather than having to add them as 'Other' responses, data collection would have been more accurate and comprehensive. This could have been addressed by piloting the survey more widely. Whilst the intention was for survey responses to remain anonymous, it would have been helpful to collect data on ethnicity, professional role, and biological sex. This would have facilitated further cross-group comparisons and demographic analyses. There were advantages

and disadvantages to allowing multiple responses to some questions. Positively, this gave respondents greater flexibility and facilitated analysis of response combinations. Negatively, these questions could not be converted to variables for inferential statistical analysis, so cross-group comparisons could not be made.

Regarding the interviews, upon reflection, the researcher asked some partially leading questions, which could have created social desirability bias to respond in a certain way (Furnham, 1986). For example, a follow-up question about "whether TGFG missed out on important aspects of CBT like supervision" was suggestive and closed, rather than encouraging interviewees to respond openly. This could have been addressed by practising follow-up questions more and learning about interview technique. The homogeneity of participant demographics was helpful for analysing the EP context. However, all participants were from the same Western, Educated, Industrialized, Rich, and Democratic (WEIRD) society (United Kingdom), meaning they likely shared cultural values and underlying assumptions about therapy, psychology, and myriad other topics (Henrich et al., 2010). Ninety-six percent of survey participants were also from this WEIRD society. The researcher acknowledges the limitations of qualitative research for generalising findings; where tentative claims for generalisation are made, the researcher does not claim that findings are representative of other societal populations (Lewis et al., 2003).

3.5.5 Conclusion

This study explored how practitioners typically use TGFG and what is helpful about supplementary resources in the therapeutic space. In the highly saturated field of literature about CBT, this study took a novel perspective; its findings have a lot to offer practitioners, researchers, and intervention designers. Adopting a mixed-methods design facilitated comparison of large-scale survey results with in-depth interviews, drawing on the benefits of qualitative and quantitative data to draw out implications for research and practice. The integration table showed examples of confirmation

(lending confidence to triangulated findings), expansion (clarifying, extending, and adding nuance), and discordance (meaning fallacious conclusions could be avoided). Overall, TGFG's self-description as a 'collection of materials' was borne out in the data, with recurring themes around flexibility, adaptation, and relevance to practitioners across the spectrum of experience supporting CYP of varying ages with a wide range of difficulties. The study's findings should, within the principles of implementation science, prompt theoretical consideration, empirical investigation, and practical application. The most important aspects of new knowledge gained as a result of this study are:

- Growing confidence changes workbook usage, facilitating flexibility.
- Practitioners commonly take a pragmatic approach to combining therapeutic modalities.
- Resources explaining cognitive elements of CBT are by far the most used.
- Views around manualization should account for CYP's preferences as well as practitioners'.
- Supplementary resources play a variety of roles within the therapeutic space from explaining content to building alliance.
- There are risks and rewards to the greater accessibility to CBT provided by a workbook.

3.6 References

Addis, M. E., & Krasnow, A. D. (2000). A national survey of practicing psychologists' attitudes toward psychotherapy treatment manuals. *Journal of Consulting and Clinical Psychology*, *68*(2), 331–339. https://doi.org/10.1037/0022-006X.68.2.331

American Psychological Association. (2006). Evidence-based practice in psychology. *American Psychologist*, *61*(4), 271–285. https://doi.org/10.1037/0003-066X.61.4.271

Anderson, K. G. (1997). Gender bias and special education referrals. *Annals of Dyslexia*, *47*, 151–162. https://doi.org/10.1007/s11881-997-0024-8

Atkinson, C., Bragg, J., Squires, G., Muscutt, J., & Wasilewski, D. (2011). Educational psychologists and therapeutic interventions: Preliminary findings from a UK-wide survey. *DECP Debate*, *140*.

Barker, C., Pistrang, N., & Elliott, R. R. (2016). *Research methods in clinical psychology: An introduction for students and practitioners* (3rd ed.). Wiley-Blackwell.

Bauer, M. S., Damschroder, L., Hagedorn, H., Smith, J., & Kilbourne, A. M. (2015). An introduction to implementation science for the non-specialist. *BMC Psychology*, *3*(1), 1–12. https://doi.org/10.1186/S40359-015-0089-9

Bauer, M. S., & Kirchner, J. A. (2020). Implementation science: What is it and why should I care? *Psychiatry Research*, *283*. https://doi.org/10.1016/j.psychres.2019.04.025

Bazeley, P. (2013). *Qualitative data analysis: Practical strategies*. Sage.

Belsher, G., & Wilkes, T. C. R. (1994). Ten key principles of adolescent cognitive therapy. In T. C. R. Wilkes, G. Belsher, A. J. Rush, & E. Frank (Eds.), *Cognitive therapy for depressed adolescents*. Guildford Press.

Bion, W. R. (1961). *Experiences in groups*. Tavistock.

Bradburn, N., Sudman, S., & Wansink, B. (2004). *Asking questions: The definitive guide to questionnaire design - for market research, political polls, and social and health questionnaires*. Jossey-Bass.

Bråten, S., & Trevarthen, C. (1994). Beginnings of cultural learning. In *In talk at the ZiF symposium on the formative process of society, Bielefeld* (pp. 17–19).

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. Sage.

Brightmore, A. (2016). *Investigating the efficacy of universally delivered cognitive behaviour therapy in the promotion of emotional literacy and mental wellbeing with year 5 [Unpublished doctoral dissertation]*. University of Nottingham.

British Psychological Society. (2018). *Code of ethics and conduct*.

Bronstein, C., & Flanders, S. (1998). The development of a therapeutic space in a first contact with adolescents. *Journal of Child Psychotherapy*, *24*(1), 5–36.

https://doi.org/10.1080/00754179808414803

Castonguay, L. G., Constantino, M. J., & Holtforth, M. G. (2006). The working alliance: Where are we and where should we go? *Psychotherapy*, *43*(3), 271–279. https://doi.org/10.1037/0033-3204.43.3.271

Chorpita, B. F., Daleiden, E. L., & Weisz, J. R. (2005). Modularity in the design and application of therapeutic interventions. *Applied and Preventive Psychology*, *11*(3), 141–156. https://doi.org/10.1016/j.appsy.2005.05.002

Chu, B. C., & Kendall, P. C. (2009). Therapist responsiveness to child engagement: Flexibility within manual-based CBT for anxious youth. *Journal of Clinical Psychology*, *65*(7), 736–754. https://doi.org/10.1002/jclp.20582

Craske, M. G., Roy-Byrne, P., Stein, M. B., Sullivan, G., Hazlett-Stevens, H., Bystritsky, A., & Sherbourne, C. (2006). CBT intensity and outcome for panic disorder in a primary care setting. *Behavior Therapy*, *37*(2), 112–119. https://doi.org/10.1016/j.beth.2005.05.003

Creswell, J. W., & Clark, V. L. P. (2017). *Designing and conducting mixed methods research* (3rd ed.). Sage.

D'Intino, J., Lysenko, E., & Shaw, S. R. (2018). Questionable research practices and evidence-based practices in school psychology. *Communique*, *47*(4), 8–11.

David-Ferdon, C., & Kaslow, N. J. (2008). Evidence-based psychosocial treatments for child and adolescent depression. *Journal of Clinical Child and Adolescent Psychology*, *37*(1), 62–104. https://doi.org/10.1080/15374410701817865

Department for Education. (2015). *Special educational needs and disability code of practice: 0 to 25 years*.

Department of Health and Department of Education. (2017). *Transforming children and young people's mental health provision: A green paper*.

Dillman, D., Smyth, J., & Christian, L. (2014). *Internet, phone, mail, and mixed-mode surveys: The tailored design method*. Wiley and Sons.

Drisko, J. W., & Grady, M. D. (2019). Step 3 of EBP: Part 2 - Evaluating research methods. In *Evidence-based practice in clinical social work* (pp. 123–154). Springer. https://doi.org/10.1007/978-3-030-15224-6_7

Dunsmuir, S., & Leadbetter, J. (2010). *Professional supervision: Guidelines for practice for educational psychologists*.

Durlak, J. A., & DuPre, E. P. (2008). Implementation matters: A review of research on the influence of implementation on program outcomes and the factors affecting implementation. *American Journal of Community Psychology*, *41*(3–4), 327–350. https://doi.org/10.1007/s10464-008-9165-0

Ely, M., Vinz, R., Downing, M., & Anzul, M. (1998). *On writing qualitative research: Living by words*. Routledge.

Erhardt, V. A. (2019). *Effectiveness and key components of school-based anxiety interventions*. University of Minnesota.

Fallon, K., Woods, K., & Rooney, S. (2010). A discussion of the developing role of educational psychologists within Children's Services. *Educational Psychology in Practice*, *26*(1), 1–23. https://doi.org/10.1080/02667360903522744

Faul, F., Erdfelder, E., Lang, A. G., & Buchner, A. (2007). G*Power 3: A flexible

statistical power analysis program for the social, behavioral, and biomedical sciences. *Behavior Research Methods*, *39*, 175–191. https://doi.org/10.3758/BF03193146

Festinger, L. (1957). *A theory of cognitive dissonance*.

Field, A. (2013). *Discovering statistics using IBM SPSS statistics* (4th ed.). Sage.

Fonagy, P., Cottrell, D., Phillips, J., Bevington, D., Glaser, D., & Allison, E. (2005). *What works for whom?: A critical review of treatments for children and adolescents*. Guilford Press.

Forman, S. G., & Barakat, N. M. (2011). Cognitive-behavioral therapy in the schools: Bringing research to practice through effective implementation. *Psychology in the Schools*, *48*(3), 283–296. https://doi.org/10.1002/pits.20547

Fox, M. (2003). Opening Pandora's box: Evidence-based practice for educational psychologists. *Educational Psychology in Practice*, *19*(2), 91–102. https://doi.org/10.1080/02667360303233

Furnham, A. (1986). Response bias, social desirability and dissimulation. *Personality and Individual Differences*, *7*(3), 385–400. https://doi.org/10.1016/0191-8869(86)90014-0

Gartlehner, G., Hansen, R., Nissman, D., Lohr, K., & Carey, T. S. (2006). Criteria for distinguishing effectiveness from efficacy trials in systematic reviews. *Agency for Healthcare Research & Quality*, *12*, 1–28.

Greig, A., MacKay, T., & Ginter, L. (2019). Supporting the mental health of children and young people: A survey of Scottish educational psychology services. *Educational Psychology in Practice*, *35*(3), 257–270. https://doi.org/10.1080/02667363.2019.1573720

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough?: An experiment with data saturation and variability. *Field Methods*, *18*(1), 59–82. https://doi.org/10.1177/1525822X05279903

Guetterman, T. C., Fetters, M. D., & Creswell, J. W. (2015). Integrating quantitative and qualitative results in health science mixed methods research through joint displays. *Annals of Family Medicine*, *13*(6), 554–561. https://doi.org/10.1370/afm.1865

Harvard University. (2007). *Tip sheet on question wording*. https://psr.iq.harvard.edu/book/questionnaire-design-tip-sheet

Henrich, J., Heine, S. J., & Norenzayan, A. (2010). The weirdest people in the world? *Behavioral and Brain Sciences*, *33*(2–3), 61–83. https://doi.org/10.1017/S0140525X0999152X

Ho, B. P. V., Carter, M., & Stephenson, J. (2010). Anger management using a cognitive-behavioural approach for children with special education needs: A literature review and meta-analysis. *International Journal of Disability, Development and Education*, *57*(3), 245–265. https://doi.org/10.1080/1034912X.2010.501169

Information Commissioner's Office. (2019). *Guide to the general data protection regulation (GDPR)*.

Jick, T. D. (1979). Mixing qualitative and quantitative methods: Triangulation in action. *Administrative Science Quarterly*, *24*(4), 602–611.

Jones, S., Hassett, A., & Sclare, I. (2017). Experiences of engaging with mental health services in 16- to 18-year-olds: An interpretative phenomenological analysis. *SAGE Open*, *7*(3). https://doi.org/10.1177/2158244017719113

Kaplan, C. A., Thompson, A. E., & Searson, S. M. (1995). Cognitive behaviour therapy in children and adolescents. *Archives of Disease in Childhood*, *73*(5), 472–475. https://doi.org/10.1136/adc.73.5.472

Kelly, B. (2016). Implementation science: Applying the evidence of effectiveness in real-world contexts. In B. Kelly, L. Woolfson, & J. Boyle (Eds.), *Frameworks for practice in educational psychology* (2nd ed., pp. 78–92). Jessica Kingsley Publishers.

Kendall, P. C., & Beidas, R. S. (2007). Smoothing the trail for dissemination of evidence-based practices for youth: Flexibility within fidelity. *Professional Psychology: Research and Practice*, *38*(1), 13–20. https://doi.org/10.1037/0735-7028.38.1.13

Kiesler, D. J. (1994). Standardization of intervention: The tie that binds psychotherapy research and practice. In P. F. Talley, H. H. Strupp, & S. F. Butler (Eds.), *Psychotherapy research and practice: Bridging the gap* (pp. 143–153). Basic Books.

Krippendorff, K. (2004). *Content analysis: An introduction to its methodology* (2nd ed.). Sage.

Krippendorff, K. (2018). *Content analysis: An introduction to its methodology* (4th ed.). Sage.

Kvale, S. (1994). *Interviews: An introduction to qualitative research interviewing*. Sage.

Lane, D. A., & Corrie, S. (2006). *The modern scientist practitioner: A guide to practice in psychology*. Routledge.

Lewis, J., Ritchie, J., & Ormston, R. (2003). Generalising from qualitative research. In *Qualitative research practice: A guide for social science students and researchers* (pp. 347–362). Sage.

Marshall, W. L. (2009). Manualization: A blessing or a curse? *Journal of Sexual Aggression*, *15*(2), 109–120. https://doi.org/10.1080/13552600902907320

Moon, K., & Blackman, D. (2014). A guide to understanding social science research for natural scientists. *Conservation Biology*, *28*(5), 1167–1177. https://doi.org/10.1111/cobi.12326

Morris, Z. S., Wooding, S., & Grant, J. (2011). The answer is 17 years, what is the question: Understanding time lags in translational research. *Journal of the Royal Society of Medicine*, *104*(12), 510–520. https://doi.org/10.1258/jrsm.2011.110180

Morse, J. M. (1991). Approaches to qualitative-quantitative methodological triangulation. *Nursing Research*, *40*(2), 120–123.

Nezu, A. M. (2020). When psychotherapy is not working: Ethical considerations. *Cognitive and Behavioral Practice*, *27*(4), 417–425. https://doi.org/10.1016/j.cbpra.2020.05.006

NHS. (2018). *Mental health of children and young people in England, 2017*.

NHS. (2019). *Overview: Cognitive behavioural therapy (CBT)*.

https://www.nhs.uk/mental-health/talking-therapies-medicine-treatments/talking-therapies-and-counselling/cognitive-behavioural-therapy-cbt/overview/

O'Cathain, A., Murphy, E., & Nicholl, J. (2007). Integration and publications as indicators of "yield" from mixed methods studies. *Journal of Mixed Methods Research*, *1*(2), 147–163. https://doi.org/10.1177/1558689806299094

Open Science Collaboration. (2015). Estimating the reproducibility of psychological science. *Science*, *349*(6251). https://doi.org/10.1126/science.aac4716

Potter, W. J., & Levine-Donnerstein, D. (1999). Rethinking validity and reliability in content analysis. *Journal of Applied Communication Research*, *27*(3), 258–284. https://doi.org/10.1080/00909889909365539

Robson, C. (2002). *Real world research* (2nd ed.). Blackwell Publishing.

Roder, V., Mueller, D. R., Mueser, K. T., & Brenner, H. D. (2006). Integrated psychological therapy (IPT) for schizophrenia: Is it effective? *Schizophrenia Bulletin*, *32*(SUPPL.1). https://doi.org/10.1093/schbul/sbl021

Sackett, D. L., Rosenberg, W. M., Gray, J. A., Haynes, R. B., & Richardson, W. S. (1996). Evidence based medicine: What it is and what it isn't. *British Medical Journal*, *312*, 71–72. https://doi.org/http://dx.doi.org/10.1136/bmj .312.7023.71

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., Burroughs, H., & Jinks, C. (2018). Saturation in qualitative research: Exploring its conceptualization and operationalization. *Quality and Quantity*, *52*(4), 1893–1907. https://doi.org/10.1007/s11135-017-0574-8

Schnotz, W., & Kürschner, C. (2007). A consideration of cognitive load theory. *Educational Psychology Review*, *19*(4), 469–508. https://doi.org/10.1007/s10648-007-9053-4

Sharpe, D. (2015). Your chi-square test is statistically significant: Now what? *Practical Assessment, Research and Evaluation*, *20*(8), 1–10.

Shaw, S. R., & Pecsi, S. (2021). When is the evidence sufficiently supportive of real-world application? Evidence-based practices, open science, clinical readiness level. *Psychology in the Schools*, *58*(10), 1891–1901. https://doi.org/10.1002/pits.22537

Shedler, J. (2018). Where is the evidence for "evidence-based" therapy? *Psychiatric Clinics of North America*, *41*(2), 319–329. https://doi.org/10.1016/j.psc.2018.02.001

Sigurvinsdóttir, A. L., Jensínudóttir, K. B., Baldvinsdóttir, K. D., Smárason, O., & Skarphedinsson, G. (2020). Effectiveness of cognitive behavioral therapy (CBT) for child and adolescent anxiety disorders across different CBT modalities and comparisons: A systematic review and meta-analysis. *Nordic Journal of Psychiatry*, *74*(3), 168–180. https://doi.org/10.1080/08039488.2019.1686653

Singla, D. R., Raviola, G., & Patel, V. (2018). Scaling up psychological treatments for common mental disorders: A call to action. *World Psychiatry*, *17*(2), 226–227. https://doi.org/10.1002/wps.20532

Squires, G. (2010). Countering the argument that educational psychologists need specific training to use cognitive behavioural therapy. *Emotional and Behavioural Difficulties*, *15*(4), 279–294. https://doi.org/10.1080/13632752.2010.523211

Stallard, P. (2002). *Think good - feel good: A cognitive behavioural therapy workbook for children and young people*. John Wiley & Sons, Ltd.

Stallard, P. (2005). *A clinician's guide to Think good - feel good: Using CBT with children and young people*. John Wiley & Sons, Ltd.

Stallard, P. (2018a). *Think good - feel good: A cognitive behavioural therapy workbook for children and young people* (2nd ed.). John Wiley & Sons, Ltd.

Stallard, P. (2018b). *Thinking good - feeling better*. John Wiley & Sons, Ltd.

Stallard, P. (2021). *A clinician's guide to CBT for children to young adults* (2nd ed.). John Wiley & Sons, Ltd.

Stebbins, R. (2001). *Exploratory research in the social sciences*. Sage. https://doi.org/10.4135/9781412984249

Teddlie, C., & Tashakkori, A. (2009). *Foundation of mixed methods reseach: Integrating quantitative and qualitative in the social and behavioral sciences*. Sage.

Tomasello, M., Carpenter, M., Call, J., Behne, T., & Moll, H. (2005). Understanding and sharing intentions: The origins of cultural cognition. *Behavioral and Brain Sciences*, *28*(5), 675–691. https://doi.org/10.1017/S0140525X05000129

Truijens, F., Zühlke-van Hulzen, L., & Vanheule, S. (2019). To manualize, or not to manualize: Is that still the question? A systematic review of empirical evidence for manual superiority in psychological treatment. *Journal of Clinical Psychology*, *75*(3), 329–343. https://doi.org/10.1002/jclp.22712

Turner, D. W. (2010). Qualitative interview design: A practical guide for novice investigators. *Qualitative Report*, *15*(3), 754–760.

Veenman, M. V. J., & Spaans, M. A. (2005). Relation between intellectual and metacognitive skills: Age and task differences. *Learning and Individual Differences*, *15*(2), 159–176. https://doi.org/10.1016/j.lindif.2004.12.001

Verduyn, C. (2000). Cognitive behaviour therapy in childhood depression. *Child Psychology and Psychiatry Review*, *5*(4), 176–180. https://doi.org/10.1017/s1360641700002379

Waller, G., Mountford, V. A., Tatham, M., Turner, H., Gabriel, C., & Webber, R. (2013). Attitudes towards psychotherapy manuals among clinicians treating eating disorders. *Behaviour Research and Therapy*, *51*(12), 840–844. https://doi.org/10.1016/j.brat.2013.10.004

Zeisel, J. (1984). *Inquiry by design: Tools for environment-behaviour research*. Cambridge University Press.

Zimmerman, M. A. (2013). Resiliency theory: A strengths-based approach to research and practice for adolescent health. *Health Education and Behavior*, *40*(4), 381–383. https://doi.org/10.1177/1090198113493782

Chapter 4: Dissemination and Impact

4.1 Introduction

This chapter explores the concepts of evidence and practice; considers the policy, practice, and research implications of findings from Chapters Two and Three; and presents a plan for disseminating findings to various audiences.

4.2 Evidence and practice

The concept of evidence is of interest to scientists, practitioners, and philosophers of science. Evidence consists of information supporting a hypothesis or proposition (Achinstein, 2001). This definition raises notions of truth and knowledge, suggesting what counts as evidence depends on your epistemological position (Crotty, 1998). An objectivist might consider evidence established through controlled experimentation; a subjectivist might consider all views as evidence regardless of whether they are shared or supported; a constructionist might compromise, considering whether views can be triangulated with others' views or objective experimentation (Moon & Blackman, 2014).

4.2.1 Evidence-based practice

Whereas the objective of evidence is explanation, the objective of practice is improvement (van Strien, 1997). Practice is pragmatic, looking to bring about tangible or noticeable benefits, whereas evidence can be pursued as an end in itself. Whilst the two concepts appear divergent, evidence-based practice (EBP) proposes that evidence can inform, and improve, practice (Cook & Cook, 2016; Hoagwood & Johnson, 2003).

The phrase 'evidence-based' is ambiguous, depending on how evidence is defined and what basis is considered appropriate or sufficient (Rycroft-Malone et al., 2004). Some definitions of EBP are broad, suggesting a combination of practitioner expertise and research evidence leads to the most effective outcomes (Sackett et al., 1996). Other definitions are specific, suggesting that, for a given intervention to be EBP, there

should be two controlled experimental studies of high-quality methodology with a combined effect size greater than zero (Gersten et al., 2005).

Professional psychology bodies in the United Kingdom and United States, including those representing EPs, advocate that evidence should be used as the basis for all aspects of practice including assessment, intervention, and evaluation (American Psychological Association, 2006; BPS, 2017; HCPC, 2016). Whilst some practitioners embrace the role of scientist-practitioner (Barker et al., 2016; Dunsmuir et al., 2009), others see research as alienating or unnecessary and rely on experience and judgment (M. Fox, 2003). These tensions are arguably mirrored in the HCPC standards of proficiency (SoPs) for psychologists, where SoP 12.1 states practitioners must "engage in evidence-based and evidence-informed practice" whilst SoP 4 states practitioners must "practise as an autonomous professional, exercising their own professional judgement" (HCPC, 2016). Legislation, including the SEND code of practice, supports professional guidance regarding the value of EBP (DfE, 2015). The balance between prioritising research evidence and professional judgment likely differs between practitioners.

Given professional and legislative pressures to embrace EBP, an important judgment concerns the quality of evidence supporting practices or interventions. Traditional evidence hierarchies rank methods on the basis of internal validity, the extent to which methods isolate the effects of independent variables and control extraneous variables (Greenhalgh, 1997; Guyatt et al., 1995). High internal validity means more confident conclusions can be drawn about the efficacy of interventions (Barker et al., 2016). At the top of hierarchies sit systematic literature reviews (SLRs) and randomised controlled trails (RCTs), and at the bottom sit surveys and case studies.

A criticism of evidence hierarchies is that they are reductive, failing to account for the variety of goals research may have. An alternative is the evidence typology, a matrix allowing consideration of which methods are most appropriate for answering different

research questions (Muir Gray, 1996; Petticrew & Roberts, 2003). Typologies facilitate nuance, showing that RCTs are well-suited to efficacy questions and ill-suited to questions around the process of service delivery, whereas qualitative research has the opposite suitability.

Another alternative (Evans, 2003) ranks evidence on the basis of three factors: effectiveness, appropriateness (how recipients view the intervention), and feasibility (how providers view the intervention and systemic factors affecting implementation). Evans' hierarchy highlights external validity, the extent to which findings apply to other settings and populations, including real-world settings (Barker et al., 2016). Even with strong evidence for the efficacy of an intervention under controlled conditions, it will not provide benefits in practice unless it is acceptable to recipients, feasible for providers, and cost-effective for systems (Bauer & Kirchner, 2020).

Judging the quality of evidence as a basis for practice is complex, as seen by the different priorities of the frameworks outlined. However, there is consensus that SLRs are effective at answering a variety of research questions and considering effectiveness, acceptability, and feasibility. Practitioners should read high-quality SLRs when deciding whether to implement interventions.

4.2.2 Practice-based evidence

As Evans (2003) highlighted, acceptability is a key criterion in judging evidence quality. A study of 49 special education teachers' attitudes towards educational research found that the status of practice as 'evidence-based' was unimportant; instead, teachers were interested in what would work for them and their students (Boardman et al., 2005). Some participants saw research as top-down dictation of what practitioners should do, making them actively resist practice described as 'evidence-based' (Cook & Cook, 2016). While the views of a small sample should not be directly generalised to the teaching population, this study highlights the dangers of

not involving practitioners in decisions around what works (Kratochwill & Shernoff, 2004; Rycroft-Malone et al., 2004).

Practice-based evidence (PBE) aims to address such criticisms by conducting research in collaboration with practitioners in real-world settings and populations (Kratochwill et al., 2012). PBE embraces the challenging complexity of real-world working, assessing the impact of variables which affect implementation, rather than controlling and filtering them out through rigorous design and statistical procedures (Bauer & Kirchner, 2020; Cook & Cook, 2016). Examples of PBE range from narrative case studies, describing a practitioner's experience in a situation of interest (Brandell & Varkas, 2010), to single-case experimental designs, in which participants serve as their own controls through baseline measurements followed by implementation of an intervention and measurement of effects (Smith, 2012).

PBE is particularly relevant to school-based practitioners because levels of EBP implementation are typically low (Forman et al., 2013). Schools are complex systems presenting numerous barriers to implementation of novel practices such as requiring the support of multiple staff members, lack of resources, competing priorities, and difficulty altering curriculums (Davies, 1999; Forman et al., 2009). Moreover, given that EPs typically work with individual CYP, the school is just one relevant system in a complex web of near and far influences on CYP's lives (Bronfenbrenner, 1979; Frederickson & Cline, 2015).

A criticism of PBE is that, by de-emphasising rigour, it becomes possible to classify anything as evidence that could shape practice (N. Fox, 2003). PBE might encourage idiosyncratic approaches such as hunch and anecdote (Flanagan, 2013). A counterpoint to this criticism is that stories can be powerful in convincing others to act because narratives are engaging, can be shaped to suggest that something will work in specific circumstances, and present evidence for reflection rather than dictating evidence as advice (Beaver, 2011).

4.2.3 The relationship between EBP and PBE

From one perspective, EBP and PBE serve different purposes (Kratochwill et al., 2012). EBP prioritises internal validity to establish efficacy under ideal, controlled conditions. PBE prioritises external validity to measure effectiveness, and explore implementation, under real-world conditions.

From another perspective, EBP and PBE have the same ultimate goal: improving practice to benefit intervention recipients (Biesta, 2007). Given the enormous resource implications of running a high-quality controlled trial (Ioannidis, 2016), researchers must suspect that a practice or intervention *could* work to make it worth exploring in detail. This starting point will likely arise from practitioners observing phenomena or trying things out. Equally, practitioners looking to engage in the research process may look to the literature to see what works under ideal conditions and implement it in their local context.

PBE and EBP inform one another in a cyclical, complementary relationship (Cook & Cook, 2016). This is borne out in the model of clinical readiness levels (CRL), which aids evidence-based decision-making by psychological practitioners (Shaw & Pecsi, 2021). Judging whether an intervention is ready for practice involves: practitioners describing, and hypothesising the causes of, an observed problem (stages 1-2); practitioners reporting on what actions seem to support the problem (stage 3); researchers conducting initial explorations followed by controlled trials of interventions to establish efficacy, and publishing detailed reports of what they did (stages 4-6); and researchers and practitioners conducting controlled trials in multiple settings as well as real-world trials, assessing acceptability, feasibility, and the extent to which practices can be adapted whilst still proving effective (stages 7-9).

Viewed broadly as research on CBT interventions, Chapters Two and Three sit within stage 8 of the CRL model. CBT has an extensive evidence-base under controlled and real-world conditions for various populations, but further research could helpfully

assess the robustness of the intervention. Chapter Two broadly assesses acceptability of CBT for CYP, exploring beneficial and detrimental factors. Chapter Three broadly assesses feasibility of CBT for practitioners, exploring the utility of a workbook and the extent to which fidelity is maintained in practice.

4.3 Implications

Implications are connections between what was found in research, what was already known, and how research findings extend or modify existing knowledge. A review of 19 methods textbooks found that only eight described how to consider and present implications (Koh et al., 2015). Despite this, in the psychological professions, implications are considered vital to answer the 'so what?' question from a pragmatic perspective (Palys & Atchison, 2008). Implications of the current research will be explored at levels of policy, practice, and research.

4.3.1 Policy implications

Mental health difficulties cause more disability among the UK population than any other factor, costing the economy around £100 billion annually (NHS, 2014). Preventing and treating these difficulties is of paramount social and economic concern, particularly with the Covid-19 pandemic raising new concerns about CYP mental health (Rider et al., 2021). The NHS expressed an ambition to hold physical and mental health in equal 'esteem' by 2020 regarding staff, funding, respect, and ending stigma (McShane, 2014; Mental Health Taskforce to the NHS in England, 2016). Practical implications of this policy for CYP were outlined in a government Green Paper, including the creation of mental health support teams and a drive to increase access to, and quality of, psychological therapies (Department of Health and Department of Education, 2017).

In the BPS briefing about the Green Paper, the second core recommendation is for co-production, or collaboration, with CYP on service development (BPS, 2019). Co-

production involves reducing the power imbalance between intervention providers and recipients, acknowledging the expertise gained by recipients through experience of difficulties (Mayer & McKenzie, 2017). Participants studied in Chapter Two were experts by experience who had received CBT for anxiety or low mood.

Some argue qualitative research should not give rise to policy implications as there is an emphasis on detail, contextualisation, and specificity (Lewis et al., 2003; Yin, 2009). However, by conducting a thematic synthesis, patterns can be identified across samples (Thomas & Harden, 2008). To make an analogy with quantitative research, these represent measures of central tendency (typical experiences) and range (diverse experiences), both of which are valid and useful when transferring findings to broader populations (Chenail, 1992; Larsson, 2009). Given the BPS recommendation for co-production, and the pragmatic perspective of this research, it seems prudent to propose policy implications. This comes with the proviso that qualitative research on CBT is in its infancy so future research will likely clarify typical experiences and identify wider diversity of experiences.

Provision of CBT is limited by material factors for providers, including funding and staffing shortages (NHS, 2014), and attitudinal factors for recipients, including stigma about mental health (Heijnders & Van Der Meij, 2006). Regarding attitudinal limitations, Chapter Two suggested framing CBT as 'upskilling', teaching independence and affecting a range of outcomes across mental health, education, and everyday life, all of which appear important to CYP. Given the widespread potency of stigma, this suggestion has policy implications for the government and mental health providers. Moving away from a medical perspective of treating a disorder, towards a holistic perspective of teaching new skills, could encourage more CYP to consider and engage in CBT at an earlier stage (DfE, 2015; Elkins, 2017). This could be addressed through re-framing how mental health practitioners explain CBT and public information campaigns explaining potential benefits of CBT.

Regarding material limitations, the findings of Chapter Three around levels of training required to practice CBT have policy implications. Given their knowledge of school systems (MacKay, 2008) and experience with therapeutic delivery (Atkinson et al., 2011), EPs are ideally placed to address gaps in CBT provision for CYP (Department of Health, 2008). EPs can work directly with CYP, supervise others working directly, and manage the process of signposting to other services (Farrell et al., 2006). Chapter Three identified innovative ways of combining these functions, such as EPs working directly with CYP to begin the therapeutic process and address cognitive concepts before supervising school staff to provide ongoing support and introduce behavioural strategies. This could represent an efficient use of EP time and an effective way of incorporating longer-term support with a trusted adult. EP services could highlight the skills of EP work around mental health and its efficiency, to appeal in the traded context where schools need to account for cost-effectiveness of EP time (Lee & Woods, 2017).

There are policy and ethical implications around the public availability of workbooks such as TGFG (Stallard, 2002, 2018). Many participants reported using TGFG as their only source of CBT training. Even if psychologists already possess the skills necessary for therapeutic work (Squires, 2010), a workbook cannot provide systemic support, such as supervision, considered vital for safe and effective practice (Dunsmuir & Hardy, 2016). Some participants argued TGFG is insufficient by itself to enable practitioners to effectively practice CBT. TGFG is not sold under any restrictions, meaning its use is unregulated and unknown; Chapter Three represented the first findings about its use by professionals but did not explore its use by non-professionals. This can be contrasted with the restricted status of certain standardised cognitive assessments, which can only be used by psychologists following extensive training (Woods & Farrell, 2006). It seems notable that there are regulated restrictions governing certain areas of psychological practice (e.g. standardised assessment) but

not others (e.g. CBT), despite there being evidence that both require training and experience to use safely and effectively.

There is no doubt that more mental health services should be available to CYP at the earliest stage possible, but practitioners and policymakers should consider whether further advice or restrictions around defining CBT are appropriate or justified. A balance should be struck between practicing broadly and practicing safely.

4.3.2 Practice implications

Chapter Two explored CYP's views of receiving CBT and Chapter Three explored practitioners' views of providing CBT, facilitating analysis of similarity and divergence. It would be helpful for practitioners to reflect on the findings from Chapter Two, to consider in which ways they are currently practicing that appear beneficial to CYP and which areas could be flagged for continuing professional development (CPD). This could raise conflicting perspectives, where a practitioner thought they were doing something helpful that CYP seemed to consider unhelpful, which could be discussed during professional supervision.

Both CYP and practitioners described the value of tangibility. This likely reflects the challenging nature of explaining and understanding CBT concepts, particularly for children with less developed language and self-reflection skills (Stallard, 2021). Within the therapeutic space, practitioners should make creative and flexible use of supplementary resources, such as worksheets or videos, particularly when explaining cognitive concepts. Both CYP and practitioners frequently recognised the value of personalising resources to fit CYP's interests or developmental understanding. Resources have additional benefits such as increasing CYP motivation, building rapport, and reducing the emotional intensity of conversations. Pragmatically, resources could increase practitioner confidence and reduce intervention planning time. Practitioners should teach CYP tangible techniques for use outside the therapeutic space such as relaxation, activity scheduling, re-framing negative

thoughts, and thought diaries. These are valued by CYP, whose motivation to engage may be reinforced by seeing evidence of change in their everyday lives. Tangibility is related to transparency so practitioners should ensure they share their thinking with CYP (and families) through written or visual formulations, to enhance collaboration and check understanding.

Chapter Two highlighted the variety and sophistication of ways that CYP conceptualise positive outcomes from CBT and barriers to engagement. For practitioners and researchers, it may be tempting to judge intervention success according to symptom reduction on standardised scales. Such measurements facilitate binary judgments of whether CYP are anxious or depressed, which are useful for clinical decision-making. However, they are likely less meaningful for CYP, who experience improvement in a range of ways including increased independence, perspective shift, more happiness, better social skills, and improved everyday functioning. Towards the end of interventions, practitioners could reflect with CYP on the myriad positive outcomes they identify and compare these with CYP's initial goals, to assess whether there were unexpected benefits. Such discussions could be therapeutically beneficial because they would be strengths-based, encourage self-reflection, and prompt holistic thinking about 'anxiety' or 'depression' as just parts of a person's life. Similarly, if practitioners acknowledge and discuss barriers to engagement with CYP, practitioners may come across as honest, flexible, and willing to collaborate with CYP. This could present an opportunity to pause and build rapport, by watching a video or completing a structured worksheet, rather than adhering to a planned schedule or manual. Discussions around positive outcomes and engagement barriers are metacognitive, because they entail reflection on the process of CBT (Schraw, 1998), so may need to be scaffolded (Veenman, 2015). They might provide therapeutic benefit to CYP but also professional benefit to practitioners as an opportunity to learn from experts by experience.

4.3.3 Research implications

Chapters Two and Three represented novel and exploratory research approaches to CBT, a topic that has received huge attention from certain methodological designs, namely RCTs (David et al., 2018). One research implication of this thesis is the value of methodological and topical diversity. By 2012, at least 269 meta-analyses of CBT efficacy and effectiveness had been published (Hofmann et al., 2012). However, at the time of writing, there is not a single published study about CBT workbooks, despite their wide usage. Building on the discussion of EBP and PBE, researchers should be mindful of a bottom-up perspective and explore what is happening in CBT practice, which could generate thought-provoking insight and highlight areas of concern. Research implications of this thesis will be explored from three perspectives: replicating and adapting the approaches taken, novel questions not previously explored, and methodological quality issues.

First, the approaches taken could be replicated or adapted in other populations and settings. Regarding Chapter Two, research could explore *practitioners'* perspectives on 'positive outcomes' from CBT and the facilitators and barriers. Studies might collect perspectives of CYP and practitioners from therapeutic dyads to explore whether agreement on defining 'positive outcomes' is related to actual experience of outcomes. Regarding Chapter Three, surveys could explore typical TGFG usage by other professional groups, such as school staff, and non-professionals. Interviews could explore usage of other CBT workbooks or resources from different psychotherapeutic modalities.

Second, novel questions could spark creative future approaches. CYP's views could be collected at multiple time-points throughout therapeutic interventions to analyse developing views of topics such as engagement, rapport, self-perspective, and goals. Conversation analysis (Sacks, 1995) could explore the terminology used by CYP and practitioners when describing difficulties, whether euphemistic ('stressed') or clinical

('anxious') terms are preferred, and the effects of linguistic choices on therapeutic relationships. Given the apparent range of therapeutic functions filled by supplementary resources, this topic would be ripe for theoretical discussion and empirical investigation. For example, video footage of therapeutic interactions would facilitate microanalysis (De Jong et al., 2013) of workbook usage and exploration of whether practitioners' reports match their behaviour.

Finally, lessons were learnt about methodological quality and study design. Several studies in Chapter Two had interviewers who were involved in intervention delivery, potentially creating uneven power dynamics and social desirability bias from participants who may have felt unable to speak honestly (Furnham, 1986). Future studies should employ interviewers who are independent of intervention design or delivery. Qualitative reviews should carefully consider their own stance, and the stances taken by reviewed studies, on epistemology and generalisation because this affects the extent to which findings can be transferred to broader populations. Chapter Two sought pragmatically to draw out practice implications based on typical views, but it would have been equally valid to focus on divergent views shaped by individual contexts. Exploratory research, including on CBT workbooks, should pilot survey measures extensively to ensure response options are not reductive. There were many 'other' responses in the current research. If these had been available to all participants, rather than having to be added by those with inclination, a more accurate and comprehensive dataset could have been collected.

4.4 Dissemination

Following the discussion of how research evidence can be translated into practice, it is important to consider how the current findings will be shared with wider audiences, with the objectives of developing understanding and changing practice (Barker et al., 2016). The dissemination process is complex and challenging; it relies on systematic consideration of factors involved and detailed planning to be successful (Kerner et al.,

2005). This section will cover dissemination aims, relevant stakeholders, dissemination routes, publication plans, a dissemination timeline, and how dissemination success will be monitored and evaluated.

The aims of disseminating the current research are to:

- Share the views of CYP who possess expertise through experience of CBT

- Highlight the broad range of 'positive outcomes' from CBT experienced by CYP

- Prompt practitioners to reflect on their implementation of CBT

- Inform about typical and diverse usage of a CBT workbook

Stakeholders are people who would be interested in knowing about, or acting upon, research findings (Harmsworth & Turpin, 2000). This includes specialists, such as researchers and mental health practitioners, and non-specialists, such as CYP and families. Stakeholders have various needs so dissemination strategies should be adapted accordingly.

Regarding dissemination format, important factors include (Scullion, 2002):

- Source – Where, and who, does information come from? How credible is the source?

- Message – Which findings and implications are chosen for dissemination? What linguistic features are used including terminology, tone, and register?

- Medium – In what contexts are findings disseminated? How will stakeholders access information?

Regarding dissemination aims, important factors include (Harmsworth & Turpin, 2000):

- Awareness – broad knowledge about what research involved and outcomes

- Understanding – detailed knowledge about background, method, results, and outcomes of research

- Action – knowledge about how to translate findings into practice

Table 4.1 outlines relevant stakeholders and dissemination aims. This section will now discuss how the current research will be disseminated for awareness, understanding, and action.

Table 4.1

Aims of Dissemination for Stakeholders

Stakeholder	Awareness	Understanding	Action
Mental health practitioners		✓	✓
Children and young people	✓		
Families	✓		
School staff	✓		✓
Intervention designers		✓	✓
Academic researchers		✓	

4.4.1 Dissemination for awareness

CYP, families, and school staff are not typically trained or experienced in research methods and interpretation. Detailed, technical presentations would risk overwhelming and alienating these stakeholders, meaning they would not take away useful or relevant information (Harmsworth & Turpin, 2000). Furthermore, specialist professionals may not have time or inclination to engage with detailed presentations, even if they have the required skills. Dissemination for awareness is ideal for informing non-specialist stakeholders and useful for attracting interest of specialists who may wish to engage further.

Part of the researcher's ethical responsibility is to inform participants of research findings (BPS, 2012). This will be done by emailing a written summary to interviewees and inviting their feedback – not to influence the researcher's interpretation of findings but to encourage practitioner reflection.

A blog post will be written, offering a summary of the background, process, and outcomes. This will be sent to EdPsy, a community website for EPs, as a 'Longer

Read', a piece of 1200-1500 words. The researcher has published a 'Longer Read' with EdPsy before so is familiar with stylistic (formal but engaging) and content expectations (Redburn, 2021). The blog would be advertised by EdPsy and the researcher through EPNET and social media, reaching a large audience of EPs, aspiring EPs, and others interested in educational psychology. Twitter hashtags (such as #TwitterEPs and #DayInTheLifeOfATEP) and user interaction (such as liking and retweeting posts) will increase the reach of social media dissemination (Cooper, 2014).

Findings will be presented orally, alongside a PowerPoint presentation, at an EPS team meeting in the researcher's placement local authority. Presenting to colleagues with whom the researcher has pre-existing professional relationships may increase engagement and interest, potentially leading to discussions about how research implications can be acted upon within the service (Scullion, 2002). Organisations including the Association of EPs (AEP) and Southend EPS run outreach webinars, free events where EPs can share research. The researcher will contact these organisations with requests to present.

A research poster will be created summarising the introduction, method, results, discussion, and implications. Posters feature at professional conferences, such as those organised by the AEP and the Division of Educational and Child Psychology (DECP). The poster could be displayed in university teaching rooms as an example of Trainee EP (TEP) research. Posters are an efficient use of researcher time, as they can be shared in multiple contexts, but they may have lower engagement than other dissemination strategies because they rely on stakeholders to stand and read the contents. Engagement may be enhanced through brevity and use of visuals.

Finally, specific organisations and individuals will be contacted with written summaries and enquiries about supporting dissemination to colleagues and members. Relevant organisations include British Association for Behavioural and Cognitive

Psychotherapies and Association for Rational Emotive Behaviour Therapy. Relevant individuals include Paul Stallard, author of TGFG, who will likely have a personal interest in how professionals typically use the workbook.

4.4.2 Dissemination for understanding

Some stakeholders are interested in interrogating details of research to assess reliability and validity, and evaluate the quality and position of research within the literature field. One medium for detailed presentation is research conferences, where professionals come together to learn; hear about developments in the research field; and question researchers on the finer points of method, results, and implications. The current research will be submitted to AEP and DECP conferences, and will be presented at the UCL research conference for an audience of TEPs.

Another medium is written publication as a journal article. Chapters Two and Three will be proposed as separate articles. When choosing journals for publication, it is important to assess the potential reach an article could have. 'Impact factor' (IF) is the de facto measurement of potential reach; it is calculated by dividing the number of citations of recent articles in a journal by the number of articles published (Garfield, 1999). IF facilitates quantitative ranking of journals, giving researchers a sense of how many colleagues might reference their research. One study found a strong correlation (r^2 = .82, p < .001) between the IF of nine journals and ratings of journal quality by physicians and research graduates, concluding that IF represented a helpful quality indicator for journals (Saha et al., 2003). However, at the individual article level, IF does not necessarily provide useful information. It is estimated that 20% of published articles generate 80% of citations; half of all articles published between 1900 and 2005 were not cited once (Garfield, 2006). Further considerations when choosing journals for publication include topical relevance and readership. For example, 'Educational Psychology in Practice' (EPiP) is affiliated with the AEP, meaning a large proportion of EPs may read and act upon its contents, even though it has a low IF

(0.26), likely because few EPs conduct research. The status of a journal as open access (free for everyone without subscription) can enhance potential readership, although it may incur prohibitive upfront costs for researchers and institutions.

The systematic literature review in Chapter Two is relevant beyond the field of educational psychology, potentially interesting all CBT practitioners. To reach the widest audience possible, journals in the fields of child clinical psychology and psychiatry have been selected for potential contact (Table 4.2). The researcher's first choice will be 'Annual Review of Clinical Psychology' because of its high status within the field and because it specifically publishes review papers. The second choice will be 'European Child & Adolescent Psychiatry' because a previous qualitative review on CBT (Neelakantan et al., 2019) was published in this journal, suggesting the editors are open to this methodological approach.

The following draft title and abstract will be submitted:

Facilitators and Barriers to 'Positive Outcomes' from Cognitive-Behavioural Therapy, According to Young People: A Thematic Synthesis

Background. Randomised controlled trials have firmly established that cognitive-behavioural therapy (CBT) is effective for many young people (YP), particularly those experiencing anxiety and low mood. However, a considerable number of people, perhaps up to 50%, do not achieve positive outcomes from CBT.

Aim. This qualitative review sought to explore how YP conceptualise positive outcomes from CBT and what YP perceive to be the facilitators and barriers to positive outcomes.

Method. A systematic literature search identified nineteen studies for review. These were critically appraised using the Gough Weight of Evidence framework to assess methodological and topical quality and relevance. A

thematic synthesis identified 34 conceptualisations of positive outcomes, 57

facilitators, and 49 barriers.

Results. Descriptive and analytic themes were identified. In line with the

review's pragmatic epistemology, the latter were worded as practice

recommendations: acknowledge YP's perspectives on outcomes, teach

tangible CBT techniques, balance autonomy and support, frame CBT as

'upskilling', explore nuanced barriers to engagement, and consider the power

of group dynamics.

Conclusions. This was the first review to establish the broad range of YP's

typical and diverse views about positive outcomes from CBT, as well as

facilitators and barriers to achieving these. Findings should prompt CBT

practitioners to reflect and consider how their practice might be shaped

through reports from YP as experts by experience.

Table 4.2

Possible Publication Sources for the Systematic Literature Review

Journal	Description[a]	Impact factor[b]
Annual Review of Clinical Psychology	'provides comprehensive reviews of significant developments in the field of clinical psychology and psychiatry. The journal covers research, theory, and the application of psychological principles to address recognized disorders... Articles also address broader issues cross-cutting the field, such as diagnosis, treatment, social policy, and cross-cultural and legal issues'	18.561
Clinical Psychology Review	'publishes substantive reviews of topics germane to clinical psychology. Papers cover diverse issues including: psychopathology, psychotherapy, behaviour therapy, cognition and cognitive therapies, behavioural medicine, community mental health, assessment, and child development'	12.792

Journal	Description[a]	Impact factor[b]
Journal of Child Psychology and Psychiatry	'coverage includes studies on epidemiology, diagnosis, psychotherapeutic and psychopharmacological treatments, behaviour, cognition, neuroscience, neurobiology and genetic aspects of childhood disorders'	8.982
Journal of Clinical Child and Adolescent Psychology	Publishes on '(a) the development and evaluation of assessment and intervention techniques for use with clinical child and adolescent populations; (b) the development and maintenance of clinical child and adolescent problems…'	4.964
European Child & Adolescent Psychiatry	'aims to further a broad understanding of psychopathology in children and adolescents… welcomes in particular papers covering neuropsychiatry, cognitive neuroscience, genetics, neuroimaging, pharmacology, and related fields of interest'	4.785
Journal of Clinical Psychology	'focuses on the clinical challenges confronting psychotherapists, in the form of either a distinct patient population or a therapeutic dilemma'	2.885

[a] Journal descriptions were obtained from journal webpages and are selectively quoted verbatim.
[b] For all journals, IF is calculated as 'number of citations in 2020 to items published in 2018 and 2019' divided by 'number of citable items in 2018 and 2019'. IFs were obtained from Web of Science Journal Citation Reports (Web of Science, 2021).

The empirical investigation in Chapter Three used mixed methods and generated a large dataset. Survey and interview results could be published separately, to allow fuller consideration of results, referencing the mixed-methods aspects in discussion sections. However, for the current purposes, Chapter Three will be proposed as a single article. Readers may put more trust in research conducted by members of their own profession or with whom they are affiliated (Scullion, 2002). From this perspective, since the researcher is a TEP, 'EPiP' would be an ideal choice for publication. Furthermore, many EPs who read 'EPiP' would have participated in the survey so may feel personal interest in reading the results. The second choice would be 'Cognitive and Behavioral Practice' because of its mission to bridge the

implementation gap between research and practice, a mission shared by the researcher.

The following draft title and abstract will be submitted:

'It's Hard Not to Use It': The Value of a Workbook for Practitioners Delivering Cognitive-Behavioural Therapy to Young People

Background. Experimental research on cognitive-behavioural therapy (CBT) uses manualised protocols to ensure practitioners deliver the same treatment. However, practitioners have mixed views about the value of manuals, with some preferring to work based on professional judgment. CBT workbooks provide resources without prescribing a particular approach. No previous research has explored the usage or function of CBT workbooks.

Aim. The current study examined how practitioners use a CBT workbook (Think Good – Feel Good, TGFG) when working with young people.

Method. A convergent mixed-methods design was employed, with an online survey producing qualitative and quantitative data from 238 respondents and semi-structured interviews with 6 practitioners. Data were analysed separately using content and statistical analysis (surveys) and thematic analysis (interviews) before being integrated using a joint display.

Results. Findings are discussed in terms of how practitioners decide to use TGFG, how TGFG is employed in practice, and the role of supplementary resources within the therapeutic space. There were five overarching themes from interviews: practitioner support, flexibility and rigidity, developmental appropriateness, limits and prerequisites, and content / rapport relationship.

Conclusions. This represented the first exploration of how professionals use a CBT workbook. Findings are relevant to CBT practitioners, designers of

manuals and workbooks, and researchers interested in the therapeutic space

and relationship.

Table 4.3

Possible Publication Sources for the Empirical Investigation

Journal	Description	Impact factor
Cognitive Behaviour Therapy	'devoted to the application of behavioural and cognitive sciences to clinical psychology and psychotherapy'	5.761
Journal of Mixed Methods Research	'focuses on empirical, methodological, and theoretical articles about mixed methods research across the social, behavioural, health, and human sciences. The scope includes delineating where mixed methods research may be used most effectively, illuminating design and procedure issues, and determining the logistics of conducting mixed methods research'	5.267
Cognitive and Behavioral Practice	'primary mission of clinical dissemination: to bridge the gap between published clinical research and the actual clinical practice of cognitive and behavioural therapies… publishes clinically rich accounts of innovative assessment and therapeutic procedures that are clearly grounded in evidence-based practice. The primary focus is on application and implementation of procedures'	2.946
Child and Adolescent Mental Health	'principal aim is to foster evidence-based clinical practice and clinically orientated research among clinicians and health services researchers working with children and adolescents, parents and their families in relation to or with a particular interest in mental health'	2.175
Psychology in the Schools	'welcomes theoretical and applied manuscripts, focusing on the issues confronting school psychologists, teachers, counsellors, administrators, and other personnel workers in schools and colleges, public and private organizations'	1.774
Educational Psychology in Practice	'aims to publish peer refereed articles representing theory, research and practice which is of relevance to practising educational psychologists working primarily in UK contexts'	0.26

Journal	Description	Impact factor
Educational and Child Psychology	'Approaches should be rigorous, firmly grounded within the discipline of psychology and intended to stimulate and deepen understanding of issues in educational and child psychology'	0.258

4.4.3 Dissemination for action

The three stakeholders most likely to take action based on this research are mental health practitioners, school staff, and intervention designers. Practitioners and designers will likely receive the research through conferences and journal articles. It is hoped they will act by reflection, changing their practice, or modifying future interventions. School staff may receive the research indirectly through conversations with practitioners or directly through awareness dissemination strategies. This research did not establish TGFG usage among school staff but, if this is happening, the implications would be relevant as they are for practitioners. Consideration of findings around 'under-trained usage' may give confidence to school staff to collaborate with practitioners such as EPs, learning from workbooks or delivering certain sections of interventions.

Chapter Two made specific practice recommendations, based on views expressed by CYP. More broadly, practitioners and designers should consider the philosophy of the research approach, collecting data and making decisions in collaboration with those who are receiving interventions, respecting their expertise through experience. Regarding Chapter Three, practitioners should consider their degree of training and confidence in the approaches they use; resources like TGFG can increase accessibility but potentially engender overconfidence. Whilst a resource like TGFG may be insufficient by itself for running a complex intervention, it can enhance experience and effectiveness in several ways, including building rapport, teaching cognitive elements, engaging attention, and reducing emotional intensity. Overall, it

is hoped that this research encourages practitioners to explore and use workbooks and resources within a supportive system and with appropriate levels of training.

4.4.4 Monitoring and evaluating dissemination

One way of monitoring dissemination success is through a timeline, to hold the researcher accountable, and act as a reminder and organisational tool (Table 4.4) (Harmsworth & Turpin, 2000). Formative feedback will be sought via question and answer sessions at the end of conference and webinar presentations, where attendees may reflect on the relevance and quality of research. If journal publications are achieved, it will be possible to measure numbers of citations as an indicator of reach within the research literature.

Table 4.4

Proposed Timeline of Dissemination Activities

Date	Activity
Spring 2022	Send written summary to interviewees
Spring 2022	Contact individuals and organisations, including Paul Stallard
Spring 2022	Edit Chapter Two for publication as an article in a journal
Spring 2022	Present at outreach webinars – AEP and Southend EPS
20 April 2022	Present at local authority EPS team meeting
4 May 2022	Present at UCL research conference
Summer 2022	Write blog post for EdPsy and promote on social media
Summer 2022	Finalise article for publication and send to journals for consideration
November 2022	Present at AEP research conference (talk or poster)
Winter 2022	Receive feedback on article, revise, and resubmit
January 2023	Present at DECP TEP research conference (talk or poster)

4.5 Conclusion

The thesis will conclude by summarising the main threads of argument permeating the work. These are:

1. CYP who have undergone CBT are experts by experience. Their views should prompt practitioners to reflect, consider CPD needs, and discuss issues in supervision.

2. CBT workbooks are different to CBT manuals and should be studied on their own terms. Following implementation science principles, it is important to explore what is happening in practice, as well as conducting controlled testing of intervention efficacy and effectiveness.

3. Supplementary resources play a range of roles in the therapeutic space. These should be examined from theoretical lenses such as secondary intersubjectivity (Bråten & Trevarthen, 1994) and joint attention (Tomasello et al., 2005).

4.6 References

Achinstein, P. (2001). *The book of evidence*. Oxford University Press.

American Psychological Association. (2006). Evidence-based practice in psychology. *American Psychologist, 61*(4), 271–285. https://doi.org/10.1037/0003-066X.61.4.271

Atkinson, C., Bragg, J., Squires, G., Muscutt, J., & Wasilewski, D. (2011). Educational psychologists and therapeutic interventions: Preliminary findings from a UK-wide survey. *DECP Debate, 140*.

Barker, C., Pistrang, N., & Elliott, R. R. (2016). *Research methods in clinical psychology: An introduction for students and practitioners* (3rd ed.). Wiley-Blackwell.

Bauer, M. S., & Kirchner, J. A. (2020). Implementation science: What is it and why should I care? *Psychiatry Research, 283.* https://doi.org/10.1016/j.psychres.2019.04.025

Beaver, R. (2011). *Educational psychology casework: A practice guide* (2nd ed.). Jessica Kingsley Publishers.

Biesta, G. (2007). Why "what works" won't work: Evidence-based practice and the democratic deficit in educational research. *Educational Theory, 57*(1), 1–22. https://doi.org/10.1111/j.1741-5446.2006.00241.x

Boardman, A. G., Argüelles, M. E., Vaughn, S., Hughes, M. T., & Klingner, J. (2005). Special education teachers' views of research-based practices. *Journal of Special Education, 39*(3), 168–180. https://doi.org/10.1177/00224669050390030401

Brandell, J. R., & Varkas, T. (2010). Narrative case studies. In B. Thyer (Ed.), *The handbook of social work research methods* (2nd ed.). Sage.

Bråten, S., & Trevarthen, C. (1994). Beginnings of cultural learning. In *In talk at the ZiF symposium on the formative process of society, Bielefeld* (pp. 17–19).

British Psychological Society. (2012). *Code of human research ethics*.

British Psychological Society. (2017). *Practice guidelines: Third edition*.

British Psychological Society. (2019). *Mental health support teams: How to maximise the impact of the new workforce for children and young people*.

Bronfenbrenner, U. (1979). *The ecology of human development*. Harvard University Press.

Chenail, R. (1992). Qualitative research: Central tendencies and ranges. *The Qualitative Report, 1*(4), 1–3. https://doi.org/10.46743/2160-3715/1992.2037

Cook, B., & Cook, L. (2016). Leveraging evidence-based practice through partnerships based on practice-based evidence. *Learning Disabilities - A Contemporary Journal, 14*(2), 143–157.

Cooper, A. (2014). The use of online strategies and social media for research dissemination in education. *Education Policy Analysis Archives, 22.* https://doi.org/10.14507/epaa.v22n88.2014

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. Sage.

David, D., Cristea, I., & Hofmann, S. G. (2018). Why cognitive behavioral therapy is the current gold standard of psychotherapy. *Frontiers in Psychiatry*, *9*, 6–8. https://doi.org/10.3389/fpsyt.2018.00004

Davies, P. (1999). What is evidence-based education? *British Journal of Educational Studies*, *47*(2), 108–121. https://doi.org/10.1111/1467-8527.00106

De Jong, P., Bavelas, J. B., & Korman, H. (2013). An introduction to using microanalysis to observe co-construction in psychotherapy. *Journal of Systemic Therapies*, *32*(3), 17–30. https://doi.org/10.1521/jsyt.2013.32.3.17

Department for Education. (2015). *Special educational needs and disability code of practice: 0 to 25 years*.

Department of Health. (2008). *Children and young people in mind: The final report of the national CAMHS review*.

Department of Health and Department of Education. (2017). *Transforming children and young people's mental health provision: A green paper*.

Dunsmuir, S., Brown, E., Iyadurai, S., & Monsen, J. J. (2009). Evidence-based practice and evaluation: From insight to impact. *Educational Psychology in Practice*, *25*(1), 53–70. https://doi.org/10.1080/02667360802697605

Dunsmuir, S., & Hardy, J. (2016). *Delivering psychological therapies in schools and communities*.

Elkins, D. N. (2017). The paradigm shift in psychotherapy: Implications for the DSM. *Journal of Humanistic Psychology*, *57*(6), 667–674. https://doi.org/10.1177/0022167817737415

Evans, D. (2003). Hierarchy of evidence: A framework for ranking evidence evaluating healthcare interventions. *Journal of Clinical Nursing*, *12*(1), 77–84. https://doi.org/10.1046/j.1365-2702.2003.00662.x

Farrell, P., Woods, K., & Lewis, S. (2006). *A review of the functions and contribution of educational psychologists in England and Wales in light of "Every child matters: Change for children."*

Flanagan, D. (2013). Evidence-based practice or practice-based evidence? *Journal of Oral Implantology*, *39*(2), 121. https://doi.org/10.1563/AAID-JOI-D-11-00042.1

Forman, S. G., Olin, S. S., Hoagwood, K. E., Crowe, M., & Saka, N. (2009). Evidence-based interventions in schools: Developers' views of implementation barriers and facilitators. *School Mental Health*, *1*(1), 26–36. https://doi.org/10.1007/s12310-008-9002-5

Forman, S. G., Shapiro, E. S., Codding, R. S., Gonzales, J. E., Reddy, L. A., Rosenfield, S. A., Sanetti, L. M. H., & Stoiber, K. C. (2013). Implementation science and school psychology. *School Psychology Quarterly*, *28*(2), 77–100. https://doi.org/10.1037/spq0000019

Fox, M. (2003). Opening Pandora's box: Evidence-based practice for educational psychologists. *Educational Psychology in Practice*, *19*(2), 91–102. https://doi.org/10.1080/02667360303233

Fox, N. (2003). Practice-based evidence: Towards collaborative and transgressive research. *Sociology*, *37*(1), 81–102. https://doi.org/10.1177/0038038503037001388

Frederickson, N., & Cline, T. (2015). *Special educational needs, inclusion and*

diversity (3rd ed.). McGraw-Hill Education.

Furnham, A. (1986). Response bias, social desirability and dissimulation. *Personality and Individual Differences*, *7*(3), 385–400. https://doi.org/10.1016/0191-8869(86)90014-0

Garfield, E. (1999). Journal impact factor: A brief review. *Canadian Medical Association Journal*, *161*(8), 979–980.

Garfield, E. (2006). The history and meaning of the journal impact factor. *Journal of the American Medical Association*, *295*(1), 90. https://doi.org/10.1001/jama.295.1.90

Gersten, R., Fuchs, L. S., Compton, D., Coyne, M., Greenwood, C., & Innocenti, M. S. (2005). Quality indicators for group experimental and quasi-experimental research in special education. *Exceptional Children*, *71*(2), 149–164. https://doi.org/10.1177/001440290507100202

Greenhalgh, T. (1997). How to read a paper: Getting your bearings (deciding what the paper is about). *British Medical Journal*, *315*(7102), 243–246. https://doi.org/10.1136/bmj.315.7102.243

Guyatt, G. H., Sackett, D. L., Sinclair, J. C., Hayward, R., Cook, D. J., Cook, R. J., Bass, E., Gerstein, H., Haynes, B., Holbrook, A., Jaeschke, R., Laupacls, A., Moyer, V., & Wilson, M. (1995). Users' guides to the medical literature: IX. A method for grading health care recommendations. *Journal of the American Medical Association*, *274*(22), 1800–1804. https://doi.org/10.1001/JAMA.1995.03530220066035

Harmsworth, S., & Turpin, S. (2000). *Creating an effective dissemination strategy: An expanded interactive workbook for educational development projects*.

Health and Care Professions Council. (2016). *Standards of proficiency for practitioner psychologists*.

Heijnders, M., & Van Der Meij, S. (2006). The fight against stigma: An overview of stigma-reduction strategies and interventions. *Psychology, Health & Medicine*, *11*(3), 353–363. https://doi.org/10.1080/13548500600595327

Hoagwood, K., & Johnson, J. (2003). School psychology: A public health framework. I. From evidence-based practices to evidence-based policies. *Journal of School Psychology*, *41*(1), 3–21. https://doi.org/10.1016/S0022-4405(02)00141-3

Hofmann, S. G., Asnaani, A., Vonk, I. J. J., Sawyer, A. T., & Fang, A. (2012). The efficacy of cognitive behavioral therapy: A review of meta-analyses. *Cognitive Therapy and Research*, *36*(5), 427–440. https://doi.org/10.1007/s10608-012-9476-1

Ioannidis, J. P. A. (2016). Why most clinical research is not useful. *PLOS Medicine*, *13*(6), 1–10. https://doi.org/10.1371/journal.pmed.1002049

Kerner, J., Rimer, B., & Emmons, K. (2005). Dissemination research and research dissemination: How can we close the gap? *Health Psychology*, *24*(5), 443–446. https://doi.org/10.1037/0278-6133.24.5.443

Koh, K., Rubenstein, E., & White, K. (2015). Practical and scholarly implications of information behaviour research: A pilot study of research literature. *Information Research*, *20*(4).

Kratochwill, T. R., Hoagwood, K. E., Kazak, A. E., Weisz, J. R., Hood, K., Vargas, L.

A., & Banez, G. A. (2012). Practice-based evidence for children and adolescents: Advancing the research agenda in schools. *School Psychology Review*, *41*(2), 215–235. https://doi.org/10.1080/02796015.2012.12087521

Kratochwill, T. R., & Shernoff, E. S. (2004). Evidence-based practice: Promoting evidence-based interventions in school psychology. *School Psychology Review*, *33*(1), 34–48. https://doi.org/10.1080/02796015.2004.12086229

Larsson, S. (2009). A pluralist view of generalization in qualitative research. *International Journal of Research and Method in Education*, *32*(1), 25–38. https://doi.org/10.1080/17437270902759931

Lee, K., & Woods, K. (2017). Exploration of the developing role of the educational psychologist within the context of "traded" psychological services. *Educational Psychology in Practice*, *33*(2), 111–125. https://doi.org/10.1080/02667363.2016.1258545

Lewis, J., Ritchie, J., & Ormston, R. (2003). Generalising from qualitative research. In *Qualitative research practice: A guide for social science students and researchers* (pp. 347–362). Sage.

MacKay, T. (2008). Educational psychology: The fall and rise of therapy. *Educational and Child Psychology*, *25*(4), 94–105.

Mayer, C., & McKenzie, K. (2017). '…It shows that there's no limits': The psychological impact of co-production for experts by experience working in youth mental health. *Health and Social Care in the Community*, *25*(3), 1181–1189. https://doi.org/10.1111/hsc.12418

McShane, M. (2014). *Parity of esteem – what are we trying to achieve?* NHS. https://www.england.nhs.uk/blog/martin-mcshane-8/

Mental Health Taskforce to the NHS in England. (2016). *The five year forward view for mental health*.

Moon, K., & Blackman, D. (2014). A guide to understanding social science research for natural scientists. *Conservation Biology*, *28*(5), 1167–1177. https://doi.org/10.1111/cobi.12326

Muir Gray, J. M. (1996). *Evidence-based healthcare*. Churchill Livingstone.

Neelakantan, L., Hetrick, S., & Michelson, D. (2019). Users' experiences of trauma-focused cognitive behavioural therapy for children and adolescents: A systematic review and metasynthesis of qualitative research. *European Child and Adolescent Psychiatry*, *28*(7), 877–897. https://doi.org/10.1007/s00787-018-1150-z

NHS. (2014). *Five year forward view*.

Palys, T. S., & Atchison, C. (2008). *Research decisions: Quantitative and qualitative perspectives*. Thomson Nelson.

Petticrew, M., & Roberts, H. (2003). Evidence, hierarchies, and typologies: Horses for courses. *Journal of Epidemiology and Community Health*, *57*, 527–529.

Redburn, J. (2021, September 21). Disproportionality in SEN referrals: Why so many boys? *Edpsy.org.uk*. https://edpsy.org.uk/features/2021/disproportionality-in-sen-referrals-why-so-many-boys/

Rider, E. A., Ansari, E., Varrin, P. H., & Sparrow, J. (2021). Mental health and wellbeing of children and adolescents during the Covid-19 pandemic. *BMJ*.

https://doi.org/10.1136/bmj.n1730

Rycroft-Malone, J., Seers, K., Titchen, A., Harvey, G., Kitson, A., & McCormack, B. (2004). What counts as evidence in evidence-based practice? *Journal of Advanced Nursing*, *47*(1), 81–90. https://doi.org/10.1111/j.1365-2648.2004.03068.x

Sackett, D. L., Rosenberg, W. M., Gray, J. A., Haynes, R. B., & Richardson, W. S. (1996). Evidence based medicine: What it is and what it isn't. *British Medical Journal*, *312*, 71–72. https://doi.org/http://dx.doi.org/10.1136/bmj .312.7023.71

Sacks, H. (1995). *Lectures on conversation*. Blackwell.

Saha, S., Saint, S., & Christakis, D. A. (2003). Impact factor: A valid measure of journal quality? *Journal of the Medical Library Association*, *91*(1), 42–46.

Schraw, G. (1998). Promoting general metacognitive awareness. *Instructional Science*, *26*(1–2), 113–125. https://doi.org/10.1007/978-94-017-2243-8_1

Scullion, P. A. (2002). Effective dissemination strategies. *Nurse Researcher*, *10*(1), 65–77. https://doi.org/10.7748/nr2002.10.10.1.65.c5880

Shaw, S. R., & Pecsi, S. (2021). When is the evidence sufficiently supportive of real-world application? Evidence-based practices, open science, clinical readiness level. *Psychology in the Schools*, *58*(10), 1891–1901. https://doi.org/10.1002/pits.22537

Smith, J. D. (2012). Single-case experimental designs: A systematic review of published research and current standards. *Psychological Methods*, *17*(4), 510–550. https://doi.org/10.1037/a0029312

Squires, G. (2010). Countering the argument that educational psychologists need specific training to use cognitive behavioural therapy. *Emotional and Behavioural Difficulties*, *15*(4), 279–294. https://doi.org/10.1080/13632752.2010.523211

Stallard, P. (2002). *Think good - feel good: A cognitive behavioural therapy workbook for children and young people*. John Wiley & Sons, Ltd.

Stallard, P. (2018). *Think good - feel good: A cognitive behavioural therapy workbook for children and young people* (2nd ed.). John Wiley & Sons, Ltd.

Stallard, P. (2021). *A clinician's guide to CBT for children to young adults* (2nd ed.). John Wiley & Sons, Ltd.

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology*, *8*, 1–10. https://doi.org/10.1186/1471-2288-8-45

Tomasello, M., Carpenter, M., Call, J., Behne, T., & Moll, H. (2005). Understanding and sharing intentions: The origins of cultural cognition. *Behavioral and Brain Sciences*, *28*(5), 675–691. https://doi.org/10.1017/S0140525X05000129

van Strien, P. J. (1997). Towards a methodology of psychological practice. *Theory & Psychology*, *7*(5), 683–700. https://doi.org/10.1177/0959354397075006

Veenman, M. V. J. (2015). Metacognition. In P. Afflerbach (Ed.), *Handbook of individual differences in reading: Reader, text, and context*. Routledge. https://doi.org/10.4324/9780203075562.ch3

Web of Science. (2021). *Journal citation reports*. https://jcr-clarivate-com.libproxy.ucl.ac.uk/jcr/home

Woods, K., & Farrell, P. (2006). Approaches to psychological assessment by educational psychologists in England and Wales. *School Psychology*

International, 27(4), 387–404. https://doi.org/10.1177/0143034306070425

Yin, R. K. (2009). *Case study research design and methods* (4th ed.). Sage.

Appendices

Appendix A

Articles excluded from the review

References of studies excluded at full text screening are provided in Table A1.

References are not provided for studies excluded at title and abstract screening but

the total number of studies excluded under each criterion is shown in Figure 2.1.

Table A1

Articles Excluded at Full Text Screening with Reference to Exclusion Criteria

Excluded study reference	Exclusion criterion
Algahtani, H. M. S., Almulhim, A., Ainajjar, F. A., Ali, M. K., Irfan, M., Ayub, M., & Naeem, F. (2019). Cultural adaptation of cognitive behavioural therapy (CBT) for patients with depression and anxiety in Saudi Arabia and Bahrain: A qualitative study exploring views of patients, carers, and mental health professionals. *The Cognitive Behaviour Therapist*, *12*.	7
Ali, A., Weiss, T. R., Dutton, A., McKee, D., Jones, K. D., Kashikar-Zuck, S., Silverman, W. K., & Shapiro, E. D. (2017). Mindfulness-based stress reduction for adolescents with functional somatic syndromes: A pilot cohort study. *The Journal of Pediatrics*, *183*, 184-190.	8
Ames, C. S., Richardson, J., Payne, S., Smith, P., & Leigh, E. (2014). Innovations in practice: Mindfulness-based cognitive therapy for depression in adolescents. *Child and Adolescent Mental Health*, *19*(1), 74-78.	5
Barron, I., & Abdallah, G. (2017). Field trial of a complicated grief psychosocial program for adolescents in Occupied Palestine. *Journal of Aggression, Maltreatment & Trauma*, *26*(4), 372-390.	10
Barron, I., Mitchell, D., & Yule, W. (2017). Pilot study of a group-based psychosocial trauma recovery program in secure accommodation in Scotland. *Journal of Family Violence*, *32*(6), 595-606.	10
Bennett, S. D., Heyman, I., Varadkar, S., Coughtrey, A. E., & Shafran, R. (2017). Simple or complex? A case study of physical and mental health co-morbidity. *The Cognitive Behaviour Therapist*, *10*.	5

Excluded study reference	Exclusion criterion
Boyle, C., Lynch, L., Lyon, A., & Williams, C. (2011). The use and feasibility of a CBT intervention. *Child and Adolescent Mental Health*, *16*(3), 129-135.	8
Bunnell, B. E., Nemeth, L. S., Lenert, L. A., Kazantzis, N., Deblinger, E., Higgins, K. A., & Ruggiero, K. J. (2020). Barriers associated with the implementation of homework in youth mental health treatment and potential mobile health solutions. *Cognitive Therapy and Research*.	10
Caughter, S., & Dunsmuir, S. (2017). An exploration of the mechanisms of change following an integrated group intervention for stuttering, as perceived by school-aged children who stutter (CWS). *Journal of Fluency Disorders*, *51*, 8-23.	8
Chesin, M. S., Brodsky, B. S., Beeler, B., Benjamin-Phillips, C. A., Taghavi, I., & Stanley, B. (2018). Perceptions of adjunctive mindfulness-based cognitive therapy to prevent suicidal behavior among high suicide-risk outpatient participants. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, *39*(6), 451.	7
Choque Olsson, N., Rautio, D., Asztalos, J., Stoetzer, U., & Bölte, S. (2016). Social skills group training in high-functioning autism: A qualitative responder study. *Autism*, *20*(8), 995-1010.	8
Conroy, D. A., Czopp, A. M., Dore-Stites, D., Dopp, R. R., Armitage, R., Hoban, T. F., & Arnedt, J. T. (2017). A pilot study on adolescents with depression and insomnia: Qualitative findings from focus groups. *Behavioral Sleep Medicine*, *15*(1), 22-38.	5
Creswell, C., Leigh, E., Larkin, M., Stephens, G., Violato, M., Brooks, E., Pearcey, S., Taylor, L., Stallard, P., Waite, P., Reynolds, S., Taylor, G., Warnock-Parkes, E., & Clark, D. M. (2021). Cognitive therapy compared with CBT for social anxiety disorder in adolescents: a feasibility study. *Health Technology Assessment*, *25*(20), 1-94.	1
Crowe, M., Whitehead, L., Carlyle, D., McIntosh, V., Jordan, J., Joyce, P., & Carter, J. (2012). The process of change in psychotherapy for depression: Helping clients to reformulate the problem. *Journal of Psychiatric and Mental Health Nursing, 19*(8), 681-689.	9

Excluded study reference	Exclusion criterion
Cumba-Avilés, E. (2017). Cognitive-behavioral group therapy for Latino youth with type 1 diabetes and depression: A case study. *Clinical Case Studies*, *16*(1), 58-75.	7
Cunningham, N. R., Nelson, S., Jagpal, A., Moorman, E., Farrell, M., Pentiuk, S., & Kashikar-Zuck, S. (2018). Development of the Aim to Decrease Anxiety and Pain Treatment (ADAPT) for pediatric functional abdominal pain disorders. *Journal of Pediatric Gastroenterology and Nutrition*, *66*(1), 16.	6
Damra, J. K. M., Nassar, Y. H., & Ghabri, T. M. F. (2014). Trauma-focused cognitive behavioral therapy: Cultural adaptations for application in Jordanian culture. *Counselling Psychology Quarterly*, *27*(3), 308-323.	10
Dhanak, D., Thackeray, L., Dubicka, B., Kelvin, R., Goodyer, I. M., & Midgley, N. (2020). Adolescents' experiences of brief psychosocial intervention for depression: An interpretative phenomenological analysis of good-outcome cases. *Clinical Child Psychology and Psychiatry*, *25*(1), 106-118.	5
Dittmann, I., & Jensen, T. K. (2014). Giving a voice to traumatized youth—Experiences with trauma-focused cognitive behavioral therapy. *Child Abuse & Neglect*, *38*(7), 1221-1230.	10
Edgington, L., Hill, V., & Pellicano, E. (2016). The design and implementation of a CBT-based intervention for sensory processing difficulties in adolescents on the autism spectrum. *Research in Developmental Disabilities*, *59*, 221-233.	8
Fernandez, K. T. G., & Lina, S. G. A. (2020). Draw me your thoughts: The use of comic strips as a cognitive behavioral therapy intervention. *Journal of Creativity in Mental Health*, *15*(1), 17-29.	7
Finucane, A., & Mercer, S. W. (2006). An exploratory mixed methods study of the acceptability and effectiveness of mindfulness-based cognitive therapy for patients with active depression and anxiety in primary care. *BMC Psychiatry, 6*, 14.	7
Fung, A. L. C. (2012). Intervention for aggressive victims of school bullying in Hong Kong: A longitudinal mixed-methods study. *Scandinavian Journal of Psychology*, *53*(4), 360-367.	9
Fung, A. L. C. (2018). Cognitive-behavioural group therapy for pure victims with internalizing problems: An evidence-based one-	9

Excluded study reference	Exclusion criterion
year longitudinal study. *Applied Research in Quality of Life*, *13*(3), 691-708.	
Garmy, P., Berg, A., & Clausson, E. K. (2015). A qualitative study exploring adolescents' experiences with a school-based mental health program. *BMC Public Health*, *15*(1), 1074.	8
Gonzalez, L. M., Mejia, Y., Kulish, A., Stein, G. L., Kiang, L., Fitzgerald, D., & Cavanaugh, A. (2020). Alternate approaches to coping in Latinx adolescents from immigrant families. *Journal of Adolescent Research*.	5
Hall, W. J., Ruiz Rosado, B., & Chapman, M. V. (2019). Findings from a feasibility study of an adapted cognitive behavioral therapy group intervention to reduce depression among LGBTQ (lesbian, gay, bisexual, transgender, or queer) young people. *Journal of Clinical Medicine*, *8*(7), 949.	5
Harris, O., Lloyd, S., & Ward, J. (2021). Integrating elements of teddy bear therapy into cognitive behavioral therapy for a child with obsessive–compulsive disorder: A case study. *Journal of Child and Adolescent Psychiatric Nursing*.	9
Hjeltnes, A., Moltu, C., Schanche, E., Jansen, Y., & Binder, P. E. (2019). Facing social fears: How do improved participants experience change in mindfulness-based stress reduction for social anxiety disorder?. *Counselling and Psychotherapy Research*, *19*(1), 35-44.	5
Hjeltnes, A., Moltu, C., Schanche, E., Jansen, Y., & Binder, P. E. (2018). Both sides of the story: Exploring how improved and less-improved participants experience mindfulness-based stress reduction for social anxiety disorder. *Psychotherapy Research*, *28*(1), 106-122.	5
Jessiman, P., Hackett, S., & Carpenter, J. (2017). Children's and carers' perspectives of a therapeutic intervention for children affected by sexual abuse. *Child & Family Social Work*, *22*(2), 1024-1033.	5
Jimenez Chafey, M. I., Bernal, G., & Rosselló, J. (2009). Clinical case study: CBT for depression in a Puerto Rican adolescent: Challenges and variability in treatment response. *Depression and Anxiety*, *26*(1), 98-103.	7
Kolomeyer, E., & Renk, K. (2016). Family-based cognitive–behavioral therapy for an intelligent, elementary school-aged child with	7

Excluded study reference	Exclusion criterion
generalized anxiety disorder. *Clinical Case Studies*, *15*(6), 443-458.	
Kroon Van Diest, A. M., Ernst, M. M., Vaughn, L., Slater, S., & Powers, S. W. (2018). CBT for pediatric migraine: A qualitative study of patient and parent experience. *Headache: The Journal of Head and Face Pain*, *58*(5), 661-675.	8
Lomholt, J. J., Johnsen, D. B., Silverman, W. K., Heyne, D., Jeppesen, P., & Thastum, M. (2020). Feasibility study of Back2School, a modular cognitive behavioral intervention for youth with school attendance problems. *Frontiers in Psychology, 11*.	7
Lowell, A., & Renk, K. (2018). Cognitive-behavioral treatment of PTSD with a young boy and his mother following the experience of chronic domestic violence. *Clinical Case Studies*, *17*(3), 166-187.	7
MacIntosh, H. B., Cloitre, M., Kortis, K., Peck, A., & Weiss, B. J. (2018). Implementation and evaluation of the Skills Training in Affective and Interpersonal Regulation (STAIR) in a community setting in the context of childhood sexual abuse. *Research on Social Work Practice*, *28*(5), 595-602.	10
Mackay, B. A., Shochet, I. M., & Orr, J. A. (2017). A pilot randomised controlled trial of a school-based resilience intervention to prevent depressive symptoms for young adolescents with autism spectrum disorder: A mixed methods analysis. *Journal of Autism and Developmental Disorders*, *47*(11), 3458-3478.	8
McGale, N., McArdle, S., & Gaffney, P. (2011). Exploring the effectiveness of an integrated exercise/CBT intervention for young men's mental health. *British Journal of Health Psychology*, *16*(3), 457-471.	8
Miçoogullari, B. O., & Kirazci, S. (2016). Effects of 6 weeks psychological skill training on team cohesion, self-confidence & anxiety: A case of youth basketball players. *Universal Journal of Educational Research*, *4*(12), 2761-2768.	8
Midgley, N., Isaacs, D., Weitkamp, K., & Target, M. (2016). The experience of adolescents participating in a randomised clinical trial in the field of mental health: A qualitative study. *Trials*, *17*(1), 1-12.	9

Excluded study reference	Exclusion criterion
Murray, L. K., Hall, B. J., Dorsey, S., Ugueto, A. M., Puffer, E. S., Sim, A., Ismael, A., Bass, J., Akiba, C., Lucid, L., Harrison, J., Erikson, A., & Bolton, P. A. (2018). An evaluation of a common elements treatment approach for youth in Somali refugee camps. *Global Mental Health*, *5*.	9
Murray, L. K., Skavenski, S., Michalopoulos, L. M., Bolton, P. A., Bass, J. K., Familiar, I., Imasiku, M., & Cohen, J. (2014). Counselor and client perspectives of trauma-focused cognitive behavioral therapy for children in Zambia: A qualitative study. *Journal of Clinical Child & Adolescent Psychology*, *43*(6), 902-914.	10
Nissim, R. S., Roth, A., Gupta, A. A., & Elliott, M. (2020). Mindfulness-Based Cognitive Therapy Intervention for Young Adults with Cancer: A Pilot Mixed-Method Study. *Journal of Adolescent and Young Adult Oncology*, *9*(2), 256-261.	5
Nowrouzi, B., Manassis, K., Jones, E., Bobinski, T., & Mushquash, C. J. (2015). Translating anxiety-focused CBT for youth in a First Nations context in northwestern Ontario. *Journal of the Canadian Academy of Child and Adolescent Psychiatry*, *24*(1), 33.	7
Puff, J., & Renk, K. (2015). Preschool PTSD treatment (PPT) for a young child exposed to trauma in the Middle East. *Clinical Case Studies*, *14*(5), 388-404.	7
Racey, D. N., Fox, J., Berry, V. L., Blockley, K. V., Longridge, R. A., Simmons, J. L., Janssens, A., Kuyken, W., & Ford, T. J. (2018). Mindfulness-based cognitive therapy for young people and their carers: A mixed-method feasibility study. *Mindfulness, 9*(4), 1063-1075.	5
Robinson, K. J., Rose, D., & Salkovskis, P. M. (2017). Seeking help for obsessive compulsive disorder (OCD): A qualitative study of the enablers and barriers conducted by a researcher with personal experience of OCD. *Psychology and Psychotherapy: Theory, Research and Practice*, *90*(2), 193-211.	9
Rodd, H., Kirby, J., Duffy, E., Porritt, J., Morgan, A., Prasad, S., & Marshman, Z. (2018). Children's experiences following a CBT intervention to reduce dental anxiety: One year on. *British Dental Journal*, *225*(3), 247-251.	9

Excluded study reference	Exclusion criterion
Sarkadi, A., Ådahl, K., Stenvall, E., Ssegonja, R., Batti, H., Gavra, P., Fängstrom, K., & Salari, R. (2018). Teaching recovery techniques: Evaluation of a group intervention for unaccompanied refugee minors with symptoms of PTSD in Sweden. *European Child & Adolescent Psychiatry*, *27*(4), 467-479.	10
Schanche, E., Vøllestad, J., Binder, P. E., Hjeltnes, A., Dundas, I., & Nielsen, G. H. (2020). Participant experiences of change in mindfulness-based stress reduction for anxiety disorders. *International Journal of Qualitative Studies on Health and Well-being*, *15*(1).	5
Scheiber, B., Greinz, G., Hillebrand, J. B., Wilhelm, F. H., & Blechert, J. (2019). Resilience training for unaccompanied refugee minors: A randomized controlled pilot study. *Kindheit und Entwicklung, 28*(3), 173-181.	2
Shafran, R., Bennett, S., Coughtrey, A., Welch, A., Walji, F., Cross, J. H., Heyman, I., Sibelli, A., Smith, J., Ross, J., Dalrymple, E., & Varadkar, S. (2020). Optimising evidence-based psychological treatment for the mental health needs of children with epilepsy: Principles and methods. *Clinical Child and Family Psychology Review, 23*, 284-295.	5
Sibeoni, J., Orri, M., Podlipski, M. A., Labey, M., Campredon, S., Gerardin, P., & Revah-Levy, A. (2018). The experience of psychiatric care of adolescents with anxiety-based school refusal and of their parents: A qualitative study. *Journal of the Canadian Academy of Child and Adolescent Psychiatry*, *27*(1), 39.	5
Simmonds, B., Turner, N., Thomas, L., Campbell, J., Lewis, G., Wiles, N., & Turner, K. (2013). Patients' experiences of participating in a large-scale trial of cognitive behavioural therapy for depression: A mixed methods study. *Family Practice*, *30*(6), 705-711.	9
Stallard, P., Simpson, N., Anderson, S., Carter, T., Osborn, C., & Bush, S. (2005). An evaluation of the FRIENDS programme: A cognitive behaviour therapy intervention to promote emotional resilience. *Archives of Disease in Childhood*, *90*(10), 1016-1019.	8
Stephenson, J. N., & Renk, K. (2019). My first time hurt: Using preschool PTSD treatment to address PTSD symptoms in a	7

Excluded study reference	Exclusion criterion
young girl with a history of pediatric cancer. *Clinical Case Studies*, *18*(2), 87-105.	
Sternheim, L., & Harrison, A. (2018). The acceptability, feasibility and possible benefits of a group-based intervention targeting intolerance of uncertainty in adolescent inpatients with anorexia nervosa. *Cogent Psychology*, *5*, 1.	9
Taylor, J. A., Phillips, R., Cook, E., Georgiou, L., Stallard, P., & Sayal, K. (2014). A qualitative process evaluation of classroom-based cognitive behaviour therapy to reduce adolescent depression. *International Journal of Environmental Research and Public Health*, *11*(6), 5951-5969.	8
Tickell, A., Byng, R., Crane, C., Gradinger, F., Hayes, R., Robson, J., Cardy, J., Weaver, A., Morant, N., & Kuyken, W. (2020). Recovery from recurrent depression with mindfulness-based cognitive therapy and antidepressants: A qualitative study with illustrative case studies. *BMJ Open, 10*(2).	7
Tong, J., Simpson, K., Alvarez-Jimenez, M., & Bendall, S. (2017). Distress, psychotic symptom exacerbation, and relief in reaction to talking about trauma in the context of beneficial trauma therapy: Perspectives from young people with post-traumatic stress disorder and first episode psychosis. *Behavioural and Cognitive Psychotherapy*, *45*(6), 561.	10
Vuthiarpa, S., Sethabouppha, H., Soivong, P., & Williams, R. (2012). Effectiveness of a school-based cognitive behavioral therapy program for Thai adolescents with depressive symptoms. *Pacific Rim International Journal of Nursing Research*, *16*(3), 206-221.	9
Westerman, N. K., Cobham, V. E., & McDermott, B. (2017). Trauma-focused cognitive behavior therapy: Narratives of children and adolescents. *Qualitative Health Research*, *27*(2), 226-235.	10

Appendix B

Criteria and rationale for Weight of Evidence (WoE) ratings in the review

WoE A: Methodological quality

WoE A is a generic judgment of whether a study is well executed (Gough, 2007). A published coding protocol designed to evaluate qualitative studies with 18 appraisal questions was used to make this judgment (Spencer et al., 2003). Questions addressed the following topics: findings (1-5), design (6), sample (7-8), data collection (9), analysis (10-13), reporting (14-15), reflexivity and neutrality (16), ethics (17) and auditability (18). For each appraisal question, a score of 0 was given if the study did not meet any quality indicators or did not sufficiently answer the question; a score of 1 was given if the study met fewer than half of the quality indicators or roughly answered the question; a score of 2 was given if a study met up to two thirds of the quality indicators or mostly answered the question; a score of 3 was given if a study met all of the quality indicators or fully answered the question. Scores were averaged to determine an overall WoE A score. A summary of scores from the coding protocol for each included study is provided in Table B1. An example coding protocol is provided in Appendix C.

Table B1

Summary of Scores from the WoE A Coding Protocol

Study	Appraisal question																		WoE A
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	
Myburgh et al. (2021)	3	3	3	2	3	2	2	2	1	2	1	1	1	1	3	1	1	1	1.83
Taylor et al. (2021)	3	3	3	1	3	3	2	1	2	3	1	2	3	2	3	3	2	2	2.33
Howells et al. (2020)	3	2	2	3	2	2	3	2	0	3	1	1	1	0	3	1	1	2	1.78
Jones et al. (2020)	3	3	3	2	2	3	3	2	3	3	1	1	2	2	3	3	2	2	2.39

Study	Appraisal question																		WoE A
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	
Krause et al. (2020)	3	3	3	3	2	3	2	1	2	3	1	1	1	2	3	2	1	2	2.11
Loucas et al. (2020)	3	3	3	3	3	3	3	2	2	3	1	1	2	2	3	1	2	3	2.39
Wilmots et al. (2020)	3	3	3	3	3	2	2	1	3	3	3	3	3	3	3	3	2	2	2.67
Claus et al. (2019)	3	3	3	3	3	3	3	1	3	3	1	2	3	3	3	3	1	3	2.61
Cunningham et al. (2019)	3	2	3	2	3	3	3	2	3	3	1	1	1	1	2	1	1	3	2.11
Kandasamy et al. (2019)	2	1	1	1	1	1	2	1	1	2	0	0	1	1	1	1	1	1	1.06
O'Keeffe et al. (2019)	3	3	3	3	3	3	3	2	2	3	3	3	3	3	3	2	2	2	2.72
Donald et al. (2018)	3	3	3	3	2	3	1	1	2	3	2	2	3	3	3	3	3	2	2.50
McKeague et al. (2018)	2	2	3	2	2	3	3	2	2	3	2	3	3	3	3	1	1	2	2.33
Clarke et al. (2017)	2	3	3	3	2	3	2	2	1	3	1	1	3	2	3	1	1	3	2.17
Lundkvist-Houndoumadi & Thastum (2017)	3	3	3	3	3	3	3	2	2	3	2	2	3	3	3	3	1	2	2.61
Jones et al. (2017)	3	3	3	2	2	3	3	2	3	3	3	3	3	3	3	3	3	2	2.78
Shahnavaz et al. (2015)	3	3	2	2	2	2	1	1	2	3	3	3	3	3	3	3	1	1	2.28
Bru et al. (2013)	3	3	3	3	3	3	3	2	2	3	3	3	3	3	3	2	2	2	2.72
Donnellan et al. (2013)	3	3	3	3	3	3	3	2	3	3	3	3	3	3	3	3	1	2	2.78

WoE B: Methodological relevance

WoE B is a judgment of the quality and relevance of the research design of a study to the review question (Gough, 2007). For this review, WoE B considered the relevance of the methodology for exploring the views of children and young people relating to facilitators and barriers to positive outcomes from CBT.

The coding protocol for WoE B was developed by the author and is provided in Table B2. There were four criteria categorised as 'sampling', 'data collection', 'analytical procedures', and 'evidence for practice'. Scores were averaged across categories to produce a WoE B rating. A summary of scores from the coding protocol for each included study is provided in Table B3.

Table B2

Criteria and Rationale for WoE B Ratings

Criteria category		Criteria	Rationale
Sampling	3	Sample selected to openly explore previous therapy experience with researchers who were not previously involved	Participants who do not feel guided by a priori aims of researchers will provide honest and broad data
	2	Sample selected to openly explore previous therapy experience with which researchers have been involved or to evaluate a specific therapeutic intervention with which researchers were not involved	
	1	Sample selected to evaluate a specific therapeutic intervention by researchers involved in the intervention	
Data collection	3	In-person, semi-structured interviews conducted less than a month post-intervention	Data collected in person will allow for nuance, while data collected immediately post-intervention will aid memory and accuracy
	2	In-person, semi-structured interviews conducted more than a month post-intervention	
	1	No in-person data collection e.g. questionnaires	

Criteria category		Criteria	Rationale
Analytical procedures	3	Capture diversity of experience within research and contexts outside research	Diverse, rich data illustrate breadth of experience with CBT
	2	Capture diversity of experience within research but don't explore contexts outside research	
	1	Record the accounts of 'most' or 'many' with little attention paid to diversity or context	
Evidence for practice	3	Clear clinical and theoretical implications	Findings of the study should have implications for practitioners or those developing interventions
	2	Clinical or theoretical implications	
	1	Limited clinical and theoretical implications	

Table B3

Summary of Scores from the WoE B Coding Protocol

Study	Criteria category				
	Sampling	Data collection	Analytical procedures	Evidence for practice	WoE B rating
Myburgh et al. (2021)	1	2	1	2	1.5
Taylor et al. (2021)	2	2	3	2	2.25
Howells et al. (2020)	2	1	1	2	1.5
Jones et al. (2020)	2	2	2	2	2
Krause et al. (2020)	1	2	1	3	1.75
Loucas et al. (2020)	1	3	1	2	1.75
Wilmots et al. (2020)	3	3	3	3	3
Claus et al. (2019)	1	3	2	3	2.25
Cunningham et al. (2019)	1	3	1	2	1.75
Kandasamy et al. (2019)	2	2	1	1	1.5
O'Keeffe et al. (2019)	3	3	3	3	3
Donald et al. (2018)	3	3	2	3	2.75
McKeague et al. (2018)	2	2	2	3	2.25
Clarke et al. (2017)	1	2	1	2	1.5
Jones et al. (2017)	3	2	3	3	2.75
Lundkvist-Houndoumadi & Thastum (2017)	2	2	3	2	2.25

	Criteria category				
Study	Sampling	Data collection	Analytical procedures	Evidence for practice	WoE B rating
Shahnavaz et al. (2015)	3	2	3	3	2.75
Bru et al. (2013)	1	3	2	2	2
Donnellan et al. (2013)	3	2	3	2	2.5

WoE C: Topic relevance

WoE C is a judgment of the quality and relevance of the research evidence to the review question (Gough, 2007). The coding protocol for WoE C was developed by the author and is provided in Table B4. There were five criteria categorised as 'intervention', 'mental health difficulties', 'interview content', 'theoretical approach to data analysis', and 'data reported'. Scores were averaged across categories to produce a WoE C rating. A summary of scores from the coding protocol for each included study is provided in Table B5.

Table B4

Criteria and Rationale for WoE C Ratings

Criteria category		Criteria	Rationale
Intervention	3	In-person individual/family CBT with fully-trained therapist for at least 6 sessions	Participants who have full,
	2	In-person individual/family CBT with fully-trained therapist for fewer than 6 sessions or group CBT with fully-trained therapist	extended experiences of CBT will likely
	1	Any form of CBT where the intervention provider is not a fully-trained therapist or an	have the most

Criteria category		Criteria	Rationale
		intervention only partially incorporating CBT principles and techniques	rounded perspectives
Mental health difficulties	3	Clear evidence establishing participants' clinical levels of anxiety/depression	Participants with clinical mental health difficulties will likely experience the broadest range of therapeutic outcomes
	2	Credible evidence establishing elevated levels of anxiety/depression	
	1	Evidence of heightened risk for anxiety/depression or vague reference to emotional difficulties	
Interview content	3	Open and non-leading questions with scope for flexible prompts or follow-up questions based on participant response	Participants will likely be more honest and expressive if they are given the chance to speak openly
	2	Open questions within a rigid structure that doesn't flexibly account for participant response and may occasionally be leading	
	1	Mainly leading questions within an explicitly evaluative framework relating to a specific intervention	
Theoretical approach to data analysis	3	Inductive as far as possible, allowing raw data to guide thematic development without reference to a priori frameworks	An inductive approach will likely retain participants' original opinions rather than manipulating them in line with researchers' assumptions
	2	Partially inductive and partially deductive	
	1	Deductive or restrictive with thematic elaboration based on a priori assumptions or frameworks	
Data reported	3	Roughly equal discussion of both facilitators and barriers to positive outcomes with CBT	A broad range of positive and negative experiences of CBT will likely clarify what factors influence positive outcomes
	2	Majority of discussion of facilitators *or* barriers to positive outcomes with CBT or a significant portion of discussion about what was learned rather than how positive outcomes occurred or failed to occur	
	1	Majority of discussion of what was learned rather than how positive outcomes occurred or failed to occur	

Table B5

Summary of Scores from the WoE C Coding Protocol

Study	Intervention	Mental health difficulties	Interview content	Theoretical approach to data analysis	Data reported	WoE C rating
			Criteria category			
Myburgh et al. (2021)	2	1	1	2	1	1.4
Taylor et al. (2021)	3	3	3	3	3	3
Howells et al. (2020)	2	1	1	1	3	1.6
Jones et al. (2020)	3	2	2	3	1	2.2
Krause et al. (2020)	3	3	2	2	1	2.2
Loucas et al. (2020)	2	2	1	1	2	1.6
Wilmots et al. (2020)	3	3	3	3	2	2.8
Claus et al. (2019)	2	1	2	1	1	1.4
Cunningham et al. (2019)	3	3	1	1	2	2
Kandasamy et al. (2019)	3	3	2	2	1	2.2
O'Keeffe et al. (2019)	3	3	3	3	2	2.8
Donald et al. (2018)	3	2	3	3	3	2.8
McKeague et al. (2018)	2	1	2	2	2	1.8
Clarke et al. (2017)	2	2	3	3	1	2.2
Jones et al. (2017)	3	2	3	3	3	2.8
Lundkvist-Houndoumadi & Thastum (2017)	2	3	2	3	2	2.4

Study	Criteria category					
	Intervention	Mental health difficulties	Interview content	Theoretical approach to data analysis	Data reported	WoE C rating
Shahnavaz et al. (2015)	3	2	2	3	2	2.4
Bru et al. (2013)	2	2	2	2	1	1.8
Donnellan et al. (2013)	3	2	2	3	3	2.6

Appendix C

Example WoE A Coding Protocol for the review

This appendix contains an example of the coding protocol for one study. The full set of protocols is available should they need to be seen.

Scoring protocol: This protocol was adapted from a report by Spencer et al. (2003). For each appraisal question a score ranging from 0 to 3 will be given. A score of 0 will be given if the study does not meet any of the quality indicators for that question or is judged to not sufficiently answer the question. A score of 1 will be given if the study meets fewer than half of the quality indicators or is judged to roughly answer the question. A score of 2 will be given if a study meets up to two thirds of the quality indicators or is judged to have mostly answered the question. A score of 3 will be given if a study meets all of the quality indicators or is judged to have fully answered the item. Scores will be averaged to determine an overall WoE A score. Quality indicators will be highlighted red if they are not met, yellow if partially met, green if fully met, blue if unclear, and crossed out if not relevant.

Study being evaluated: Myburgh, N., Muris, P., & Loxton, H. (2021). Promoting braveness in children: A pilot study on the effects of a brief, intensive CBT-based anxiety prevention programme conducted in the South African context. *Child Care in Practice*, 1-23. https://doi.org/10.1080/13575279.2021.1902785

Appraisal question	Quality indicators	Score and notes
1. Findings How credible are the findings?	Findings/conclusions are supported by data/study evidence (i.e. the reader can see how the researcher arrived at his/her conclusions; the 'building blocks' of analysis and interpretation are evident) Findings/conclusions 'make sense'/have a coherent logic Findings/conclusions are resonant with other knowledge and experience (this might include peer or member review) Use of corroborating evidence to support or refine findings (i.e. other data sources have been used to examine phenomena; other research evidence has been evaluated: see also Q14)	Score: 3 Statistical pre-/post-analysis too
2. Findings	Literature review (where appropriate) summarising knowledge to date/key issues raised by previous research	Score: 3

Appraisal question	Quality indicators	Score and notes
How has knowledge/ understanding been extended by the research?	Aims and design of study set in the context of existing knowledge/ understanding; identifies new areas for investigation (for example, in relation to policy/practice/ substantive theory) Credible/clear discussion of how findings have contributed to knowledge and understanding (e.g. of the policy, programme or theory being reviewed); might be applied to new policy developments, practice or theory Findings presented or conceptualised in a way that offers new insights/alternative ways of thinking Discussion of limitations of evidence and what remains unknown/unclear or what further information/research is needed	
3. Findings How well does the evaluation address its original aims and purpose?	Clear statement of study aims and objectives; reasons for any changes in objectives Findings clearly linked to the purposes of the study – and to the initiative or policy being studied Summary or conclusions directed towards aims of study Discussion of limitations of study in meeting aims (e.g. are there limitations because of restricted access to study settings or participants, gaps in the sample coverage, missed or unresolved areas of questioning; incomplete analysis; time constraints?)	Score: 3
4. Findings	Discussion of what can be generalised to wider population from which sample is drawn/case selection has been made	Score: 2

Appraisal question	Quality indicators	Score and notes
Scope for drawing wider inference – how well is this explained?	Detailed description of the contexts in which the study was conducted to allow applicability to other settings/contextual generalities to be assessed Discussion of how hypotheses/ propositions/findings may relate to wider theory; consideration of rival explanations Evidence supplied to support claims for wider inference (either from study or from corroborating sources) Discussion of limitations on drawing wider inference (e.g. re-examination of sample and any missing constituencies: analysis of restrictions of study settings for drawing wider inference)	
5. Findings How clear is the basis of evaluative appraisal?	Discussion of how assessments of effectiveness/ evaluative judgements have been reached *(i.e. whose judgements are they and on what basis have they been reached?)* Description of any formalised appraisal criteria used, when generated and how and by whom they have been applied Discussion of the nature and source of any divergence in evaluative appraisals Discussion of any unintended consequences of intervention, their impact and why they arose	Score: 3
6. Design	Discussion of how overall research strategy was designed to meet aims of study Discussion of rationale for study design	Score: 2 Unclear what kind of mixed methods

Appraisal question	Quality indicators	Score and notes
How defensible is the research design?	Convincing argument for different features of research design (e.g. reasons given for different components or stages of research; purpose of particular methods or data sources, multiple methods, time frames etc.) Use of different features of design/data sources evident in findings presented Discussion of limitations of research design and their implications for the study evidence	
7. Sample How well defended is the sample design/ target selection of cases/ documents?	Description of study locations/areas and how and why chosen Description of population of interest and how sample selection relates to it (e.g. typical, extreme case, diverse constituencies etc.) Rationale for basis of selection of target sample/settings/documents (e.g. characteristics/features of target sample/settings/documents, basis for inclusions and exclusions, discussion of sample size/number of cases/setting selected etc.) Discussion of how sample/selections allowed required comparisons to be made	Score: 2
8. Sample Sample composition/ case inclusion – how well is the eventual	Detailed profile of achieved sample/case coverage Maximising inclusion (e.g. language matching or translation; specialised recruitment; organised transport for group attendance)	Score: 2

Appraisal question	Quality indicators	Score and notes
coverage described?	Discussion of any missing coverage in achieved samples/cases and implications for study evidence (e.g. through comparison of target and achieved samples, comparison with population etc.) Documentation of reasons for non-participation among sample approached/non-inclusion of selected cases/documents Discussion of access and methods of approach and how these might have affected participation/coverage	
9. Data Collection How well was the data collection carried out?	Discussion of: • who conducted data collection • procedures/documents used for collection/recording • checks on origin/status/authorship of documents Audio or video recording of interviews/discussions/conversations (if not recorded, were justifiable reasons given?) Description of conventions for taking field notes (e.g. to identify what form of observations were required/to distinguish description from researcher commentary/analysis) Discussion of how fieldwork methods or settings may have influenced data collected Demonstration, through portrayal and use of data, that depth, detail and richness were achieved in collection	Score: 1
10. Analysis	Description of form of original data (e.g. use of verbatim transcripts, observation or interview notes, documents, etc.)	Score: 2

Appraisal question	Quality indicators	Score and notes
How well has the approach to and formulation of the analysis been conveyed?	Clear rationale for choice of data management method/tool/package Evidence of how descriptive analytic categories, classes, labels etc. have been generated and used (i.e. either through explicit discussion or portrayal in the commentary) Discussion, with examples, of how any constructed analytic concepts/typologies etc. have been devised and applied	
11. Analysis Contexts of data sources – how well are they retained and portrayed?	Description of background or historical developments and social/organisational characteristics of study sites or settings Participants' perspectives/observations placed in personal context (e.g. use of case studies/vignettes/individual profiles, textual extracts annotated with details of contributors) Explanation of origins/history of written documents Use of data management methods that preserve context (i.e. facilitate within case description and analysis)	Score: 1
12. Analysis How well has diversity of perspective and content been explored?	Discussion of contribution of sample design/case selection in generating diversity Description and illumination of diversity/multiple perspectives/alternative positions in the evidence displayed Evidence of attention to negative cases, outliers or exceptions	Score: 1

Appraisal question	Quality indicators	Score and notes
	Typologies/models of variation derived and discussed Examination of origins/influences on opposing or differing positions Identification of patterns of association/linkages with divergent positions/groups	
13. Analysis How well has detail, depth and complexity (i.e. richness) of the data been conveyed?	Use and exploration of contributors' terms, concepts and meanings Unpacking and portrayal of nuance/subtlety/intricacy within data Discussion of explicit and implicit explanations Detection of underlying factors/influences Identification and discussion of patterns of association/conceptual linkages within data Presentation of illuminating textual extracts/observations	Score: 1
14. Reporting	Clear conceptual links between analytic commentary and presentations of original data (i.e. commentary and cited data relate; there is an analytic context to cited data, not simply repeated description)	Score: 1

Appraisal question	Quality indicators	Score and notes
How clear are the links between data, interpretation and conclusions – i.e. how well can the route to any conclusions be seen?	Discussion of how/why particular interpretation/significance is assigned to specific aspects of data – with illustrative extracts of original data Discussion of how explanations/ theories/conclusions were derived – and how they relate to interpretations and content of original data (i.e. how warranted); whether alternative explanations explored Display of negative cases and how they lie outside main proposition/theory/ hypothesis etc.; or how proposition etc. revised to include them	
15. Reporting How clear and coherent is the reporting?	Demonstrates link to aims of study/research questions Provides a narrative/story or clearly constructed thematic account Has structure and signposting that usefully guide reader through the commentary Provides accessible information for intended target audience(s) Key messages highlighted or summarised	Score: 3
16. Reflexivity & Neutrality How clear are the assumptions/ theoretical	Discussion/evidence of the main assumptions/hypotheses/theoretical ideas on which the evaluation was based and how these affected the form, coverage or output of the evaluation (the assumption here is that no research is undertaken without some underlying assumptions or theoretical ideas)	Score: 1

Appraisal question	Quality indicators	Score and notes
perspectives/ values that have shaped the form and output of the evaluation?	Discussion/evidence of the ideological perspectives/values/philosophies of research team and their impact on the methodological or substantive content of the evaluation (again, may not be explicitly stated) Evidence of openness to new/ alternative ways of viewing subject/ theories/assumptions (e.g. discussion of learning/concepts/ constructions that have emerged from the data; refinement restatement of hypotheses/theories in light of emergent findings; evidence that alternative claims have been examined) Discussion of how error or bias may have arisen in design/data collection/analysis and how addressed, if at all Reflections on the impact of the researcher on the research process	
17. Ethics What evidence is there of attention to ethical issues?	Evidence of thoughtfulness/sensitivity about research contexts and participants Documentation of how research was presented in study settings/to participants (including, where relevant, any possible consequences of taking part) Documentation of consent procedures and information provided to participants Discussion of confidentiality of data and procedures for protecting Discussion of how anonymity of participants/sources was protected Discussion of any measures to offer information/advice/services etc. at end of study (i.e. where participation exposed the need for these)	Score: 1

Appraisal question	Quality indicators	Score and notes
	Discussion of potential harm or difficulty through participation, and how avoided	
18. Auditability How adequately has the research process been documented?	Discussion of strengths and weaknesses of data sources and methods Documentation of changes made to design and reasons; implications for study coverage Documentation and reasons for changes in sample coverage/data collection/ analytic approach; implications Reproduction of main study documents (e.g. letters of approach, topic guides, observation templates, data management frameworks etc.)	Score: 1

Total score: 33

WoE A rating: 1.83

Appendix D

Further details about the thematic synthesis

Table D1

List of Studies, Unique Codes, and Total References

Study	Codes	References
Myburgh et al. (2021)	34	295
Taylor et al. (2021)	36	95
Howells et al. (2020)	31	60
Jones et al. (2020)	33	55
Krause et al. (2020)	33	114
Loucas et al. (2020)	49	170
Wilmots et al. (2020)	63	190
Claus et al. (2019)	48	140
Cunningham et al. (2019)	44	132
Kandasamy et al. (2019)	33	91
O'Keeffe et al. (2019)	22	43
Donald et al. (2018)	64	172
McKeague et al. (2018)	53	136
Clarke et al. (2017)	33	135
Jones et al. (2017)	59	288
Lundkvist-Houndoumadi & Thastum (2017)	44	126
Shahnavaz et al. (2015)	41	190
Bru et al. (2013)	52	244
Donnellan et al. (2013)	79	267

Table D2

List of Codes, Initial Coding Categories, Studies, and Total References

Code	Studies	References
a issues before therapy	1	1
a anxiety, stress	3	12
a being encouraged to seek help	2	7
a difficult social relationships	3	11
a needing someone to speak to	2	3
a parents feel powerless to help	2	7
a powerless	4	5
a pressure to conform to social norms	1	6
a unable to communicate emotions	5	11
a unable to control emotions	5	6

Code	Studies	References
a unhelpful coping strategies	3	4
a unsupportive context	2	9
a unwillingness to burden others	2	3
a worthless	5	9
b child characteristics	15	114
b difficult to accept	1	4
b difficult to understand	4	8
b difficulty committing time and effort	3	4
b difficulty implementing techniques	5	19
b disagreed from experience	2	2
b forgetting useful learning	3	3
b lack of engagement	4	8
b lack of motivation	1	6
b mental health difficulties innate	4	4
b mental health impeding engagement	3	7
b negative preconceptions of therapy	4	7
b not ready for therapy	3	4
b not recognising mental health problems	2	2
b not seeing therapy as helpful	4	15
b shame or guilt about mental health	3	12
b therapy a reminder of negativity	2	2
b therapy as anxiety or fear provoking	1	4
b violating expectations	3	3
b delivery format	7	32
b group format	6	17
b group, emotional leakage	1	1
b group, feeling judged	1	2
b group, not personalised enough	6	9
b group, others not understanding	1	2
b group, unable to open up	1	3
b insufficient duration of therapy	4	7
b physical environment	3	4
b workshop overly long	2	4
b intervention content	13	38
b cliché examples	2	3
b goal setting issues	2	3

Code	Studies	References
b homework	4	10
b repetitive or nothing new	4	8
b unhelpful techniques	8	14
b systemic context	11	34
b difficulties accessing service	2	2
b disruptive life circumstances	2	3
b lack of time	4	10
b missing out on schoolwork	1	1
b parent or teacher, lacking support from therapist	2	8
b practical issues outside therapy	3	3
b uninvolved in decision to access cbt	3	7
b therapist characteristics	10	46
b being directed with authority	1	2
b developmental inappropriateness	5	9
b feeling not allowed to be sad	1	3
b feeling unable to be honest	5	6
b inflexibility	3	8
b lack of authenticity	3	5
b lack of autonomy	1	2
b over formality	3	6
b own problem to solve	1	1
b therapist not taking the lead	1	1
b unkind	2	3
f child characteristics	14	104
f accepting or recognising therapy as helpful	3	9
f cbt feels enjoyable	2	2
f engagement	5	12
f motivation	4	18
f self-awareness	4	13
f suffering for own benefit	8	27
f tangible progress monitoring	8	23
f delivery format	10	44
f appropriate pacing	4	10
f follow up communication	2	7
f group format	5	23
f group, engaging with others	3	5

Code	Studies	References
f group, less pressure to talk	2	3
f group, positive peer pressure	1	1
f group, sharing experiences and learning	5	12
f group, small size	1	2
f pre-defined endpoint to therapy	1	1
f routine of therapy	2	2
f school setting is comfortable	1	1
f intervention content	18	181
f being actively involved	6	17
f cognitive and behavioural techniques	18	140
attention training	2	3
behavioural experiments	3	10
cognitive restructuring	11	25
emotion management	10	29
exposure	7	14
goal setting	5	5
mindfulness	1	1
organisational skills	3	3
organising pleasurable activities	2	4
problem solving	4	7
psychoeducation	8	14
relaxation exercises	8	17
social skills	1	1
thought diaries	2	2
visualisation	4	5
f examples providing context	1	2
f homework	3	7
f recognised from experience	1	2
f understandable	3	6
f variety	2	7
f systemic context	5	12
f duty to others	1	3
f resolution of stressful life circumstances	2	2
f strong support network	2	2
f support whilst on wait-list	1	5
f therapist characteristics	15	151

Code	Studies	References
f able to be honest	4	5
f able to express everything	3	5
f authenticity	3	5
f being directed with authority	2	3
f control over the therapy process	7	12
f developing familiarity and trust	2	6
f developmental appropriateness	2	9
f feeling safe	7	10
f feeling understood and heard	11	36
f having someone to talk to	8	18
f kindness	4	8
f not feeling judged	3	5
f respecting therapist expertise	2	3
f responsive, personalised, flexible	7	19
f scaffolding independence	3	3
f therapist modelling	3	3
f therapist separate from normal life	1	1
m misc	4	6
m medication	3	5
m parent suggestions	1	1
n neutral	5	14
n general comments on therapeutic relationship	3	4
n techniques not useful	1	5
n unpredictable pace of change	1	4
p positive outcomes	18	435
p able to leave the house	1	2
p able to open up	5	10
p able to understand and help others	4	9
p absence of problems	6	9
p being active	3	3
p coping strategies	10	37
p educational functioning	8	15
p emotional regulation	8	32
p executive functioning	5	11
p family - better communication	6	10
p family - others more understanding	2	4

Code	Studies	References
p family - others' wellbeing and functioning	1	1
p family - system management	1	4
p feeling safe	1	5
p financial management	1	1
p future orientation	7	10
p happiness	4	9
p independence	10	20
p life skills, generalisation	9	15
p more open to seeking help	1	1
p normalisation of mental health	2	2
p perspective shift	14	42
p reduced negative behaviours	5	7
p reduced negative emotions	9	26
p return to self before problems	4	8
p self-confidence	8	21
p self-control	12	48
p self-development	5	10
p self-esteem	5	6
p social functioning	6	17
p standing up for self	1	3
p taking initiative	4	4
p thinking or behaving more logically	6	14
p understanding emotions and mental health	12	17
r researcher suggestions	10	53
r suggestions for practice	10	41
r suggestions for research	6	12
t therapist views	1	10
t coping strategies	1	1
t cyp locus of change	1	1
t flexibility and personalisation	1	2
t hearing and understanding cyp	1	1
t putting self 'out there'	1	1
t seeing evidence of change	1	1
t self-confidence	1	1
t uncertainty around change	1	2

Appendix E

List of places where the survey was shared

Table E1

List of Places it was Confirmed that the Survey was Shared

	Place shared	Dates
1.	UCL EP training course	11/11/20
2.	Kent EPS	12/11/20
3.	Twitter (researcher's profile and re-tweets)	13/11/20, 8/2/21
4.	Tower Hamlets EPS	13/11/20
5.	Hackney EPS	13/11/20
6.	Cambridgeshire EPS	13/11/20
7.	EPNET mailing list	13/11/20, 4/3/21
8.	ED-DEV-RESNET mailing list	13/11/20
9.	COUNSELTHERAPY mailing list	13/11/20
10.	Harrow EPS	13/11/20
11.	Wandsworth EPS	13/11/20
12.	Hampshire EPS	13/11/20
13.	Northamptonshire EPS	13/11/20
14.	Kingston & Richmond EPS	13/11/20
15.	Facebook (EP training applicants group)	15/11/20
16.	Dundee EP training course	3/12/20
17.	Exeter EP training course	20/11/20
18.	Newcastle EP training course	20/11/20
19.	UEA EP training course	4/12/20
20.	Nottingham EP training course	4/12/20
21.	Manchester EP training course	4/12/20
22.	Tavistock EP training course	20/11/20
23.	Bangor CP training course	20/11/20
24.	UEL CP training course	20/11/20
25.	Hertfordshire CP training course	20/11/20
26.	Manchester CP training course	20/11/20
27.	Newcastle CP training course	20/11/20
28.	Royal Holloway CP training course	20/11/20
29.	Kings IAPT training course	20/11/20
30.	Reading EMHP training course	20/11/20
31.	UEA EMHP training course	20/11/20
32.	Facebook (assistant psychologists group)	22/11/20
33.	Aberdeenshire EPS	11/1/21
34.	Northern Ireland EPSs	15/1/21
35.	Argyll EPS	15/1/21
36.	Hampshire EPS	20/1/21
37.	Bournemouth EPS	21/1/21
38.	Buckinghamshire EPS	22/1/21
39.	Carmarthenshire EPS	5/2/21

	Place shared	Dates
40.	Essex EPS	5/2/21
41.	Croydon EPS	8/2/21
42.	Dorset EPS	9/2/21
43.	Dudley EPS	9/2/21
44.	Schools Choice EPS	10/2/21
45.	Waltham Forest EPS	25/2/21
46.	PSYCH-POSTGRADS mailing list	4/3/21
47.	Lancashire North EPS	11/3/21
48.	Glasgow City South EPS	11/3/21
49.	ClinPsy forum	12/3/21
50.	Westminster, Kensington, & Chelsea EPS	7/4/21
51.	Lambeth EPS	7/4/21
52.	Knowsley EPS	8/4/21
53.	Medway EPS	8/4/21
54.	Surrey North West EPS	8/4/21
55.	Surrey South West EPS	8/4/21
56.	Surrey North East EPS	8/4/21
57.	Surrey South East EPS	8/4/21
58.	Newcastle EPS	9/4/21
59.	Hertfordshire EPS	9/4/21
60.	Northumberland EPS	16/4/21
61.	Reading EPS	19/4/21
62.	Sandwell EPS	19/4/21
63.	Shropshire EPS	21/4/21
64.	Slough EPS	21/4/21
65.	Warrington EPS	22/4/21
66.	West Berkshire EPS	22/4/21
67.	York EPS	30/4/21

Note. EP – educational psychology. EPS – educational psychology service. CP – clinical psychology. EMHP – education mental health practitioner.

Think Good - Feel Good

Page 1: Welcome

Thank you for considering taking part in this survey about the cognitive behavioural therapy (CBT) workbook, 'Think Good – Feel Good' (TGFG). It should take 5-10 minutes.

This survey is part of a research study titled: *'Think Good – Feel Good': Is this intervention effective and what happens during the interactions between practitioners and children that makes a difference?* The study has been approved by the University College London (UCL) Research Ethics Committee, with the Project ID Number: 18753/001.

There is an initial question to ensure you are eligible to complete this survey. You are eligible if you have ever used TGFG with an individual child or young person (CYP) or a group of CYP between the ages of 5 and 18. You can answer this survey if you have used TGFG in the past but no longer use the workbook.

Responses to this survey will remain anonymous. Responses will only be submitted once you click 'Finish' at the end of the survey.

For more information about how this research complies with data protection legislation such as the General Data Protection Regulation (GDPR) and the Data Protection Act 2018 (DPA), please read the UCL General Privacy Notice for Participants and Researchers in Health and Care Research Studies at this website.

Page 2: Eligibility

Have you used the 'Think Good - Feel Good' intervention before, with individuals or groups of children and young people aged 5-18? * *Required*

- ○ Yes
- ○ No

Page 3: The support you provide

Do you typically use TGFG with individuals, groups, or both?

- ○ Individuals
- ○ Groups
- ○ Both individuals and groups

What is the average number of sessions of TGFG you would use with an individual/group?

- ○ 1-3
- ○ 4-6
- ○ 7-9
- ○ 10-12
- ○ 13-15
- ○ 16+

Page 4: The children and young people with whom you work

What is the *youngest* age of children with whom you use TGFG?

What is the *average* age of children with whom you use TGFG?

What social, emotional and mental health difficulties do the children with whom you work experience? Please select all that apply.

- ☐ Anxiety
- ☐ Depression / low mood
- ☐ Behaviours that challenge
- ☐ Attachment difficulties
- ☐ Difficulties with attention / hyperactivity
- ☐ Eating disorders
- ☐ Bullying / social exclusion
- ☐ Emotionally-based school avoidance
- ☐ Other

If you selected Other, please specify:

How do you decide whether TGFG is an appropriate intervention? Please select all that apply.

☐ I always use TGFG for all social, emotional, and mental health difficulties

☐ It depends on the difficulty the child is experiencing

☐ It depends on the severity of the child's difficulties

☐ Other

If you selected Other, please specify:

Page 5: Your use of the TGFG workbook

During a typical TGFG session, which statement best describes how you make use of the TGFG workbook?

- ○ I read directly from the workbook, sharing it with the child
- ○ I read directly from the workbook but don't share it with the child
- ○ I use the workbook as a prompt or reminder but don't read directly from it
- ○ I do not bring the workbook with me into sessions but use it to plan beforehand
- ○ Other

If you selected Other, please specify:

[   ]

During a typical TGFG session, which statement best describes how you make use of the TGFG worksheets?

- ○ I bring printed worksheets into sessions and complete them with the child
- ○ I give the child printed worksheets to complete for homework
- ○ I do not make use of the worksheets
- ○ Other

If you selected Other, please specify:

[   ]

Which TGFG worksheets engage children and young people's attention particularly well?

6 / 12

252

Which chapters of the TGFG workbook do you find particularly helpful to draw from as a practitioner?

Page 6: Your opinions on TGFG

Which of these aspects of the TGFG workbook help you deliver effective mental health support? Please select all that apply.

- ☐ Introductory chapters about CBT
- ☐ Using the workbook as a 'manual' to read from
- ☐ Using the workbook as a planning aide outside of sessions
- ☐ Worksheets
- ☐ Helpful Tips sections
- ☐ Characters – Thought Tracker, Feelings Finder, Go Getter
- ☐ Other

If you selected Other, please specify:

Which of these aspects of the TGFG workbook do CYP find engaging? Please select all that apply.

- ☐ Being read to directly from the workbook
- ☐ Reading directly from the workbook themselves
- ☐ Helpful Tips sections
- ☐ Worksheets
- ☐ Characters – Thought Tracker, Feelings Finder, Go Getter
- ☐ Other

If you selected Other, please specify:

Is there anything else you would like to say about your opinions on TGFG or how you use the intervention?

Page 7: About you

How many years of experience do you have working in children's mental health?

- ○ <1
- ○ 1-2
- ○ 3-5
- ○ 6-10
- ○ 11+

What level of training did you have before first using TGFG? Please select all that apply.

- ☐ Self-taught by reading the workbook / clinician's guide myself
- ☐ General CBT training, not specific to TGFG
- ☐ Training specifically about TGFG
- ☐ Other

If you selected Other, please specify:

In which country do you work in children's mental health?

Page 8: Opportunity for further participation

The next phase of this research study will involve online interviews with practitioners to explore TGFG in further detail. The interviews will consider how practitioners use TGFG, what young people find engaging about the workbook, how practitioners feel supported or restricted by the workbook, and how TGFG compares with other resources and methods of delivering CBT. We hope this research will contribute to knowledge about how TGFG can be delivered effectively and how practitioners can relate and interact positively with CYP.

If you would like further information about participating in the second phase of this research, please send an email to the researcher (james.redburn.19@ucl.ac.uk). Emailing the researcher does not obligate you to further participate, nor does it guarantee that the researcher will follow up communication.

These are some of the benefits your participation may bring to yourself, other practitioners, and CYP experiencing anxiety:

- Growth in knowledge about the research process for yourself
- Growth in knowledge about using TGFG and other similar CBT interventions in different, possibly more effective, ways
- Growth in knowledge about how mental health practitioners can relate to and interact positively with CYP
- Growth in knowledge about the role of a workbook in CBT interventions provided to CYP

Page 9: Thank you

Thank you very much for taking the time to complete this survey.

We would greatly appreciate if you could pass on the link to this survey to anybody you know who has used the TGFG intervention.

Appendix G

Survey data alterations

Table G1

Alterations Made to Survey Data Prior to Analysis

Question	Alterations	Rationale
4. What is the youngest age of children with whom you use TGFG? *and* 5. What is the average age of children with whom you use TGFG?	• Re-wrote number words as numerals (e.g. 'ten' was replaced by '10') • Kept the lowest number where a range of ages was supplied (e.g. '8-9' was replaced by '8') • Re-wrote descriptive phrases as typically representative numerals, according to the UK government's national curriculum website (e.g. 'Lower key stage 2' was replaced by '7') • Deleted irrelevant extra data (e.g. '8 but I also use with Adults with ID' was replaced by '8') • Deleted clearly mistaken responses (e.g. '1' for question 5)	To make the data suitable for quantitative analysis
6. What social, emotional and mental health difficulties do the children with whom you work experience?	• Created new options based on 'other' responses (e.g. 'diabetes', 'autism', 'trauma')	To display the full range of difficulties with which practitioners use TGFG
10. Which TGFG worksheets engage children and young people's attention particularly well? *and* 11. Which chapters of the TGFG workbook do you find particularly helpful to draw from as a practitioner?	• There was considerable heterogeneity in the way worksheets were referred to, partly because worksheets have different titles in the two editions of TGFG and partly because some participants described worksheets while others used the TGFG titles; the researcher used best judgment to identify which worksheets were being referred to and used the worksheet titles from the second edition of TGFG for analysis • Looked up references to page and chapter numbers and replaced with worksheet and chapter titles (e.g. replaced 'P.59' with 'Focus on your breathing') – these alterations were complicated by the fact that the two editions of TGFG have different page	To make the data suitable for quantitative analysis To exclude irrelevant data from analysis

Question	Alterations	Rationale
	numbering and chapters – in some instances it was possible to identify which edition participants were referring to because the page numbers only lined up with worksheets or chapter titles in one of the two editions • Individual participants' responses were cross-referenced between questions 10 and 11 if participants wrote 'as above' in response to question 11 • Deleted responses referring to the fact that the participant could not remember (e.g. 'I dont have the resource with me to answer') • Deleted clearly irrelevant responses (e.g. 'n/a' and 'I haven't used every one of them')	
12. Which of these aspects of the TGFG workbook help you deliver effective mental health support?	• It appeared one participant misinterpreted the question to be about CBT training so this response was deleted ('proper training in CBT - I did the children's iapt pg dip')	To exclude irrelevant data from analysis
13. Which of these aspects of the TGFG workbook do CYP find engaging?	• Deleted responses referring to the fact that the participant could not remember (e.g. 'Apologies, don't remember well enough') • Deleted clearly irrelevant responses (e.g. 'n/a for me')	To exclude irrelevant data from analysis
16. What level of training did you have before first using TGFG?	• Re-coded 'other' responses where they clearly fit with existing options provided by the question, if the participant had not already selected 'other' in addition to the existing relevant option (e.g. 'I have a diploma in CBT' was re-coded to the existing option 'General CBT training, not specific to TGFG') • Where 'other' responses did not clearly indicate that the participant had had CBT training, a new category was created (e.g. 'Elsa training and Cert Ed' and 'Psychology degree and counselling training' were re-coded as 'Non-specific mental health training')	To make the data suitable for quantitative analysis
17. In which country do you work in	• Responses containing multiple countries were counted in all countries referred to (e.g. 'Australia and UK',	To make the data suitable for

Question	Alterations	Rationale
children's mental health?	'Currently NI previously England & NZ') • Re-wrote initialled responses as country names using best judgment (e.g. 'NI' was replaced by 'Northern Ireland' and 'NZ' was replaced by 'New Zealand') • Responses of member countries of the United Kingdom were not re-coded (e.g. 'England', 'Scotland', 'Wales', 'Northern Ireland' were not re-coded as 'United Kingdom') • Re-wrote miscellaneous responses using best judgment (e.g. 'nhs' was replaced by 'United Kingdom')	quantitative analysis To represent participants' preferred national identity as accurately as possible

Appendix H

You may keep a copy of this Information Sheet.

Title of Study: 'Think Good – Feel Good': Is this intervention effective and what happens during the interactions between practitioners and children that makes a difference?
Department: Research Department of Clinical, Educational and Health Psychology
Name and Contact Details of the Researcher: James Redburn (james.redburn.19@ucl.ac.uk)
Name and Contact Details of the Principal Researcher: Dr Benjamin Hayes (b.hayes@ucl.ac.uk)
Name and Contact Details of the UCL Data Protection Officer: Alex Potts (data-protection@ucl.ac.uk)
This study has been approved by the UCL Research Ethics Committee. Project ID number: 18753/001

1. **Invitation Paragraph**
   You are being invited to take part in a doctoral research project. The research project will look at how practitioners use the cognitive-behavioural therapy (CBT) workbook, 'Think Good – Feel Good' and what practitioners consider to be the important components of the workbook for bringing about therapeutic change. Before you decide whether you would like to take part it is important to understand why the research is being done and what participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please email me (James) if there is anything that is unclear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

2. **What is the project's purpose?**
   CBT is an effective intervention for children experiencing emotional distress. However, the reasons why CBT is effective are less clear. This project aims to gain a greater understanding of what aspects of interactions between practitioner and child during CBT interventions make a difference. Through analysing the opinions and experiences of practitioners, this project hopes to better understand how CBT can be conducted most effectively. This will provide guidance for CBT practitioners so they are better able to support children in future.

3. **Why have I been chosen?**
   You have been chosen to participate because you are a mental health practitioner who has experience using the workbook 'Think Good – Feel Good'.

   These inclusion criteria must be met by all practitioner participants in the study:
   1. The practitioner has received formal training in cognitive-behavioural therapy
   2. The practitioner has experience using the workbook 'Think Good – Feel Good' with individuals or groups of children and young people aged 5-18 (you may participate if you have used 'Think Good – Feel Good' but no longer use it)

4. **Do I have to take part?**
   It is up to you to decide whether or not to take part. If you decide to take part you will be given this information sheet to keep and be asked to sign a consent form. You can withdraw at any time without giving a reason. If you decide to withdraw you will be asked what you wish to happen to the data you have provided up to that point. If you

decide to withdraw prior to the data being pseudonymised (real names will be removed and replaced with numerical identifiers) for analysis, it will be possible to delete all your data. After data analysis has commenced, I will not be able to withdraw your data from the study.

5. **What will happen to me if I take part?**
You will be sent a short Demographics Form to complete electronically. You will take part in a virtual interview with the researcher. This will be conducted using Microsoft Teams software and will last between 30-60 minutes. You will be asked how you typically use (or used) 'Think Good – Feel Good', what aspects of the workbook are helpful to you in delivering therapy, what aspects are engaging to children and young people, ways in which the workbook supports or restricts you as a practitioner, and how the workbook compares with other methods of delivering CBT. The interview will be recorded and transcribed for data analysis. After transcription, the recording will be deleted.

The following personal identifiers will be collected from you (the information that is **bold and underlined** may form part of the final report; all other information will be deleted or pseudonymised so that it cannot be linked directly to you): name (converted to **numerical identifiers** for analysis), **gender identity**, **ethnicity**, **years of experience working in mental health**, **current (or most recent) job role**, physical likeness and sound of voice (video footage).

All personal information will be stored securely, on an encrypted hard-drive of a laptop, an encrypted USB stick, and OneDrive cloud storage. All of these will be accessible only to the researcher. You will be asked to provide written, informed consent for your participation with your name and signature.

6. **Will I be recorded and how will the recorded media be used?**
Video and audio footage will be recorded of the interview. This will be done using Microsoft Teams software. The recordings will be stored *securely* and *confidentially* and will be *accessible only to members of the UCL research team*. The recordings will be deleted following transcription. The video footage will not be used for analysis.

7. **What are the possible disadvantages and risks of taking part?**
Some of the questions in the interview will ask about your experiences and identity as a mental health practitioner. It is possible this may involve considering uncomfortable topics such as anxiety and self-confidence or may bring up memories of emotionally challenging work with distressed children and young people. You are free not to answer any questions without giving a reason and may terminate the interview at any point without giving a reason. If you would like, at the end of the interview, the researcher can signpost you to online forms of wellbeing support.

8. **What are the possible benefits of taking part?**
There will be a possible indirect benefit in terms of contributing to future guidance about how CBT can be delivered most effectively. Your participation in this research will hopefully inform other researchers and practitioners how to create positive interactions with children, in order to lead to positive mental health outcomes.

9. **What if something goes wrong?**
If you are unhappy about any aspect of the project, then please speak to me (James) in the first instance. You may also contact Dr Benjamin Hayes (b.hayes@ucl.ac.uk) if you have a more significant complaint or feel that your concern has not been heard. If you still feel that your complaint has not been handled to your satisfaction, then you can contact the Chair of the UCL Research Ethics Committee (ethics@ucl.ac.uk).

10. **Will my taking part in this project be kept confidential?**

All the information that we collect about you during the course of the research will be kept strictly confidential. Your name will be replaced with a numerical identifier (e.g. Practitioner 1) in the final report and any ensuing publications. At the end of the project data will be deleted. Data will be stored on a secure UCL system until this point.

11. Limits to confidentiality
Please note that confidentiality will be maintained as far as possible, unless during the interview I hear anything which causes concern that someone might be in danger of harm. If this were the case, it may be necessary to inform relevant safeguarding agencies.

12. What will happen to the results of the research project?
The results of the research will be presented within a doctoral thesis in June 2022 and may be published. However, no school or individual will be identifiable in any reports or publications. If you would like a copy of the results please email me (James) and I will provide you with a copy.

13. Local Data Protection Privacy Notice

The controller for this project will be University College London (UCL). The UCL Data Protection Officer provides oversight of UCL activities involving the processing of personal data, and can be contacted at data-protection@ucl.ac.uk. This 'local' privacy notice sets out the information that applies to this particular study. Further information on how UCL uses participant information can be found in our 'general' privacy notice: https://www.ucl.ac.uk/legal-services/privacy/ucl-general-research-participant-privacy-notice. The information that is required to be provided to participants under data protection legislation (GDPR and DPA 2018) is provided across both the 'local' and 'general' privacy notices.

The categories of personal data used will be as follows: Name, Email address, Gender identity, Years of experience working in mental health, Current (or most recent) job role, Physical likeness, and Sound of voice. The lawful basis that would be used to process your *personal data* will be performance of a task in the public interest. The special categories of personal data used will be as follows: ethnicity. The lawful basis used to process *special category personal data* will be for scientific and historical research or statistical purposes.

Your personal data will be processed so long as it is required for the research project, until August 2022. If we are able to pseudonymise the personal data you provide we will undertake this, and will endeavour to minimise the processing of personal data wherever possible. If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at data-protection@ucl.ac.uk. If you remain unsatisfied, you may wish to contact the Information Commissioner's Office (ICO). Contact details, and details of data subject rights, are available on the ICO website at: https://ico.org.uk/for-organisations/data-protection-reform/overview-of-the-gdpr/individuals-rights/

14. Contact for further information
If you have any questions about the research project please contact James Redburn (james.redburn.19@ucl.ac.uk) or Dr Benjamin Hayes (b.hayes@ucl.ac.uk).

This information sheet is for you to keep. If you are happy to participate, please read and sign the consent form. Thank you for reading this information sheet and for considering taking part in this research study.

Appendix I

<p align="center"><u>Participant Consent Form</u>
UCL Research Ethics Committee Approval ID Number: 18753/001</p>

Please complete this form after you have read the Information Sheet.

Title of Study: 'Think Good – Feel Good': Is this intervention effective and what happens during the interactions between practitioners and children that makes a difference?
Department: Research Department of Clinical, Educational and Health Psychology
Name and Contact Details of the Researcher: James Redburn (james.redburn.19@ucl.ac.uk)
Name and Contact Details of the Principal Researcher: Dr Benjamin Hayes (b.hayes@ucl.ac.uk)
Name and Contact Details of the UCL Data Protection Officer: Alex Potts (data-protection@ucl.ac.uk)
This study has been approved by the UCL Research Ethics Committee. Project ID number: 18753/001

Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

I confirm that I understand that by ticking each box below I am consenting to this element of the study. I understand that it will be assumed that unticked boxes means that I DO NOT consent to that part of the study. I understand that by not giving consent for any one element that I may be deemed ineligible for the study.

		Tick Box
1.	I confirm that I have read and understood the Information Sheet for the above study. I have had an opportunity to consider the information and ask questions which have been answered to my satisfaction.	☐
2.	I consent to participate in the study. I understand that my personal information (email, name, gender identity, ethnicity, years of experience as a mental health practitioner, current (or most recent) job role, physical likeness, audio recording of my voice) will be used for the purposes explained to me. Personal information will be pseudonymised, with names being replaced by numerical identifiers (e.g. Participant 1).	☐
	I understand that according to data protection legislation, 'public task' will be the lawful basis for processing. The legal basis used to process *special category personal data* will be for scientific research.	☐
3.	I understand that all personal information will remain confidential unless during the interview the researcher hears anything which causes concern that someone might be in danger of harm. In this case, it may be necessary to inform relevant safeguarding agencies.	☐

4.	I understand that my information may be subject to review by responsible individuals from the University for monitoring and audit purposes.	☐
5.	I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason.	☐
	I understand that, once the data is pseudonymised for analysis, it will no longer be possible to withdraw from the study.	☐
6.	I understand the potential risks of participating and the support that will be available to me should I become distressed during the course of the research.	☐
7.	I understand the indirect benefits of participating.	☐
8.	I understand that the data will not be made available to any commercial organisations but is solely the responsibility of the researcher(s) undertaking this study.	☐
9.	I understand that I will not benefit financially from this study or from any possible outcome it may result in in the future.	☐
10.	I understand that the information I have submitted will be presented within a doctoral thesis and may be published. I understand that if I wish to receive a copy I can email the researcher.	☐
11.	I consent to the interview being recorded.	☐
	I consent to the recordings being shared between members of the UCL research team.	☐
12.	I understand the inclusion criteria as detailed in the Information Sheet and explained to me by the researcher.	☐
13.	I am aware of who I should contact if I wish to lodge a complaint.	☐
14.	I am aware that all data provided in this project will be deleted following project completion and only the transcriptions will be kept.	☐

_____ _____

_____

Name of participant   Date   Signature

_____ _____

_____

Researcher   Date   Signature

Appendix J

Please complete this form after you have read the Information Sheet and signed the Consent Form.

Title of Study: 'Think Good – Feel Good': Is this intervention effective and what happens during the interactions between practitioners and children that makes a difference?
Department: Research Department of Clinical, Educational and Health Psychology
Name and Contact Details of the Researcher: James Redburn (james.redburn.19@ucl.ac.uk)
Name and Contact Details of the Principal Researcher: Dr Benjamin Hayes (b.hayes@ucl.ac.uk)
Name and Contact Details of the UCL Data Protection Officer: Alex Potts (data-protection@ucl.ac.uk)
This study has been approved by the UCL Research Ethics Committee. Project ID number: 18753/001

The following information is being collected for the purposes of transparency and rigour in the research process. Please answer all the questions you feel comfortable with. There is an opportunity at the bottom to indicate any considerations you would like the researcher to take into account during the interview or when analysing the data. Thank you for taking the time to complete this form and participate in this study.

Age

_____

Gender identity

Female ☐   Male ☐   Prefer not to say ☐   Other   (please   state)   ☐
_____

Ethnicity

White
- English, Welsh, Scottish, Northern Irish, or British ☐
- Irish ☐
- Gypsy or Irish Traveller ☐
- Any other White background (please state) ☐ _____

Mixed or Multiple ethnic groups
- White and Black Caribbean ☐
- White and Black African ☐
- White and Asian ☐
- Any other Mixed or Multiple ethnic background (please state) ☐ _____

Asian or Asian British
- Indian ☐

- Pakistani ☐
- Bangladeshi ☐
- Chinese ☐
- Any other Asian background (please state) ☐ _____

Black, African, Caribbean, or Black British
- African ☐
- Caribbean ☐
- Somalian ☐
- Any other Black, African, or Caribbean background (please state) ☐ _____

Other ethnic group
- Arab ☐
- Latin American ☐
- Any other ethnic group (please state) ☐ _____

Prefer not to say ☐

Number of years' experience working in children's mental health
_____

Current (or most recent) role in which you used 'Think Good – Feel Good'
_____

Which versions of 'Think Good – Feel Good' you have used

Think Good – Feel Good Workbook, 1st Edition (2002) ☐
Think Good – Feel Good Workbook, 2nd Edition (2018) ☐
A Clinician's Guide to Think Good – Feel Good (2005) ☐
A Clinician's Guide to CBT for Children to Young Adults (2020) ☐
Thinking Good, Feeling Better Workbook (2018) ☐

Roughly how many occasions you have used 'Think Good – Feel Good'

1 ☐   2-3 ☐   4-5 ☐   6-10 ☐   11+ ☐

Any considerations you would like the researcher to take into account during the interview or when analysing the data (e.g. hearing impairment, caring responsibilities in the home, preference for certain pronouns to be used)

Appendix K

Semi-structured interview schedule

<u>Introduction statement</u>:

Thank you for agreeing to take part in this research project. The purpose of the project is to explore how mental health practitioners use the cognitive-behavioural therapy workbook, 'Think Good - Feel Good', and what happens between practitioners and children and young people to bring about positive therapeutic change.

This interview will be recorded and transcribed but everything you say will be kept confidential and will be pseudonymised when the data is analysed, so your name will be replaced by 'Participant X'. When I transcribe the recording any mention of names or any other potentially identifying information will be pseudonymised. After I have transcribed the recording it will be deleted. You can choose to withdraw your data at any point until it is transcribed without providing a reason. The transcript won't be shared with anyone until it has been pseudonymised.

Please feel free to ask for repetition or clarification of any questions I ask. During the interview, we may talk about mental health of children and young people you have worked with, as well as your feelings and identity as a mental health practitioner. Please only share information that you feel comfortable with, and do not feel that you have to answer all the questions that I ask.

The interview today should last no longer than one hour. Would you like me to clarify anything or ask any questions before we start?

<u>Opening question</u>: Could you tell me about your experience working in children's mental health?

- <u>What kind of CBT training have you had?</u>
- <u>What client group do you work with?</u>
- When did you start working in children's mental health?
- What are some of the reasons you wanted to work in children's mental health?
- Do you enjoy working in children's mental health?

<u>Question one</u>: Thinking about the 'Think Good Feel Good' (TGFG) workbook now, how would you typically use the workbook in your practice?

- <u>Do you also make use of the clinician's guide? If so, how?</u>
- <u>How/when do you choose to use TGFG?</u>
- When did you first use TGFG?
- How did you come across TGFG?
- Are you still using TGFG? Which edition? [see Demographics Form first]
- How often do you use TGFG?
- If you could define TGFG in one sentence, what would you say?

<u>Question two</u>: Which aspects of TGFG help you, as a practitioner, to deliver effective mental health support to children and young people (CYP)?

- <u>Do you use worksheets? How?</u> Do you adapt them? Do you use them within the session or for homework?
- <u>Do you use the TGFG workbook to plan your sessions?</u>
- Do you make reference to characters (go getter, feelings finder, thought tracker)?
- Do you read directly from TGFG during sessions?
- Does the Clinician's Guide help with your planning or reflection?

<u>Question three</u>: That question was about what helps you as a practitioner. Which aspects of TGFG do CYP find *engaging*?

- <u>Do you feel it is helpful/necessary to adapt the worksheets to be more engaging?</u>

- Are the things CYP find engaging also the things that you, as a practitioner, feel are most helpful for the process of therapeutic change?
  - If not, are the engaging aspects of TGFG distracting for CYP in terms of achieving positive therapeutic change?
- How do you get CYP to engage with TGFG?
  - Do you think it is aspects of TGFG (e.g. workbooks) or the way they are delivered that CYP find engaging?
- Worksheets? Characters? Listening to psychoeducation?

Question four: On a more personal level, is there anything about TGFG that supports you as a mental health practitioner, in terms of your confidence or identity for example?

- Does TGFG reduce any anxieties you may have as a practitioner?
- Are there any crucial aspects of the CBT process that are not addressed by TGFG? In terms of support for the practitioner, such as self-care or supervision?
  - Would you find it helpful for TGFG to have sections or chapters addressing the challenges associated with being a practitioner?
- Does TGFG boost your confidence as a practitioner?
- Do you ever feel overwhelmed, given the huge number of resources in TGFG?
- Do you ever feel restricted when using the workbook or worksheets, to do them as you're advised by the workbook?
- Would you prefer that the workbook guided or structured your thinking more in terms of how to run a course of CBT or which areas to focus on?
- Do you trust that the contents of the TGFG workbook are structured in a helpful way?

Question five: How is TGFG similar or different to other ways of delivering CBT?

- Would implementing a manualised approach to CBT, with a pre-defined structure, feel different to using TGFG?
  - More confident / less anxious? More restrictive?
- Have you used other forms of media (e.g. comic stories, explanatory videos, movie clips) in CBT with CYP? What was your experience of this?
- What would make you not use TGFG or choose an alternative way to plan/deliver CBT?
- Have you heard of CBT manuals and could you define what a CBT manual is?
- Have you used a CBT manual before, for example 'Coping Cat'? If so, how did your experience of that differ from your experience of TGFG?
- Do you always use worksheets or extra resources when working with CYP?

Question six: Thinking back over all aspects of our discussion so far, could you pick out one main reason why you continue using TGFG *OR* why you kept using TGFG *OR* why you stopped using TGFG? [depending on practitioner's situation]

Closing question: Is there anything else you would like to say about TGFG and/or the process of delivering CBT to CYP?

Closing statement:

Thank you very much for taking part in this interview, I really appreciate your opinions. If you are interested, I can send you a summary of the findings of the research when the project ends. Thank you very much for your time

Appendix L

Full survey results

In the following tables, options that were created as codes during the process of content analysis are highlighted in light grey. Options that were presented in the survey are not highlighted. All tables are ordered by count. The 'Re-coding' column records the number of responses in 'other' sections of questions that fit into the original survey options. The '% Respondents selected option' column is displayed for questions which permitted multiple responses and records the proportion of participants who responded to that question and chose that option. It is not calculated for options created during the content analysis as these were not available to all participants. Tables labelled 'Combinations of Multiple Responses' show all permutations of responses provided on multiple response questions.

Table L1

Survey Results for Question 2: Do You Typically Use TGFG with Individuals, Groups, Or Both?

Option	Count	% Total
Individuals	178	75.11
Both individuals and groups	51	21.52
Groups	8	3.38

Table L2

Survey Results for Question 3: What is the Average Number of Sessions of TGFG You Would Use with an Individual/Group?

Option	Count	% Total
4-6	111	46.64
1-3	49	20.59
7-9	46	19.33
10-12	26	10.92
13-15	6	2.52
16+	0	0

Survey Results for Question 4: What is the <u>Youngest</u> Age of Children with Whom You Use TGFG?

M = 9.01 (SD = 2.26)

Range = 5-16

Table L3

Frequency Table of Youngest Age

Youngest age	Count	% Total
8	60	25.42
7	41	17.37
9	30	12.71
10	28	11.86
11	23	9.75
6	16	6.78
12	13	5.51
13	10	4.24
5	5	2.12
15	5	2.12
14	3	1.27
16	2	0.85

Figure L1

Histogram of Youngest Age
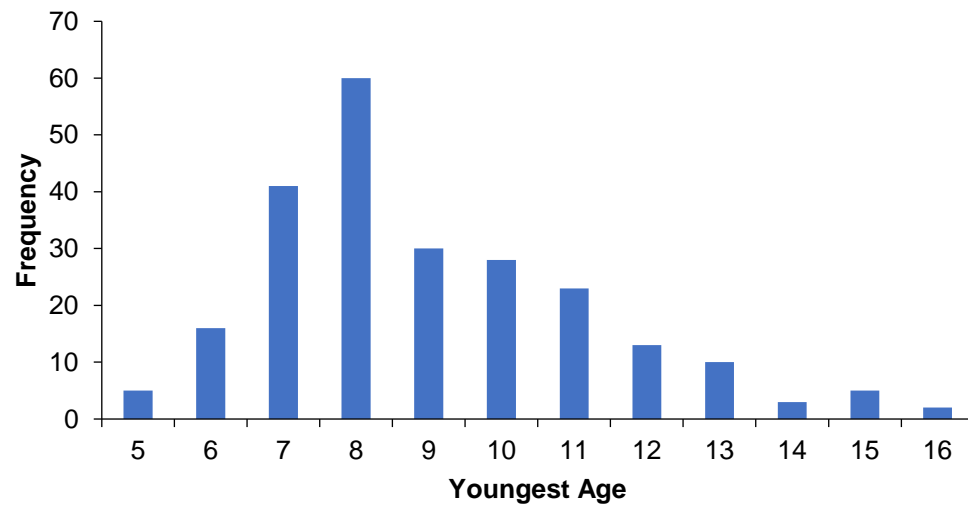
Survey Results for Question 5: What is the <u>Average</u> Age of Children with Whom You Use TGFG?

M = 11.26 (SD = 2.03)

Range = 7-17

Table L4

Frequency Table of Average Age

Average age	Count	% Total
10	54	23.08
13	41	17.52
12	34	14.53
9	32	13.68
11	25	10.68
8	16	6.84
14	16	6.84
15	10	4.27
16	4	1.71
7	1	0.43
17	1	0.43

Histogram of Average Age
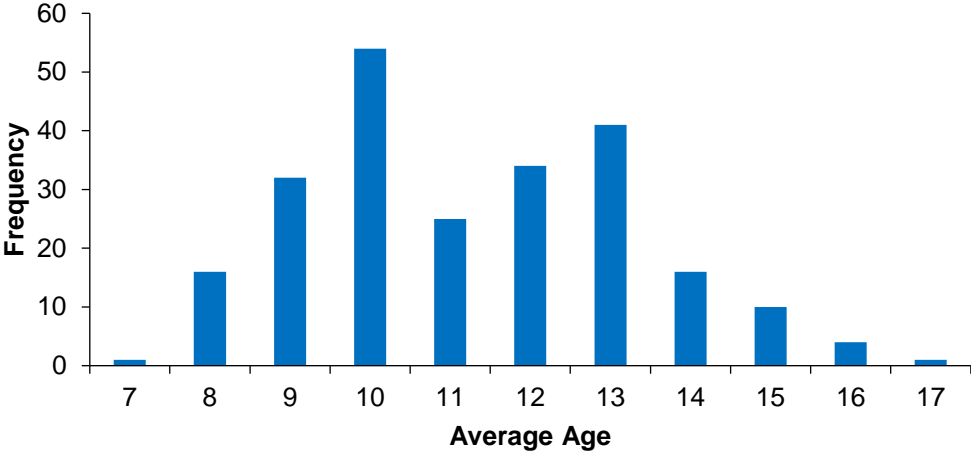
Table L5

Survey Results for Question 6: What Social, Emotional and Mental Health Difficulties do the Children with Whom You Work Experience? Please Select All That Apply.

Option	Re-coding	Count	% Respondents selected option	% Total
Anxiety		228	96.2	25.97
Behaviours that challenge		152	64.1	17.31
Depression / low mood		144	60.8	16.40
Emotionally-based school avoidance		93	39.2	10.59
Attachment difficulties		78	32.9	8.88
Difficulties with attention / hyperactivity	1	66	27.4	7.52
Bullying / social exclusion		59	24.9	6.72
Other		19	8	2.16
Eating disorders		16	6.8	1.82
Autism spectrum disorder		7		0.80
Non-specific mental health difficulties		4		0.46
Obsessive compulsive disorder		3		0.34
Anger		2		0.23
Learning difficulties		2		0.23
Trauma		2		0.23
Bereavement		1		0.11
Tourette syndrome		1		0.11
Selective mutism		1		0.11

Table L6

Survey Results for Question 6 (Combinations of Multiple Responses): What Social, Emotional and Mental Health Difficulties do the Children with Whom You Work Experience? Please Select All That Apply.

| Option	Count	% Total
Anxiety, Depression / low mood	22	9.28
Anxiety, Behaviours that challenge	20	8.44
Anxiety	19	8.02
Anxiety, Depression / low mood, Behaviours that challenge	18	7.59
Anxiety, Depression / low mood, Behaviours that challenge, Attachment difficulties, Difficulties with attention / hyperactivity, Bullying / social exclusion, Emotionally-based school avoidance	13	5.49
Anxiety, Depression / low mood, Emotionally-based school avoidance	12	5.06
Anxiety, Behaviours that challenge, Emotionally-based school avoidance	8	3.38
Anxiety, Behaviours that challenge, Difficulties with attention / hyperactivity	7	2.95
Anxiety, Depression / low mood, Behaviours that challenge, Attachment difficulties, Difficulties with attention / hyperactivity, Bullying / social exclusion	6	2.53
Anxiety, Depression / low mood, Behaviours that challenge, Attachment difficulties	5	2.11
Anxiety, Depression / low mood, Behaviours that challenge, Attachment difficulties, Difficulties with attention / hyperactivity, Emotionally-based school avoidance	5	2.11
Anxiety, Other	4	1.69
Anxiety, Emotionally-based school avoidance	4	1.69
Anxiety, Depression / low mood, Behaviours that challenge, Attachment difficulties, Difficulties with attention / hyperactivity, Eating disorders, Bullying / social exclusion, Emotionally-based school avoidance	4	1.69
Anxiety, Depression / low mood, Behaviours that challenge, Emotionally-based school avoidance	4	1.69
Anxiety, Depression / low mood, Behaviours that challenge, Attachment difficulties, Emotionally-based school avoidance	4	1.69
Anxiety, Depression / low mood, Behaviours that challenge, Attachment difficulties, Bullying / social exclusion, Emotionally-based school avoidance	4	1.69
Anxiety, Depression / low mood, Behaviours that challenge, Difficulties with attention / hyperactivity	3	1.27
Anxiety, Behaviours that challenge, Attachment difficulties, Emotionally-based school avoidance	3	1.27

Option	Count	% Total
Anxiety, Depression / low mood, Behaviours that challenge, Attachment difficulties, Difficulties with attention / hyperactivity, Eating disorders, Bullying / social exclusion, Emotionally-based school avoidance, Other	3	1.27
Anxiety, Behaviours that challenge, Attachment difficulties	3	1.27
Anxiety, Depression / low mood, Behaviours that challenge, Attachment difficulties, Difficulties with attention / hyperactivity	2	0.84
Behaviours that challenge, Attachment difficulties	2	0.84
Anxiety, Depression / low mood, Difficulties with attention / hyperactivity	2	0.84
Anxiety, Depression / low mood, Behaviours that challenge, Bullying / social exclusion, Emotionally-based school avoidance	2	0.84
Anxiety, Depression / low mood, Bullying / social exclusion, Emotionally-based school avoidance	2	0.84
Anxiety, Depression / low mood, Behaviours that challenge, Attachment difficulties, Bullying / social exclusion	2	0.84
Anxiety, Depression / low mood, Attachment difficulties, Emotionally-based school avoidance	2	0.84
Anxiety, Depression / low mood, Behaviours that challenge, Bullying / social exclusion	2	0.84
Anxiety, Behaviours that challenge, Attachment difficulties, Difficulties with attention / hyperactivity, Bullying / social exclusion, Emotionally-based school avoidance	2	0.84
Anxiety, Depression / low mood, Behaviours that challenge, Attachment difficulties, Difficulties with attention / hyperactivity, Bullying / social exclusion, Emotionally-based school avoidance, Other	2	0.84
Behaviours that challenge	2	0.84
Anxiety, Behaviours that challenge, Other	2	0.84
Anxiety, Behaviours that challenge, Attachment difficulties, Bullying / social exclusion	2	0.84
Anxiety, Behaviours that challenge, Difficulties with attention / hyperactivity, Emotionally-based school avoidance	1	0.42
Depression / low mood, Behaviours that challenge, Difficulties with attention / hyperactivity, Emotionally-based school avoidance	1	0.42
Anxiety, Eating disorders	1	0.42
Anxiety, Difficulties with attention / hyperactivity	1	0.42
Anxiety, Depression / low mood, Behaviours that challenge, Other	1	0.42
Anxiety, Bullying / social exclusion, Other	1	0.42
Anxiety, Behaviours that challenge, Attachment difficulties, Difficulties with attention / hyperactivity, Emotionally-based school avoidance	1	0.42

Option	Count	% Total
Anxiety, Depression / low mood, Behaviours that challenge, Eating disorders, Emotionally-based school avoidance	1	0.42
Anxiety, Attachment difficulties, Bullying / social exclusion	1	0.42
Anxiety, Depression / low mood, Behaviours that challenge, Attachment difficulties, Difficulties with attention / hyperactivity, Eating disorders, Emotionally-based school avoidance	1	0.42
Behaviours that challenge, Difficulties with attention / hyperactivity	1	0.42
Anxiety, Behaviours that challenge, Attachment difficulties, Bullying / social exclusion, Emotionally-based school avoidance	1	0.42
Depression / low mood, Behaviours that challenge, Attachment difficulties	1	0.42
Anxiety, Behaviours that challenge, Bullying / social exclusion, Emotionally-based school avoidance	1	0.42
Anxiety, Depression / low mood, Attachment difficulties, Difficulties with attention / hyperactivity	1	0.42
Anxiety, Depression / low mood, Behaviours that challenge, Attachment difficulties, Eating disorders, Bullying / social exclusion	1	0.42
Anxiety, Bullying / social exclusion, Emotionally-based school avoidance	1	0.42
Anxiety, Depression / low mood, Behaviours that challenge, Difficulties with attention / hyperactivity, Emotionally-based school avoidance	1	0.42
Anxiety, Depression / low mood, Behaviours that challenge, Bullying / social exclusion, Emotionally-based school avoidance, Other	1	0.42
Behaviours that challenge, Attachment difficulties, Emotionally-based school avoidance	1	0.42
Anxiety, Difficulties with attention / hyperactivity, Other	1	0.42
Anxiety, Depression / low mood, Attachment difficulties, Bullying / social exclusion	1	0.42
Anxiety, Depression / low mood, Difficulties with attention / hyperactivity, Eating disorders, Emotionally-based school avoidance	1	0.42
Anxiety, Behaviours that challenge, Attachment difficulties, Difficulties with attention / hyperactivity	1	0.42
Depression / low mood	1	0.42
Anxiety, Depression / low mood, Attachment difficulties	1	0.42
Anxiety, Depression / low mood, Behaviours that challenge, Attachment difficulties, Emotionally-based school avoidance, Other	1	0.42
Anxiety, Depression / low mood, Behaviours that challenge, Attachment difficulties, Eating disorders, Bullying / social exclusion, Emotionally-based school avoidance	1	0.42

Option	Count	% Total
Anxiety, Bullying / social exclusion	1	0.42
Anxiety, Depression / low mood, Eating disorders	1	0.42
Anxiety, Depression / low mood, Difficulties with attention / hyperactivity, Bullying / social exclusion	1	0.42
Anxiety, Depression / low mood, Bullying / social exclusion	1	0.42
Anxiety, Depression / low mood, Emotionally-based school avoidance, Other	1	0.42
Anxiety, Depression / low mood, Other	1	0.42
Anxiety, Depression / low mood, Behaviours that challenge, Difficulties with attention / hyperactivity, Bullying / social exclusion, Emotionally-based school avoidance	1	0.42
Anxiety, Depression / low mood, Attachment difficulties, Difficulties with attention / hyperactivity, Emotionally-based school avoidance	1	0.42
Anxiety, Depression / low mood, Behaviours that challenge, Emotionally-based school avoidance, Other	1	0.42
Anxiety, Depression / low mood, Behaviours that challenge, Eating disorders	1	0.42
Anxiety, Depression / low mood, Behaviours that challenge, Difficulties with attention / hyperactivity, Bullying / social exclusion	1	0.42
Anxiety, Behaviours that challenge, Difficulties with attention / hyperactivity, Eating disorders, Bullying / social exclusion, Emotionally-based school avoidance	1	0.42

Table L7

Survey Results for Question 7: How Do You Decide Whether TGFG is an Appropriate Intervention? Please Select All That Apply.

Option	Re-coding	Count	% Respondents selected option	% Total
Depends on SEMH difficulty	4	212	87.4	48.51
Depends on SEMH severity	1	99	41.2	22.65
Other		48	20.2	10.98
Depends on child's level of understanding / language		28		6.41
Depends on practitioner's formulation / judgment		7		1.60
Depends on child's motivation levels		6		1.37
Practical constraints (e.g. time) for practitioner		6		1.37
Whether the issue is better resolved by other means		4		0.92
Always, for all SEMH needs		3	1.3	0.69
Depends on child's age		3		0.69
Depends on child's literacy skills		3		0.69
Depends on others being available and able to deliver the intervention, as managed by a practitioner		3		0.69
Use TGFG alongside other resources		2		0.46
Depends on schools' willingness to 'purchase' practitioner time for intervention delivery		2		0.46
Depends on child's level of insight into their difficulties		2		0.46
Depends on close adults' opinions of child's suitability for the intervention		2		0.46
Whether child is likely to complete homework		1		0.23
Whether child will attend sessions regularly		1		0.23
Whether child has supportive home circumstances		1		0.23
Statutory recommendation		1		0.23
Depends on the extent to which adaptations may need to be made and their impact		1		0.23
Only resource available		1		0.23
Not analysed - irrelevant		1		0.23

Table L8

Survey Results for Question 7 (Combinations of Multiple Responses): How Do You Decide Whether TGFG is an Appropriate Intervention? Please Select All That Apply.

Option	Count	% Total
It depends on the difficulty the child is experiencing	102	45.95
It depends on the difficulty the child is experiencing, It depends on the severity of the child's difficulties	80	36.04
Other	22	9.91
It depends on the difficulty the child is experiencing, It depends on the severity of the child's difficulties, Other	13	5.86
It depends on the severity of the child's difficulties	5	2.25

Table L9

Survey Results for Question 8: During a Typical TGFG Session, Which Statement Best Describes How You Make Use of the TGFG Workbook?

Option	Re-coding	Count	% Respondents selected option	% Total
I use the workbook as a prompt or reminder but don't read directly from it		96	40.7	38.71
I do not bring the workbook with me into sessions but use it to plan beforehand		86	36.4	34.68
I read directly from the workbook, sharing it with the child	3	44	17.4	17.74
Other		12	5.1	4.84
Adapt workbook resources		5		2.02
Not analysed - unclear		3		1.21
Greater use of Clinician's manual		1		0.4
I read directly from the workbook but don't share it with the child		1	0.4	0.4

Table L10

Survey Results for Question 9: During a Typical TGFG Session, Which Statement Best Describes How You Make Use of the TGFG Worksheets?

Option	Re-coding	Count	% Respondents selected option	% Total
I bring printed worksheets into sessions and complete them with the child	4	192	79.7	75.29
I do not make use of the worksheets		17	7.2	6.67
Other		16	6.8	6.27
I give the child printed worksheets to complete for homework		15	6.4	5.88
Adapt worksheets for child's interests / needs		6		2.35
Worksheets used both in sessions and as homework		4		1.57
Use more practical approaches instead		1		0.39
Share worksheets with parents		1		0.39
Depends on child's understanding		1		0.39
Depends on support available around child		1		0.39
Not analysed - irrelevant		1		0.39

Table L11

Survey Results for Question 10 (Worksheet Names): Which TGFG Worksheets Engage Children and Young People's Attention Particularly Well?

Worksheet (1st ed.)	Worksheet (2nd ed.)	1st Ed. Pg. No.	2nd Ed. Pg. No.	Count	% Total
What thinking errors do you make?	Thinking traps quiz	76-77	104-105	33	15.49
The magic circle / The negative trap	What you think, how you feel, and what you do / The negative trap	46-47	75-76	20	9.39
Thought thermometer / Feelings thermometer	The thermometer	87 / 134	166	17	7.98
Thoughts and feelings (diary)	'Hot' thoughts	58-59	87	14	6.57
What happens when I feel sad / angry / anxious / happy?	"	129-132	161-164	10	4.69
What I think, what I do or how I feel	Thoughts, feelings, or what you do?	49	79	9	4.23
What are they thinking?	What are they thinking? / More than one thought	65-68	94-95	8	3.76
My 'hot' thoughts	"	60	88	7	3.29
The IF/THEN quiz	My predictions	48	78	6	2.82
Nice thoughts about myself / Nice thoughts about my future	Thoughts about me / Thoughts about the future	61-62	91-92	6	2.82
Balanced thinking (diary)	N/A	85-86	N/A	6	2.82
Positive self-talk	"	112	144	6	2.82
Looking for evidence (diary)	N/A	83-84	N/A	5	2.35
Test your thoughts and beliefs	"	109	141	5	2.35
Anger volcano	The anger volcano	143	176	5	2.35
My relaxing place	My calming place	145	178	4	1.88
Small steps	"	162	196	4	1.88
Stop, plan and go	Stop, plan, and go	180	216	4	1.88
Identifying core beliefs	Finding core beliefs	94-95	124	3	1.41
Looking for the positive	"	111	143	3	1.41
Coping self-talk	"	113	145	3	1.41

Worksheet (1st ed.)	Worksheet (2nd ed.)	1st Ed. Pg. No.	2nd Ed. Pg. No.	Count	% Total
Next step up the ladder	Habit ladder	157	197	3	1.41
Identifying possible solutions (self / other)	Identify possible solutions - 'OR' / Ask someone who is successful	174-175	211-212	3	1.41
Challenging core beliefs	Are my beliefs always true?	96	125	2	0.94
The thought challenger	"	110	142	2	0.94
The 'worry safe'	The worry safe	114	146	2	0.94
What feeling goes where?	"	127	159	2	0.94
My feelings	"	128	160	2	0.94
Learning to relax	Learn to relax	144	177	2	0.94
Things that make me feel good	"	158	193	2	0.94
Things that make me feel unpleasant	"	159	194	2	0.94
Face your fears	"	161	198	2	0.94
Identifying thinking errors (diary)	N/A	74-75	N/A	1	0.47
Common beliefs	"	97-100	126-129	1	0.47
Turn the tape off	Turn the CD off	115	147	1	0.47
Practise being successful	"	116	149	1	0.47
Thought stopping	"	117	150	1	0.47
Thoughts and feelings (Good / Unpleasant)	Thoughts and feelings	124	156	1	0.47
Activities and feelings (Good / Unpleasant)	What you do and how you feel	125	157	1	0.47
The Feeling Finder word search	Feelings word search	126	158	1	0.47
The 'feeling strong room'	"	142	175	1	0.47
Dump your habits	"	163	199	1	0.47
What are the consequences of my solutions?	What are the consequences?	176	213	1	0.47
Unpleasant thoughts about myself / Worrying thoughts about what I do	N/A	63-64	N/A	0	0
Feelings and places	"	133	165	0	0
My relaxing activities	"	146	179	0	0

Worksheet (1st ed.)	Worksheet (2nd ed.)	1st Ed. Pg. No.	2nd Ed. Pg. No.	Count	% Total
Activity diary	"	156	192	0	0
Things I would like to do	Have more fun	160	195	0	0
Looking for solutions	"	177	214	0	0
Talk yourself through it	"	178-179	215	0	0
N/A	Treat yourself like a friend	N/A	44	0	0
N/A	Accept who I am	N/A	45	0	0
N/A	Care for yourself	N/A	46	0	0
N/A	A kinder inner voice	N/A	47	0	0
N/A	Finding kindness	N/A	48	0	0
N/A	FOCUS on your breathing	N/A	59	0	0
N/A	FOCUS on your eating	N/A	60	0	0
N/A	FOCUS on an object	N/A	61	0	0
N/A	Make a clutter jar	N/A	62	0	0
N/A	Thought spotting	N/A	63	0	0
N/A	Let feelings float away	N/A	64	0	0
N/A	Make a film strip	N/A	77	0	0
N/A	STOP thoughts	N/A	89	0	0
N/A	GO thoughts	N/A	90	0	0
N/A	Thoughts about what I do	N/A	93	0	0
N/A	Finding thinking traps	N/A	103	0	0
N/A	What is the evidence?	N/A	116	0	0
N/A	The '4Cs'	N/A	117	0	0
N/A	How would you help a friend?	N/A	118	0	0
N/A	Worry time	N/A	148	0	0
N/A	Reward yourself	N/A	200	0	0

Note. " = the worksheet has the same name in both editions of TGFG; N/A = the worksheet is not in that edition of TGFG

Table L12

Survey Results for Question 10 (Descriptive Comments): Which TGFG Worksheets Engage Children and Young People's Attention Particularly Well?

Label	Count	% Total
Not analysed - irrelevant	18	20
Those with pictures / visuals	11	12.22
All / most / a range	10	11.11
Varies according to child's needs	7	7.78
Those which involve drawing	6	6.67
Not analysed - unclear	5	5.56
Chapter 5 - automatic thoughts	4	4.44
None	3	3.33
Those which are practical / concrete	3	3.33
Need adapting	3	3.33
Those about emotions / feelings	3	3.33
Those which encourage discussion	2	2.22
Those with analogies / metaphors	2	2.22
Those with simple layout	2	2.22
Chapter 11 - controlling your feelings	2	2.22
Those with characters	1	1.11
Those with thought bubbles	1	1.11
Relaxation activities	1	1.11
Questionnaires	1	1.11
Chapter 9 - controlling your thoughts	1	1.11
Chapter 13 - solving problems	1	1.11
Not diaries	1	1.11
Those which use tables	1	1.11
Depends how they are presented	1	1.11

Table L13

Survey Results for Question 11 (Chapter Names): Which Chapters of the TGFG Workbook Do You Find Particularly Helpful To Draw From as a Practitioner?

Chapter (1st Ed.)	Chapter (2nd Ed.)	Count	% Total
6 - Thinking errors	8 - Thinking traps	46	19.41
4 - Thoughts, feelings, and what you do	6	27	11.39
5 - Automatic thoughts	7	26	10.97
7 - Balanced thinking	9	20	8.44
Whole workbook / a wide range		20	8.44
9 - Controlling your thoughts	11	16	6.75
8 - Core beliefs	10	12	5.06
11 - Controlling your feelings	13	11	4.64
3 - TGFG: Overview	3	10	4.22
12 - Changing your behaviour	14	10	4.22
10 - How you feel	12	8	3.38
13 - Learning to solve problems	15	6	2.53
1 - CBT: Theoretical origins, rationale and techniques	1	5	2.11
2 - CBT with CYP	2	4	1.69
N/A	4 - Be kind to yourself	4	1.69
Psychoeducational materials (CG)		4	1.69
3 - Formulations (CG)		2	0.84
5 - Involving parents in child-focused CBT (CG)		2	0.84
N/A	5 - Here and now	1	0.42
2 - Engagement and readiness to change (CG)		1	0.42
8 - Core components of CBT programmes for internalising problems (CG)		1	0.42
Whole CG		1	0.42
1 - Overview (CG)		0	0

	0	0
4 - The Socratic process and inductive reasoning (CG)	0	0
6 - The process of child-focused CBT (CG)	0	0
7 - Adapting CBT for children (CG)	0	0

Note. (CG) = Clinician's Guide (Stallard, 2005), N/A = the chapter is not in that edition of TGFG

Table L14

Survey Results for Question 11 (Descriptive Comments): Which Chapters of the TGFG Workbook Do You Find Particularly Helpful To Draw From as a Practitioner?

Label	Count	% Total
Not analysed - irrelevant	17	38.64
Varies depending on child	14	31.82
Not analysed - unclear	6	13.64
Need adapting	2	4.55
Sections on developing understanding	2	4.55
Visual elements	1	2.27
Thought tracker	1	2.27
Sections on management strategies	1	2.27

Table L15

Survey Results for Question 12: Which of These Aspects of the TGFG Workbook Help You Deliver Effective Mental Health Support? Please Select All That Apply.

Option	Re-coding	Count	% Respondents selected option	% Total
Worksheets	1	191	80.2	26.49
Using the workbook as a planning aide outside of sessions		190	80.2	26.35
Introductory chapters about CBT		109	46	15.12
Characters – Thought Tracker, Feelings Finder, Go Getter		104	43.9	14.42
Helpful Tips sections		75	31.6	10.40
Using the workbook as a 'manual' to read from		47	19.8	6.52
Other		3	1.3	0.42
All of it		1		0.14
Not analysed - irrelevant		1		0.14

Table L16

Survey Results for Question 12 (Combinations of Multiple Responses): Which of these Aspects of the TGFG Workbook Help You Deliver Effective Mental Health Support? Please Select All That Apply.

Option	Count	% Total
Using the workbook as a planning aide outside of sessions, Worksheets	32	13.50
Using the workbook as a planning aide outside of sessions, Worksheets, Characters – Thought Tracker, Feelings Finder, Go Getter	21	8.86
Introductory chapters about CBT, Using the workbook as a planning aide outside of sessions, Worksheets	18	7.59
Introductory chapters about CBT, Using the workbook as a planning aide outside of sessions, Worksheets, Helpful Tips sections	12	5.06
Using the workbook as a planning aide outside of sessions	11	4.64
Using the workbook as a planning aide outside of sessions, Worksheets, Helpful Tips sections, Characters – Thought Tracker, Feelings Finder, Go Getter	11	4.64
Introductory chapters about CBT, Using the workbook as a planning aide outside of sessions, Worksheets, Characters – Thought Tracker, Feelings Finder, Go Getter	11	4.64
Introductory chapters about CBT, Using the workbook as a planning aide outside of sessions, Worksheets, Helpful Tips sections, Characters – Thought Tracker, Feelings Finder, Go Getter	10	4.22
Introductory chapters about CBT, Using the workbook as a 'manual' to read from, Using the workbook as a planning aide outside of sessions, Worksheets, Helpful Tips sections, Characters – Thought Tracker, Feelings Finder, Go Getter	9	3.80
Introductory chapters about CBT, Worksheets, Characters – Thought Tracker, Feelings Finder, Go Getter	8	3.38
Using the workbook as a planning aide outside of sessions, Characters – Thought Tracker, Feelings Finder, Go Getter	7	2.95
Using the workbook as a planning aide outside of sessions, Worksheets, Helpful Tips sections	7	2.95
Introductory chapters about CBT, Using the workbook as a planning aide outside of sessions	7	2.95
Worksheets	7	2.95
Introductory chapters about CBT, Using the workbook as a 'manual' to read from, Using the workbook as a planning aide outside of sessions, Worksheets	6	2.53
Using the workbook as a 'manual' to read from, Using the workbook as a planning aide outside of sessions, Worksheets	4	1.69

Option	Count	% Total
Introductory chapters about CBT, Using the workbook as a planning aide outside of sessions, Helpful Tips sections	4	1.69
Worksheets, Characters – Thought Tracker, Feelings Finder, Go Getter	4	1.69
Using the workbook as a planning aide outside of sessions, Helpful Tips sections, Characters – Thought Tracker, Feelings Finder, Go Getter	3	1.27
Introductory chapters about CBT, Using the workbook as a 'manual' to read from, Worksheets	3	1.27
Introductory chapters about CBT, Using the workbook as a 'manual' to read from	3	1.27
Worksheets, Helpful Tips sections, Characters – Thought Tracker, Feelings Finder, Go Getter	3	1.27
Using the workbook as a 'manual' to read from, Using the workbook as a planning aide outside of sessions, Worksheets, Characters – Thought Tracker, Feelings Finder, Go Getter	3	1.27
Introductory chapters about CBT, Using the workbook as a 'manual' to read from, Using the workbook as a planning aide outside of sessions, Worksheets, Helpful Tips sections	3	1.27
Introductory chapters about CBT, Worksheets	3	1.27
Using the workbook as a 'manual' to read from, Using the workbook as a planning aide outside of sessions, Worksheets, Helpful Tips sections	2	0.84
Using the workbook as a 'manual' to read from, Worksheets, Characters – Thought Tracker, Feelings Finder, Go Getter	2	0.84
Using the workbook as a 'manual' to read from, Worksheets	2	0.84
Using the workbook as a 'manual' to read from, Using the workbook as a planning aide outside of sessions, Worksheets, Helpful Tips sections, Characters – Thought Tracker, Feelings Finder, Go Getter	2	0.84
Introductory chapters about CBT, Using the workbook as a planning aide outside of sessions, Helpful Tips sections, Characters – Thought Tracker, Feelings Finder, Go Getter	2	0.84
Other	2	0.84
Introductory chapters about CBT, Characters – Thought Tracker, Feelings Finder, Go Getter	2	0.84
Introductory chapters about CBT, Using the workbook as a planning aide outside of sessions, Characters – Thought Tracker, Feelings Finder, Go Getter	1	0.42
Introductory chapters about CBT, Using the workbook as a 'manual' to read from, Helpful Tips sections, Characters – Thought Tracker, Feelings Finder, Go Getter	1	0.42
Introductory chapters about CBT, Using the workbook as a 'manual' to read from, Worksheets, Helpful Tips sections, Characters – Thought Tracker, Feelings Finder, Go Getter	1	0.42

Option	Count	% Total
Using the workbook as a planning aide outside of sessions, Worksheets, Other	1	0.42
Using the workbook as a 'manual' to read from, Using the workbook as a planning aide outside of sessions	1	0.42
Using the workbook as a 'manual' to read from, Worksheets, Helpful Tips sections	1	0.42
Introductory chapters about CBT, Using the workbook as a 'manual' to read from, Using the workbook as a planning aide outside of sessions, Characters – Thought Tracker, Feelings Finder, Go Getter	1	0.42
Worksheets, Helpful Tips sections	1	0.42
Introductory chapters about CBT, Helpful Tips sections	1	0.42
Using the workbook as a 'manual' to read from, Worksheets, Helpful Tips sections, Characters – Thought Tracker, Feelings Finder, Go Getter	1	0.42
Introductory chapters about CBT, Using the workbook as a 'manual' to read from, Using the workbook as a planning aide outside of sessions, Worksheets, Characters – Thought Tracker, Feelings Finder, Go Getter	1	0.42
Introductory chapters about CBT	1	0.42
Introductory chapters about CBT, Using the workbook as a 'manual' to read from, Worksheets, Helpful Tips sections	1	0.42

Table L17

Survey Results for Question 13: Which of these Aspects of the TGFG Workbook Do CYP Find Engaging? Please Select All That Apply.

Option	Re-coding	Count	% Respondents selected option	% Total
Worksheets		191	84.1	45.48
Characters		104	45.8	24.76
Helpful Tips		64	28.2	15.24
Reading directly from the workbook themselves		19	8.4	4.52
Being read to directly from the workbook		16	7	3.81
Other		13	5.7	3.10
Workbook not used directly within sessions		3		0.71
Workbook made engaging through adaptation		3		0.71
TGFG resources as basis of extended discussion		2		0.48
Workbook not particularly engaging		2		0.48
Not analysed		2		0.48
Having control over the CBT process		1		0.24

Table L18

Survey Results for Question 13 (Combinations of Multiple Responses): Which of these Aspects of the TGFG Workbook Do CYP Find Engaging? Please Select All That Apply.

Option	Count	% Total
Worksheets	63	27.75
Worksheets, Characters	52	22.91
Helpful Tips, Worksheets, Characters	23	10.13
Helpful Tips, Worksheets	22	9.69
Characters	12	5.29
Other	10	4.41
Reading directly from the workbook themselves, Worksheets	8	3.52
Helpful Tips, Characters	6	2.64
Being read to directly from the workbook, Worksheets	5	2.20
Helpful Tips	4	1.76
Being read to directly from the workbook, Worksheets, Characters	4	1.76
Worksheets, Other	3	1.32
Reading directly from the workbook themselves, Helpful Tips, Worksheets	3	1.32
Reading directly from the workbook themselves	2	0.88
Reading directly from the workbook themselves, Helpful Tips, Worksheets, Characters	2	0.88
Being read to directly from the workbook	2	0.88
Being read to directly from the workbook, Reading directly from the workbook themselves, Helpful Tips, Worksheets, Characters	2	0.88
Being read to directly from the workbook, Helpful Tips, Worksheets, Characters	1	0.44
Being read to directly from the workbook, Helpful Tips, Worksheets	1	0.44
Reading directly from the workbook themselves, Worksheets, Characters	1	0.44
Being read to directly from the workbook, Reading directly from the workbook themselves, Worksheets, Characters	1	0.44

Table L19

Survey Results for Question 14: Is There Anything Else You Would Like To Say About Your Opinions On TGFG Or How You Use The Intervention?

Option	Count	% Total
Should be combined with other techniques and resources	20	8.13
Helpful flexibility in structuring interventions	19	7.72
TGFG as not manual or prescriptive	16	6.50
Helpful planning resource	15	6.10
Helpful to 'dip into'	15	6.10
Resources should be adapted for effective use	14	5.69
TGFG as manual or prescriptive	11	4.47
Helpful accessibility	10	4.07
Recommended to school staff	9	3.66
Helpful for ideas and inspiration	8	3.25
Helpful adaptability of resources	7	2.85
Helpful worksheets	7	2.85
Engaging for CYP	6	2.44
Helpful introduction to CBT and educational resource for practitioners	6	2.44
Professional role restricts usability due to time constraints	6	2.44
Resources seem old-fashioned or out-of-date	6	2.44
Hard to understand or complex	5	2.03
Not appropriate for all CYP	5	2.03
Helpful as a prompt	4	1.63
Helpful for psycho-education	4	1.63
Helpful for practitioner's thinking	3	1.22
Less engaging than other resources	3	1.22
Memorable resources	3	1.22
Resources should be differentiated for effective use	3	1.22

Option	Count	% Total
Helpful for addressing SEMH needs	2	0.81
Helpful range of resources	2	0.81
Helpful to make intangible ideas more concrete	2	0.81
Interpersonal skills are additionally important	2	0.81
Learning from TGFG insufficient to deliver CBT	2	0.81
More useful for mild rather than severe mental health difficulties	2	0.81
Reading directly from book not engaging	2	0.81
Too much material or overwhelming	2	0.81
Not analysed - irrelevant	2	0.81
Chapters could be used as standalone interventions	1	0.41
Convenience	1	0.41
Could be made into a session plan format	1	0.41
Effective usage depends on practitioner's skill level	1	0.41
Feels like a lesson	1	0.41
Greater use of Clinician's Guide than Workbook	1	0.41
Helpful for brief, solution-focused work	1	0.41
Helpful for CYP to read themselves	1	0.41
Helpful for designing and delivering training	1	0.41
Helpful for developing shared understanding	1	0.41
Helpful for eliciting core beliefs	1	0.41
Helpful if warranted by formulation	1	0.41
Helpful management strategies	1	0.41
Helpful structure	1	0.41
Helpful theory sections	1	0.41
Helpful to have resources online	1	0.41
More engaging for older children	1	0.41
More helpful with systemic support	1	0.41

Option	Count	% Total
Reading directly from workbook is helpful	1	0.41
Resources can be shared with parents	1	0.41
Should have accompanying sets of baseline measures	1	0.41
Too much flexibility - certain concepts should be covered before others	1	0.41
Word of mouth recommendation	1	0.41

Table L20

Survey Results for Question 15: How Many Years of Experience Do You Have Working in Children's Mental Health?

Option	Count	% Total
11+	84	35.6
3-5	64	27.1
6-10	60	25.4
1-2	22	9.3
<1	6	2.5

Table L21

Survey Results for Question 16: What Level of Training Did You Have Before First Using TGFG? Please Select All That Apply.

Option	Re-coding	Count	% Respondents selected option	% Total
General CBT training, not specific to TGFG	10	179	71.3	55.76
Self-taught by reading the workbook / clinician's guide myself		102	43	31.78
Other		22	9.3	6.85
Non-CBT-specific professional training		10		3.12
Training specifically about TGFG		7	3	2.18
ELSA		1		0.31

Note. ELSA = Emotional literacy support assistant

Table L22

Survey Results for Question 16 (Combinations of Multiple Responses): What Level of Training Did You Have Before First Using TGFG? Please Select All That Apply.

Option	Count	% Total
General CBT training	112	47.26
Self-taught, General CBT training	50	21.10
Self-taught	47	19.83
Other	13	5.49
General CBT training, Other	5	2.11
Self-taught, Other	3	1.27
Training specifically about TGFG	3	1.27
Self-taught, Training specifically about TGFG	1	0.42
Self-taught, General CBT training, Training specifically about TGFG	1	0.42
Training specifically about TGFG, Other	1	0.42
General CBT training, Training specifically about TGFG	1	0.42

Table L23

Survey Results for Question 17: In Which Country Do You Work In Children's Mental Health?

Option	Count	% Total
United Kingdom	109	47.0
England	78	33.6
Scotland	19	8.2
Northern Ireland	6	2.6
Ireland	5	2.2
Wales	5	2.2
No response	5	2.2
Australia	2	0.9
Gibraltar	1	0.4
New Zealand	1	0.4
United States of America	1	0.4

Appendix M

Annotated screenshots of qualitative analyses

Figure M1

Screenshots of NVivo Analyses

Separate files were created for each participant's transcript. Yellow highlighted sections were assigned a code or codes. Stripes (on the right) show which codes were assigned to passages. A complete list of codes was available on the left.

Each code could be opened up to display all the references across all participants.

Question 6

What social, emotional and mental health difficulties do the children with whom you work experience? [Other responses]

Response	Code
Autism / social communication	2
Mental health difficulties	6
OCD, Tourette's, ASD, ADHD, Learning disability	5, 7, 2, Re-coded as 'Difficulties with attention / hyperactivity', 4
Anxiety for ASC children	2
Autism	2
OCD, Fear of failing	5, 6
Varied Additional Support Needs i.e. ASD	2
ASD - rigidity of thought in social contexts	2
Bereavement	3
OCD (may fall under remit of anxiety)	5
trauma	8
Anger and trauma	1, 8
unhelpful 'if-then' thinking patterns	6
autism, learning disabilities	2, 4
Selective Mutism	9
Low self-efficacy beliefs	6
difficulties regulating feeling of anger	1

For each survey question, a table was created in Microsoft Word, with verbatim responses pasted into the left-hand columns. Codes (explained below) were assigned in the right-hand column. Responses were re-coded to original response categories if appropriate.

	A	B	C	D
1	**Code**	**Label**	**Quantity**	
2	2	Autism	7	
3	6	Non-specific mental health difficulties	4	
4	5	OCD	3	
5	1	Anger	2	
6	4	Learning difficulties	2	
7	8	Trauma	2	
8	3	Bereavement	1	
9	7	Tourette's	1	
10	9	Selective mutism	1	
11				

For each survey question, a table was created in Microsoft Excel. Labels and codes were created and then counted.

303

Appendix N

Ethics approval letter

UCL RESEARCH ETHICS COMMITTEE
OFFICE FOR THE VICE PROVOST RESEARCH

9th November 2020

Dr Benjamin Hayes
Research Department of Clinical, Educational and Health Psychology
UCL

Cc: James Redburn

Dear Dr Hayes

Notification of Ethics Approval with Provisos
Project ID/Title: 18753/001: Think Good – Feel Good: Is this intervention effective and what happens during the interactions between practitioners and children that makes a difference?

Further to your satisfactory responses to the Committee's comments, I am pleased to confirm in my capacity as Chair of the UCL Research Ethics Committee (REC) that your study has been ethically approved by the UCL REC until **31st August 2022.**

Ethical approval is subject to the following conditions:

Notification of Amendments to the Research
You must seek Chair's approval for proposed amendments (to include extensions to the duration of the project) to the research for which this approval has been given. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing an 'Amendment Approval Request Form'
http://ethics.grad.ucl.ac.uk/responsibilities.php

Adverse Event Reporting – Serious and Non-Serious
It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator (ethics@ucl.ac.uk) immediately the incident occurs. Where the adverse incident is unexpected and serious, the Joint Chairs will decide whether the study should be terminated pending the opinion of an independent expert. For non-serious adverse events the Joint Chairs of the Ethics Committee should again be notified via the Ethics Committee Administrator within ten days of the incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Joint Chairs will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

Final Report
At the end of the data collection element of your research we ask that you submit a very brief report (1-2 paragraphs will suffice) which includes in particular issues relating to the ethical implications of the research

Appendix O

Two examples are provided to illustrate how analytical themes (Figure 2.5) were derived from descriptive themes (Figures 2.3 and 2.4, Tables 2.6 and 2.7) in the systematic literature review.

Example 1: Acknowledge CYP's perspectives on outcomes

This analytical theme was based primarily on the diversity of findings outlined in Figure 2.3 and Table 2.6. The fact that CYP identified so many different 'positive outcomes' from CBT shows that it is important for practitioners to acknowledge and explore each individual's goals and achievements. This analytical theme was supported by several descriptive themes and codes outlined in Figure 2.4 and Table 2.7. Under the descriptive theme 'Therapist characteristics', participants valued a therapist who *Enabled CYP to feel understood and heard*, was *Responsive, flexible, personalising therapy*, and who *Gave CYP some control over therapy*. In contrast, CYP were put off by a therapist who was *Unresponsive, inflexible, not personalising therapy*. This shows how the analytical theme was derived from findings in relation to both RQs, although it was based primarily on findings from RQ1. It was worded so as to be a helpful, concise takeaway implication for practitioners.

Example 2: Frame CBT as 'upskilling'

This analytical theme was based more evenly on findings from both RQs. In relation to RQ1, the descriptive theme 'Knock-on effects, generalisation of skills' illustrated that CYP valued learning a range of life skills from CBT. These life skills did not necessarily relate directly to the reasons they originally accessed therapy, namely anxiety or depression. In relation to RQ2, under the descriptive theme 'CYP characteristics', barriers included *Negative preconceptions of therapy* and *Having shame or guilt about mental health*. In contrast, a facilitator was *Seeing tangible evidence of change and monitoring progress*. The analytical theme was defined

based on findings from both RQs. Given that CYP valued learning life skills, and felt that accessing mental health support could be stigmatising, the researcher believed that practitioners could frame CBT as 'upskilling' rather than an intervention solely addressing mental health. This would hopefully encourage greater engagement with CBT and acknowledge the importance CYP place on more general outcomes.