Depression in adolescence: requesting and receiving treatment in secondary school.

Submitted thesis for: Doctor of Philosophy

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March 2021

Declaration

I confirm that this is my own work and the use of all materials from other sources have been properly and fully acknowledged.

Iona Lewis-Smith

March 2021

Contribution to papers

Iona Lewis-Smith was the lead researcher on the second and third papers included in this thesis. On the first paper, Iona's supervisors were the principle investigators and gained the ethical approval, however, Iona lead participant recruitment, data collection, data entry and conducted the analyses. Iona and her co-authors' specific contributions to each paper are described below.

Paper 1: '*Would you like some help*?' Asking for help with depression among adolescents.

Co-authors SR and LP designed the data collection method, recruited the participating secondary schools and gained ethical approval for the study. With support from the co-authors and the wider research team, Iona liaised with the participating schools to organise participant recruitment and lead the data collection. Iona conducted the majority of data entry, with support from other members of the research team, and she conducted the data analyses. Iona wrote the first draft of the manuscript and made subsequent revisions based on feedback from the co-authors JH, SR and LP.

Iona's estimated percentage contribution: 70%

Paper 2: How adolescents understand their values: A qualitative study.

Iona designed the study, gained ethical approval and planned participant recruitment with support from co-authors SR and LP. Iona conducted, transcribed and coded all participant interviews. Iona lead the thematic analysis, with SR and LP contributing to the process of shaping and defining of themes. Iona prepared the first draft of the manuscript and made revision based on feedback from SR and LP.

Iona's estimated percentage contribution: 80%

Paper 3: "*…it shows that if I care about stuff, then other people care about me*.": Adolescents' experiences of helpful and unhelpful aspects of Brief Behavioural Activation therapy (Brief BA) for depression.

Iona designed the study alongside co-authors LP and SR, with support from the wider research team. Iona contributed to the process of gaining ethical approval for the study in collaboration with LP and other members of the research team. Iona lead participant recruitment with support from the research team, and she conducted all participant interviews. Iona transcribed the majority and coded all of the interviews. Iona and co-authors LP, SR and DJ contributed to the process of identifying and defining the themes. Iona wrote the first draft of the manuscript and made revisions based on feedback from LP, SR and DJ.

Iona's estimated percentage contribution: 75%

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Acknowledgements

A big thank you to all the young people who participated in these studies and who made this experience worthwhile. Thank you to the school staff who facilitated participant recruitment - without dedicating their time, none of this research would have been possible. I am very grateful to my supervisors and all the members of the research team who supported the Brief BA in schools project.

Special thanks to my aunt, Professor Lorna Smith, who is an all-round inspiration. Lorna, your selfless support reminded me that I was capable of achieving this. Thank you to Peeps, Mum and Callum. I am always grateful for your unwavering faith in my abilities. Finally, all my love to my little family: Martyn & River (Beansie, Bubadie, etc.). Martyn, you show me that life *is* a game and love *is* the prize!

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Abstract

Around 2.6% of adolescents are clinically depressed and around 1 in 4 adolescents experience substantial symptoms of depression at any given time (Polanczyk, Salum, Sugaya, Caye, & Rohde, 2015; Patalay & Gage, 2019). Timely access to treatment for adolescent depression is important in order to minimise the risks of harm, such as self-injury (Barrocas, Giletta, Hankin, Prinstein, & Abela, 2015) and suicide (Nrugham, Larsson, & Sund, 2008). However, the majority of children and adolescents with depression do not receive support from mental health services (Wu et al., 2001). This thesis explored the identification and treatment of adolescents experiencing symptoms of depression at school using quantitative and qualitative research methods. This thesis is comprised of three research papers which aimed to: a) investigate using one screening question, 'would you like some help?', to increase depressed secondary school students' access to mental health services; b) explore adolescents' experiences of values, which can inform their use in psychological therapies; and c) explore adolescents' experiences of the helpful and unhelpful aspects of Brief Behavioural Activation for depression at school. The findings of the research presented in this thesis highlight the practicality of school as a setting for the identification and treatment of adolescents experiencing depression symptoms, in addition to providing evidence of the helpfulness and importance of adolescents' values in the context of normal development and in the context of psychological therapy for depression.

Chapter 1: General Introduction

1.1 Depression in adolescence

Mental illness is one of the largest burdens of disease globally, with mental disorder affecting most people at some point in their lifetime (Ginn & Horder, 2012; Steel, et al., 2014; Vigo, Thornicroft, & Atun, 2016). Half of all mental health disorders begin by the age of 14 (Kessler, et al., 2005) and half of mental health disorders which onset in childhood and adolescence continue into adulthood (Kim-Cohen, et al., 2003). It is estimated that between 2.6 and 4.8% of children and adolescents experience depression (Polanczyk, Salum, Sugaya, Caye, & Rohde, 2015; Sadler, et al., 2018).

The eleventh edition of the International Classification of Diseases defines depressive disorders as the presence of depressed mood or loss of pleasure, presenting alongside other cognitive symptoms (such as inappropriate guilt) and behavioural or physical symptoms (such as social withdrawal or psychomotor agitation; World Health Organisation, 2018). The central features of Major Depressive Disorder in children, adolescents and adults are the same; however, the diagnostic criteria of the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders specifies that, while depressed mood is necessary for the diagnosis of Major Depressive Disorder in adults, this may present as irritable mood in children or adolescents (American Psychiatric Association, 2013).

Depression in childhood and adolescence is a significant concern because of its association with increased risk of harm. For instance, research has indicated that adolescent depression is associated with substance misuse (Fergusson & Woodward, 2002), non-suicidal self-injury (Barrocas, Giletta, Hankin, Prinstein, & Abela, 2015) and suicidal acts (Nrugham, Larsson, & Sund, 2008). There is also evidence of an association between depression symptoms

in adolescence and an increased risk of school drop-out (Fletcher, 2010; Quiroga, Janosz, Bisset, & Morin, 2013).

Beyond these associations with poor outcomes in adolescence, depression in adolescence is also associated with poorer outcomes in adulthood. Most notably, many adolescents who experience depression will go on to experience depression as adults (Birmaher, et al., 2004). Moreover, research has highlighted associations between depression in adolescence and poorer self-rated health status (Naicker, Galambos, Zeng, Senthilselvan, & Colman, 2013), greater health-related work impairments (Keenan-Miller, Hammen, & Brennan, 2007), poorer quality of relationships, increased unemployment and substance misuse (Naicker, et al., 2013), and increased risk of suicide in adulthood (Harrington, et al., 1994).

1.2 Young peoples' access to treatment for depression

In light of the associations between adolescent depression and negative outcomes in adolescence and adulthood, treatment of persistent depression in adolescents is recommended by the UKs National Institute for Health and Care Excellence (NICE). NICE recommend that, following an offer of information and support, steps should be taken to adequately detect, assess and manage adolescent depression at a primary care level (National Institute for Health and Care Excellence, 2019). In the event of increasing severity, comorbidity or the presence of other risk factors, referral from primary care to specialist child and adolescent mental health services may then be made. In this way, primary care providers often act as the gateway to the mental health services that offer specific treatments for depression in young people.

For adolescents, accessing mental health support via traditional primary care providers, such as general practitioners (GPs), may require parents facilitating their access – for example, by providing transport. Furthermore, research suggests adolescents may experience significant

anxiety about attending the GP for mental health concerns and often would only consider doing so as a 'last resort'(Corry & Leavey, 2017). Even when adolescents do present to primary care practitioners, research suggests that only around half of those young people likely to be experiencing mental disorder are correctly identified by GPs (Haller, Sanci, Sawyer, & Patton, 2009). GPs can feel unable to meet the needs of adolescents who present with mental health difficulties because of insufficient formal training, difficulties in referring young people to appropriate services and/or uncertainty about what is expected of them in their role as a GP (Roberts, Crosland, & Fulton, 2014). Thus, GPs may miss opportunities to offer adolescents early intervention or timely referrals to specialist mental health services.

When young people are referred to Child and Adolescent Mental Health Services (CAMHS), nearly one quarter are turned away because of high treatment thresholds and the rest often experience a long wait until there is availability within the service to treat them (Frith, 2016). Despite this, the majority of local authorities' spending on CAMHS has declined since 2010 and the Care Quality Commission has acknowledged that young people and their families often reach a point of crisis before they receive the help they need (Care Quality Commission, 2018). In one community sample of adolescents in England, only 38% with a current mental disorder had had contact with mental health services in the past year (Neufeld, Dunn, Jones, Croudace, & Goodyer, 2017).

The Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) scheme was launched in 2011 by the UK Department of Health, with the aim of increasing young people's timely access to effective, evidence-based psychological therapies. This was initially to be achieved through the training of existing CAMHS practitioners to deliver evidence-based psychological therapies, as well as the introduction of self-referral routes and the

mandatory use of routine outcome measures to inform treatment and service delivery. Between 2011 and 2015, NHS England and the Department of Health invested over £60 million in the scheme (National Health Service, 2015). While the implementation of CYP IAPT was associated with a reduction in average wait time from referral to assessment (Edbrooke-Childs, O'Herlihy, Wolpert, Pugh, & Fonagy, 2015), the Department of Health acknowledged that there were still "significant and unacceptable" gaps and inconsistencies in the availability and quality of services, resulting from a "backdrop of fiscal constraint" (p.22; (National Health Service, 2015)). In light of these challenges, from 2017 the primary goal of CYP IAPT shifted from training existing staff to training and expanding the number of new staff (Ludlow, Hurn, & Lansdell, 2020).

1.3 School as a primary mental health care setting

In view of the barriers to accessing specialist mental health services, the role of schools in preventing, identifying and supporting young people with mental health problems is increasingly emphasized (Department of Health and Department for Education, 2017). NICE recommend that the majority of young people with depression should be treated in the community where possible (National Institute for Health and Care Excellence, 2019) and the UK government has asserted that schools are responsible for the provision of universal and targeted mental health services (Parkin, Long, & Bate, 2017). Research suggests that most secondary schools in England have internal student referral pathways and pastoral care services to manage student mental health concerns (Taggart, Lee, & McDonald, 2014). However, the Department of Health has highlighted the need for more transparent and accessible mental health support strategies in schools (National Health Service, 2015). To achieve this they proposed that some school staff be trained to act as Designated Mental Health Leads for their school and that mental health

practitioners should be integrated within school settings as part of 'Mental Health Support Teams' (National Health Service, 2015). Similarly, NICE recommend that CAMHS should introduce Mental Health Workers into every secondary school to manage student referrals to specialist services (National Institute for Health and Care Excellence, 2019). Furthermore, in March 2018, the independent Care Quality Commission called for better integration of mental health promotion throughout school activities, with school inspectorates to consider this as a key aspect of school functioning (Care Quality Commission, 2018).

In response to these recommendations, and as part of recent developments in the CYP IAPT initiative, the placement of new CYP IAPT practitioners within schools – called Educational Mental Health Practitioners (EMHPs) – is currently being rolled out. EMHPs are being trained to deliver psychological interventions for mild to moderate mental health difficulties in young people, following a Guided Self-Help treatment model (Ludlow, et al., 2020). The rationale for offering low-intensity interventions to young people in schools is that, since CAMHS prioritise treating those young people presenting with severe or complex problems, young people with mild to moderate difficulties who receive prompt, effective treatment at school will be less likely to develop persistent or severe difficulties that would require the input of specialist CAMHS. However, the implementation of EMHPs in schools is still a relatively recent development and further evaluation is required to establish how effectively it will meet the aims of the CYP IAPT initiative.

1.4 Identifying student mental health needs at school

In order for schools to offer early intervention for student mental health issues, those students experiencing mental health difficulties need to be identified. The potentially significant role teachers play in young peoples' access to mental health support is highlighted by research

which shows that parents are more likely to first approach a teacher than a doctor when seeking help for their child's mental health (Green, McGinnity, Meltzer, Ford, & Goodman, 2005). Teachers spend a significant amount of time with students each day and although they often feel a duty of care in relation to student mental health, teachers also feel uncertain in their ability to recognise mental health difficulties in their students (Rothì, Leavey, & Best, 2008). In a 2018 survey of teachers in England, just under 1 in 5 said they didn't feel able to recognise behaviour that may be the result of student mental health issues and nearly 1 in 4 said they didn't know how to help students with mental health issues access support offered by their school (Smith, et al., 2018). Qualitative research suggests that teachers would welcome help or advice about how to better identify students with mental health difficulties and, while they may feel confident in spotting visible signs of mental health difficulties (such as self-harm), teachers would like further advice on how to identify more subtle signs (Shelemy, Harvey, & Waite, 2019). Teachers' perception of their limitations in the recognition of student mental health issues is supported by observational evidence. For example, primary teachers are less able to accurately identify emotional symptoms than behavioural symptoms (Loades & Mastroyannopoulou, 2010), primary teachers view externalising problems as more concerning and serious than internalising problems, and they are less likely to perceive students with moderate or subclinical symptoms to require input from school-based mental health professionals (Splett, et al., 2019).

To help support teachers' care and referral of students with mental health difficulties, NHS England and the Department for Education have been piloting closer collaboration between schools and CAMHS through the implementation of single points of contact in CAMHS (Parkin, Long, & Bate, 2017). While this may make it easier for teachers to refer students to CAMHS and allow them to receive feedback from CAMHS about the appropriateness of their referrals, this

pathway still relies on teachers' ability to recognise the signs of mental health difficulties in their students.

In light of the evidence that adolescents may be reluctant to refer themselves to primary care services when experiencing mental health problems (Corry & Leavey, 2017) and that teachers often find it difficult to identify those students in need of support (Loades & Mastroyannopoulou, 2010; Shelemy, et al., 2019; Splett, et al., 2019), universal mental health screening in schools has been proposed as an effective method of early identification (Humphrey & Wigelsworth, 2016). Universal screening involves all students completing emotional and/or behavioural symptom measures, regardless of whether they are perceived to be 'at risk' of experiencing mental health difficulties. The aim of universal mental health screening it to help identify those students who may require further support or treatment and who would be unlikely to be identified through teacher referral. In their systematic review of school-based universal screening studies, Anderson, et al. (2019) found evidence for the effectiveness of universal screening, especially in identifying those students who do not display obvious signs of mental disorder and thus who may not be identified by school staff. However, universal screening may be challenging for schools to implement due to financial and time constraints (Graham, Phelps, Maddison, & Fitzgerald, 2011; Langley, Nadeem, Kataoka, Stein, & Jaycox, 2010) and research indicates that universal mental health screening may be associated with a high false positive rate (Anderson, et al., 2019). In other words, many of the young people identified through universal screening may not need or want support with their mental health.

Currently, mental health screening in schools is rare (Marshall, Wishart, Dunatchik, & Smith, 2017), thus research is needed to help establish whether are more acceptable and efficient alternative methods of identifying school students who both want and need support with their

mental health. One potential alternative to symptom screening might be to offer all students the opportunity to ask for help with mental health difficulties, such as depression. Research suggests that young people are more likely to have previously sought help for depression when currently reporting depression symptoms (Mariu, Merry, Robinson, & Watson, 2012) , however no study has investigated whether adolescents reporting significant symptoms of depression will ask for help at school when it is available. Examining this could help determine whether giving adolescent an opportunity to ask for help at school may help increase young peoples' treatment access.

1.5 School-based psychological therapies

In order for the identification of students experiencing mental health difficulties at school to help increase service access, schools also need to be able to offer support to the students they identify. A report published by the independent Mental Health Taskforce to the NHS in England proposed that every individual needing mental health support should have access to a choice of talking therapy (Mental Health Taskforce, 2016). The Institute for Public Policy Research assert that, by providing early interventions for young people with mental health difficulties, secondary schools could: improve accessibility; resolve causes of emerging mental health difficulties that are school-related; reduce the demand on over-stretched specialist CAMHS; promote whole-school approaches to mental health (Thorley, 2016). Research suggests that even subthreshold depression is both highly prevalent in adolescents and associated with significant morbidity (Carrellas, Biederman, & Uchida, 2017), thus early school-based interventions may reduce or prevent individuals' need for high intensity treatments or specialist services.

A survey of teachers in England in 2015 found that the most common methods of providing mental health support to students were via counselling services, staff training on

mental health and teacher engagement with students and their families (Harland, Dawson, Rabiasz, & Sims, 2015). In the same year, The Department of Health encouraged "more and better use of counselling in schools" (p.5, National Health Service, 2015). In Wales and Northern Ireland, all secondary schools provide school-based counselling and in Scotland 64-80% do (Cooper, 2013). Past estimates for the provision of counselling in secondary schools in England varied from 61% to 86% (Cooper, 2013; Taggart, et al., 2014).

Despite the widespread provision of school-based counselling in the UK, there is currently little choice of interventions available to young people at school and some individuals may prefer a more directive or structured approach than offered by school counselling (Cooper, 2013). Even the Department of Health - who in 2015 placed a special focus on promoting the provision of counselling in schools - acknowledged that counselling is not the only effective intervention for mental health difficulties in young people (National Health Service, 2015). In the 2017 Green Paper *Transforming Young People's Mental Health Provision*, the Department of Health and Department for Education proposed that school staff be trained to deliver specific, evidence-based interventions for anxiety, low mood and common behavioural difficulties in young people. They suggested that these interventions could include CBT, 'family-based behaviour change' or group interventions (Department of Health and Department for Education, 2017).

The NICE recommendations for the types of talking therapies suitable for adolescents with mild depression are group cognitive behavioural therapy (CBT), group non-directive supportive therapy or group interpersonal therapy (IPT) (National Institute for Health and Care Excellence, 2019). For moderate to severe depression in adolescence, NICE recommends individual CBT or, if this is unsuitable, IPT, family therapy, psychodynamic psychotherapy or

brief psychosocial intervention. In an update to their recommendations in 2019, NICE state that psychological therapies should be made available across a number of settings, including schools and colleges (National Institute for Health and Care Excellence, 2019). This recommendation for offering evidence-based interventions for depression in young people outside of traditional CAMHS settings is made against the backdrop of findings which suggest that, despite recent investments in CYP IAPT, "a substantial proportion of young service users were still not receiving the recommended evidence-based treatment" (p. 432, Skuse, Bruce, & Dowdney, 2017). Furthermore, even within CAMHS, evidence suggests that only around half of cases are closed by mutual agreement of clinician and client to end treatment (Edbrooke-Childs, et al., 2015). It therefore appears that traditional CAMHS are struggling offer young people in England equal access to evidence-based psychotherapeutic interventions that they find acceptable and engaging. This further highlights the rationale behind the implementation and development of school-based mental health interventions.

1.6 Brief Behavioural Activation

Treatment discontinuation is a significant issue for psychotherapeutic interventions targeting community adolescents, with estimated dropout rates for child and adolescent outpatient services of 16-72% (De Haan, Boon, de Jong, Hoeve, & Vermeiren, 2013). In a meta-analysis of 52 randomised controlled trials of psychotherapeutic treatments for depression in children and adolescents it was found that dropout rates were significantly higher in cognitive behavioural therapies and cognitive therapies than interpersonal therapies or problems solving therapies (Zhou, et al., 2015). The authors suggest that therapeutic approaches which emphasise cognitive change may be more challenging for depressed youth to engage with (Zhou, et al., 2015), since symptoms of depression often include poorer memory and concentration problems

(Kaser, Zaman, & Sahakian, 2017). Non-cognitive behavioural therapies have been proposed as less complex, and therefore potentially more acceptable and engaging, treatment options for depressed adolescents (Brent, et al., 2020).

Behavioural Activation (BA) is a psychological therapy based on the principles of operant conditioning and primarily involves activity scheduling to increase exposure to positive reinforcers of psychologically 'healthy' behaviour (Martell, Dimidjian, & Herman-Dunn, 2013). NICE make a key recommendation for research on the effectiveness of BA for child and adolescent depression (National Institute for Health and Care Excellence, 2019). The potential suitability of BA-based interventions for depression in young people is suggested by the meta-analytic finding that non-cognitive psychotherapies for youth depression are as effective as their cognitive counterparts (Weisz, McCarty, & Valeri, 2006). Furthermore, preliminary evidence from 3 randomised controlled trials indicates that behavioural activation therapies may be effective in reducing depression symptoms in young people (Tindall, et al., 2017) and they may also be more cost effective than CBT, as research has shown that BA can be delivered by less highly trained professionals with no less effect (Richards, et al., 2016). However, further research on the acceptability, effectiveness, and cost-effectiveness of behavioural activation therapies for depression in adolescents is needed, as per the NICE research recommendation.

In line with the assertion of the UK government and NICE that mental health interventions should be made available in schools (Department of Health and Department for Education, 2017; National Institute for Health and Care Excellence, 2019), there is early evidence to suggest a version of Behavioural Activation for the Treatment of Depression (Lejuez, Hopko, & Hopko, 2001) developed specially for the treatment of adolescents (called Brief BA) can be feasibly delivered in the school setting (Pass, Sancho, Brett, Jones, & Reynolds, 2018).

While the UK government's 2017 Green Paper made the suggestion of offering CBT for the treatment adolescents experiencing mild to moderate 'low mood' in schools (Department of Health and Department for Education, 2017), the number of qualified CBT therapists is currently limited (Cavanagh, 2014). This is because CBT therapists are generally trained to a Masters or Doctoral level in the UK, which makes CBT therapists costly both to train and employ (Richards, et al., 2016). Since Brief BA can be delivered by non-specialist clinicians or other professionals working under the supervision of a psychologist (Pass, Lejuez, & Reynolds, 2018), Brief BA could help meet the objective of increasing young peoples' timely access to mental health support through school-based interventions.

The therapeutic principles of Brief BA are being used to shape the training of EMHPs to deliver Guided Self-Help for adolescents with mild to moderate depression in schools (Ludlow, et al., 2020). However, while there is initial evidence that Brief BA is as an effective treatment for adolescent depression (Pass, Lejuez, et al., 2018), there is currently no evidence of its long-term efficacy or how effective it will be when delivered in a self-help format. Furthermore, little is currently known about adolescents' experiences of the treatment, for instance, how helpful or unhelpful they find the elements of activity scheduling and values work, or their views on receiving treatment at school. Exploring how and why young people experience aspects of Brief BA as helpful or unhelpful can help elucidate the mechanisms or processes of change associated with the therapy. Developing an understanding of what and how the therapeutic aspects of Brief BA work to bring about positive change for adolescents could help shape its implementation in schools, both as an individual therapy and in the guided self-help format.

1.7 Values as a component of Brief BA and other psychological therapies

A significant element of Brief BA that it shares with the therapy from which it was developed, Behavioural Activation for the Treatment of Depression (BATD; Lejuez, et al., 2001), is the elicitation and use of clients' individual values to structure behaviour change. This component is also found in other psychological therapies, such as Acceptance and Commitment Therapy (ACT; S. C. Hayes, Strosahl, & Wilson, 2012). In Brief BA, BATD and ACT, values are conceptualised as personally meaningful guiding principles that influence behaviour across contexts or situations. In these therapies, people are encouraged to consciously consider and enact their personal values with the aim of improving subjective quality of life. In a similar vein, meaning-centred psychotherapy aims to enhance peoples' quality of life through fostering a sense of meaning and significance. The concepts of meaning and values share many similarities, as evidenced by their interchangeable and parallel use in research and writings from both theoretical perspectives. For instance, in his book *Man's Search for Meaning* (Frankl, 1963), Victor Frankl (the 'father' of meaning therapy) asserts the relevance of personal values and meaning by saying:

"There are some authors who contend that meanings and values are 'nothing but defense mechanisms, reaction formations and sublimations.' But as for myself, I would not be willing to live merely for the sake of my 'defense mechanisms', nor would I be ready to die merely for the sake of my 'reaction formations.' Man, however, is able to live and even to die for the sake of his ideals and values!"(1984 ed, pp. 104).

The theoretical link between values and the experience of well-being has received support from empirical study. Using ACT as an example, there is a growing body of evidence to support the treatment of mental health difficulties in adolescents using ACT, including the

treatment of eating disorders (Juarascio, et al., 2013), posttraumatic stress (Woidneck, Morrison, & Twohig, 2014) and depression (L. Hayes, Boyd, & Sewell, 2011). Verbally stated values in Brief BA and ACT are used to augment the reinforcing properties of behaviour or behavioural consequences. In other words, they are used to increase the likelihood that personally desirable, constructive behaviour will occur (Kanter, Bush, & Rusch, 2009). Humans have a unique ability to use language to construct purpose based on verbal relations between immediate actions and perceived future consequences, even in the absence of previous action-consequence pairings, i.e. operant conditioning (Barnes-Holmes, Barnes-Holmes, & Cullinan, 2000). In fact, when values and behaviour are relationally linked through language, behaviours alone may function as reinforcers, without the need for tangible consequences (Wilson & DuFrene, 2009). In Brief BA, depression is conceptualised as resulting from a loss of contact with positive reinforcement of non-depressed behaviour and/or increased negative reinforcement of depressed behaviour (Pass, Brisco, & Reynolds, 2015). For example, a person may stop going to the gym when they no longer have a friend to go with (loss of positive reinforcement of non-depressed behaviour) or a person may start sleeping-in longer and longer so as to reduce the time in which they have to cope with negative thoughts (negative reinforcement of depressed behaviour). By asking adolescents to describe their values and identify ways to enact them, Brief BA aims to enable individuals to re-establish contact with reinforcers of non-depressed, personally meaningful behaviour (Pass, et al., 2015).

In addition to acting as an instrument for behaviour change in depressed young people, research from the perspective of ACT suggests values are also associated with psychological wellbeing in non-clinical populations. For example, in a sample of over 300 undergraduate students, valued living (conceptualised as the concordance between an individuals' values and

how they behave) was found to be negatively correlated with depression symptoms, anxiety symptoms and relationship difficulties, as well as positively correlated with functioning despite emotional or physical problems (Wilson, Sandoz, Kitchens, & Roberts, 2010). Similarly, in a sample of over 150 German adults, valued living was negatively correlated with scores on a self-report measure of anxiety and depression symptoms (Ostermann, et al., 2017). It should be noted that while these studies indicate an association between psychological wellbeing and peoples' subjective perception of how well they embody their values, they do not suggest a causal role for values nor indicate the direction of the relationship between valued living and wellbeing. Nevertheless, behavioural activation theory would suggest that by living according to their values, people are able to access consistent, varied sources of positive reinforcement for behaviour that promotes and maintains psychological wellbeing (Kanter, et al., 2009).

Despite the centrality of values to psychological therapies such as Brief BA, BATD and ACT, these approaches make little reference to existing values theories or literature. The most commonly used, contemporary theory of value content and structure comes from Shalom Schwartz (1992). Schwartz described a limited number of 'universal' values, which he suggested were underpinned by human physiological and psychological needs (Schwartz, 2012). Research suggests that these values are represented across cultures (Spini, 2003) and from childhood to adulthood (Lee, Ye, Sneddon, Collins, & Daniel, 2017). However, the labels given to the limited set of values in Schwartz's theory differ considerably from those used in the research on valued living, and in ACT, BATD and Brief BA. For example, Schwartz described four higher-order values: openness to change, self-transcendance, conservation and self-enhancement. By contrast, in Brief BA and ACT, people are asked to identify their values tied to specific 'life areas', including family relationships, romantic relationships, friendships, education/work, recreation

activities, citizenship/'the bigger picture' and self-care. While these differences in descriptions and labelling of value content can be attributed to the different aims of each approach (i.e. to describe universal human motivation in Schwartz's theory and to elicit an individual's life goals in Brief BA, BATD and ACT) the conceptualisation of values as personal, guiding principles which motivate behaviour across situations is common to both (Hayes, et al., 2012; Pass, et al., 2015; Schwartz, 1994).

The structure and content of Schwartz's values and the valued 'life areas' utilised in ACT, BATD and Brief BA have been developed on the basis of research that has, for the most part, solely focused on adults. Research indicates that young peoples' values undergo development across childhood and adolescence (Cieciuch, Davidov, & Algesheimer, 2016), however research providing a detailed understanding of young peoples' values over the course of their development is currently lacking. Evidence of how young people understand and perceive values (both as a concept and in their own lives) is needed in order inform the treatment of adolescents using psychological therapies that include values as a key component.

1.8 Summary and aims of the thesis

A small yet significant proportion of adolescents experience depression (Costello, Erkanli, & Angold, 2006). Despite the risks associated with adolescent depression (e.g. self-injury and suicide attempt (Barrocas, et al., 2015; Nrugham, et al., 2008) , many depressed young people do not access mental health services (Wu et al., 2001). The importance of schools as a setting for primary mental health care is increasingly emphasised (Appleton, 2000; Department of Health and Department for Education, 2017), however, young peoples' mental health difficulties may be unrecognised at school (Loades & Mastroyannopoulou, 2010). Universal, school-based mental health screening could help increase the identification of students

experiencing symptoms of depression who are not already receiving help. However, universal school-based symptom screening is rare, likely because of the time and financial pressures faced by schools (Graham, et al., 2011; Langley, et al., 2010). Offering all students an opportunity to ask for help with low mood or depression may be a simple alternative to depression symptom screening, however, there is no existing evidence of how effective and efficient this would be.

In light of the evidence that only around one quarter of adolescents identified through school-based mental health screening have accessed CAMHS (Wright, Garside, Allgar, Hodkinson, & Thorpe, 2020), offering treatment for depression in schools might help increase timely treatment access and therefore potentially reduce the short- and long-term risks of harm associated with adolescent depression (Naicker, et al., 2013). Brief BA is a recently developed behavioural activation therapy for adolescent depression, which focusses on the importance of adolescents' values as potential reinforcers of non-depressed behaviour (Pass, et al., 2015). While Brief BA shows initial promise as an acceptable and effective treatment for adolescent depression in the school setting (Pass, Sancho, Brett, Jones, & Reynolds, 2018), young peoples' experiences of the helpful and unhelpful aspects of Brief BA have yet to be explored. Understanding the aspects of Brief BA that adolescents experience as helpful and unhelpful may reveal the mechanisms or processes of change associated with the therapy, and thus inform both its improvement and application. Similarly, while values form a significant component of Brief BA and other psychological therapies used to treat adolescents, little is known about how adolescents perceive, experience or understand their values. Expanding our comprehension of the development and meaning of values in adolescence can help inform the values work in Brief BA and other psychological therapies.

Using both quantitative and qualitative methods, this thesis aimed to:

i. Assess the efficacy and efficiency of existing referral pathways and the screening question 'would you like some help with low mood/depression?' in relation to self-reported depression symptoms in adolescents.

ii. Explore adolescents' understanding and experience of having and using values.

iii. Examine adolescents' experiences of the helpful and unhelpful aspects of Brief BA therapy for depression.

The rationale for considering school-based screening for depression alongside an exploration of adolescent values and adolescents' experiences of school-based psychological therapy for depression is to tie the ideational process of requesting and accessing treatment for mental health disorder to the individual phenomenon of being helped to overcome barriers to living a personally meaningful life. An individual's values underpin the desirability of situations, experiences and states of being. In this way, they are part of the lens through which young people understand their experience of depression and therapeutic intervention. In a similar way, young people asking for help with depression is an important but basic snapshot of a uniquely personal experience of identifying and voicing a desire or need. This thesis therefore bridges the pragmatic process of requesting and receiving treatment for depression in secondary school and young peoples' individual experiences and understandings.

1.9 Thesis outline

This thesis is composed of three papers. Paper 1 uses a quantitative method and papers 2 and 3 use qualitative methods. The studies reported in papers 2 and 3 were conducted sequentially, while the study reported in paper 1 was conducted in parallel with both studies 2 and 3. This therefore prevented a concrete flow of findings and interpretations from paper 1 into

the formulation and execution of papers 2 and 3. Papers 2 and 3 have been published, paper 1 has yet to be submitted for publication.

All participants in paper 2 had taken part in the research presented in paper 1. The survey described in paper 1 was one of the routes into the therapeutic intervention described in paper 3, thus some of the participants in study 3 may also have taken part in study 1.

Paper 1

Paper 1 examined asking for help with low mood or depression among adolescent school students with the aim of assessing the efficacy and efficiency of existing referral pathways and the screening question 'would you like some help?' in relation to self-reported depression symptoms. In order to address this aim, this study examined the sensitivity and specificity of existing referral pathways and the single screening question. Sensitivity was conceptualised as the proportion of adolescents with elevated symptoms of depression who were receiving help or responded positively to being asked if they would like help for low mood or depression. Specificity was conceptualised as the proportion of adolescents without elevated symptoms of depression who were not already receiving help nor asked for it. Using a large sample of English secondary school students, this paper addressed the following four research questions:

Q 1: What is the sensitivity and specificity of existing referral pathways?

Q2: What is the sensitivity and specificity of a single screening question asking 'Would you like some help?' with low mood/depression?

Q3: What is the combined sensitivity and specificity of both existing referral pathways and asking students whether they would like help with low mood or depression?

Q4: What proportion of depressed adolescents are missed by both existing referral pathways and asking students whether they would like help with low mood/depression?

Paper 2

There had been no existing research on adolescents' experiences of having and using values, despite idiographic values forming the basis of behavioural interventions in psychological therapies used to treat adolescents, such as ACT, BATD and Brief BA. Paper 2 addressed this research gap through qualitative exploration of adolescents' understanding and experience of values. This paper aimed to collate and describe rich, detailed data on the meaning and function of values in the lives of adolescents in order to inform the application of psychological therapies that use values as a tool to enhance adolescent wellbeing.

Paper 3

The third paper included in this thesis aimed to develop an understanding of the experiences of adolescents who took part in Brief BA therapy for depression at school. The focus of the qualitative investigation was on the helpful and unhelping aspects of the therapy. One-to-one interviews were conducted with young people following their participation in Brief BA. An adapted version of the *Client Change Interview for Young People* (Lynass, Pykhtina, & Cooper, 2012) was used, which included questions relating to the unique features of Brief BA: identifying and using values, the school setting and parental involvement. Thematic analysis was used to identify the main themes relating to young peoples' experiences of the helpful and unhelpful aspects of Brief BA, with the aim of informing the development and application of this new psychological therapy for adolescents experiencing low mood.

1.10 Epistemological position and personal reflection

The research presented in this thesis was undertaken from the perspective of critical realism, i.e. with the view that one shared reality exists but that this can only be understood through appropriate critical investigation. The author's epistemological stance was aligned with

constructionism, thus the research was approached with the premise that information and understanding is generated from interaction between the subject and the object (the object being the researcher).

In accordance with her constructionist stance, the author (ILS) considered the influence of her pre-existing ideas, assumptions and comprehension in the design and execution of her research. The author's preconceptions are necessarily influenced by her background and prior experiences, thus transparency about relevant personal experiences helps provide important context for understanding the work presented in this thesis. ILS has lived experience of mental illness, both in adolescence and adulthood. ILS has also received psychological therapy and counselling for the treatment of anorexia nervosa and depression. ILS developed her interest in psychological therapies and values while supporting the work of a paediatric clinical psychologist who used ACT in their practice. These experiences played a role in drawing ILS to research adolescent mental health and values. ILS believes that people are experts in their own experience and she was therefore particularly interested in conducting research that aimed to explore young peoples' unique experiences and perspectives.

1.11 Ethical considerations

The studies reported in Papers 1 and 3 were approved by the University of Reading's Research Ethics Committee (UREC). The study reported in Paper 2 was approved by the University of Reading's School of Psychology and Clinical Language Sciences Research Ethics Committee (SREC), since the study did not involve a clinical population and did not cover sensitive topics. Across all studies reported in this thesis, informed and written assent (for students under 16 years of age) or consent (for students 16 years of age or older) was obtained for all participants.

Careful consideration was paid to the ethical issues raised by the study reported in Paper 1. While all participants in the school surveys gave voluntary, active assent or consent, passive parental consent was used for those students under the age of 16. In the UK, guidelines relating to the requirement and form of parental consent for young peoples' participation in research are unspecified or dependent upon the research context. For example, the British Psychological Society (BPS) suggest that, for children under 16 years of age, "the additional consent of parents or those with legal responsibility for the individual should normally also be sought" (p.16, British Psychological Society, 2014). However, the BPS also advise that in "special circumstances" where obtaining parental consent might inhibit findings about the young person, parental consent is not necessary (BPS, 2014). Active, informed consent from parents/guardians of participants under the age of 16 is often desirable because it gives parents/guardians the opportunity to learn about the research, ask questions and make an informed decision in the best interests of their child. However, there are significant implications for research that makes active parental consent a requirement for participation. For example, a meta-analysis examining the impact of requiring active parental consent for research concerning adolescent risk behaviours found that response rates, and consequently participation rates, were lower, demographic variety was restricted and rates of self-reported substance use were lower in studies requiring active parental consent (Liu, Cox Jr, Washburn, Croff, & Crethar, 2017). Parents' involvement with their children is associated with a variety of childhood outcomes, including academic achievement (Jeynes, 2005), wellbeing (Boutelle, Eisenberg, Gregory, & Neumark-Sztainer, 2009) and mental health (Wang & Sheikh-Khalil, 2014). Active consent requires parents to invest effort, for example reading study information and returning a signed consent form. Requiring active consent from parents whose involvement may already be restricted could potentially lead

to sampling bias and thus limit the generalisability of research findings. The alternative to active parental consent is passive consent. Passive parental consent involves parents only communicating if they are unwilling for their child to take part in a research study. Passive consent is often associated with significantly greater participation rates, with some studies finding differences in participation rates between passive and active arms of the same research study to be around 50% to 60% (Cross, et al., 2009; Ellwood, Asher, Stewart, & Group, 2010). Furthermore, passive consent is more often used in school settings, with BPS guidelines stating that "where the research procedures are judged by a senior member of staff or other appropriate professional within the institution to fall within the range of usual curriculum or other institutional activities, and where a risk assessment has identified no significant risk, consent from the participants and the granting of approval and access from a senior member of school staff legally responsible for such approval can be considered sufficient" (p.17, BPS, 2014). In a study examining the acceptability of screening for mental health difficulties in primary schools, parents did not express a clear preference for either active or passive consent, with the majority indicating that they would find either method acceptable (Soneson, et al., 2018).

The most significant reason for adopting passive parental consent in the study reported in Paper 1 was to offer as many young people as possible the opportunity to ask for help with the issues listed in the survey. Young people with lower parental involvement, who may be less likely to give active consent, might also be more likely to be experiencing emotional difficulties (Wang & Sheikh-Khalil, 2014). Furthermore, research suggests that the majority of young people cite parental influence as important in facilitating their help-seeking for mental health difficulties (Wahlin & Deane, 2012), thus those parents who are less likely to give active consent may potentially be less likely to facilitate help-seeking through the usual school or primary care

routes. Overall, there is reason to suggest that it could have been unethical to only offer help to those young people whose parents had the time and ability to give active consent.

Included in the school surveys reported in Paper 1 was a questionnaire where young people could ask for help with issues including self-harm and suicidal thoughts. Given the risk of harm associated with these issues, the names of those students who asked for help with one or more issues in the survey were passed on to the schools' safeguarding teams as soon as the surveys had been conducted, so that each schools' established safeguarding procedure could be followed. All young people surveyed were provided with a debriefing sheet, which reiterated the purpose of the survey and reminded participants that they could still withdraw from the study if they wished. The debriefing sheet also contained a URL to an online 'useful resources' sheet, which listed a range of resources for information and support, including books, websites and help-lines.

In Paper 2, participants in the study were adolescents aged 12-18 years who took part in a research interview about their understanding and experience of values. For participants under the age of 16 years, information about the study was sent to parents/guardians and written consent for participation was gained from parents/guardians. While the interviews did not aim to cover sensitive topics, participants were assured that they could stop taking part at any time and were provided with the researchers' contact details should they wish to contact them after the interview. All participants were given a debriefing sheet which included the URL to the online 'useful resources' sheet used in the study reported in Paper 1.

The study reported in Paper 3 involved interviewing adolescents who had been identified as experiencing low mood before taking part in 8 sessions of Brief Behavioural Activation at school. During the interviews, participants were asked potentially sensitive questions about their

current and past moods, feelings, thoughts and behaviours. Furthermore, participants may have been identified during their participation in Brief BA as being at risk of harm, for example through engaging in self-harm or experiencing suicidal thoughts. In order to minimise potential distress to participants and to ensure that any risk information arising from the research interviews was managed appropriately, all young people were given a written and verbal explanation about what the study would involve and participants were told that they did not have to answer any questions or talk about anything that they did not want to. Furthermore, the terms of participation and confidentiality were explained to the young people so that they were aware they could withdraw from the study at any time and that what they said would remain anonymous, unless they mentioned risk of harm to themselves or others. All participants were told before the interview that any new risk information arising during the interview (which had not already arisen during the course of Brief BA, and thus been managed by the Brief BA therapist) would be passed on to the researcher's clinical supervisor, and that they would share this information with the young person's parent/guardian. Active parental consent was gained for all students who took part.

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Chapter 2. Paper 1:

Publication status: yet to be submitted for publication

Improving treatment access for depression in adolescence: try asking 'Would you like some help?'.

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Abstract

Background: The majority of children and adolescents with depression do not receive support from mental health services (Wu et al., 2001). Reasons include stigma, lack of access and mental health knowledge (Radez et al., 2020). The aim of this study was to establish whether asking adolescent students whether they would like help in the context of help being offered is an efficient way of increasing the identification of depressed adolescents and thus potentially increasing treatment access.

Methods: English school students (N = 2337, 11-19 years) who had access to school-based psychological treatment for depression were surveyed. They completed a standardised

self-report measure of adolescent depression (the Short Mood and Feelings Questionnaire, SMFQ) and one question 'Would you like some help with depression or low mood?' The sensitivity and specificity of existing referral pathways and the single screening question in relation to student self-reported depression symptoms was calculated.

Results: Using a SMFQ score 12+ as the criterion for depression, the sensitivity of existing referral pathways was 14% and the specificity was 97%. The sensitivity of the single screening question was 34% and the specificity was 97%. The sensitivity of both identification methods combined was 49% and the specificity was 94%.

Conclusions: Giving adolescents the opportunity to ask for help with low mood or depression could increase the identification of depressed adolescents and thus potentially increase access to support for those who need it. Future research should explore why many depressed students do not ask for help when it is available.

Key points

- The majority of depressed children and adolescents do not receive support from mental health services.
- This study is the first to examine the use of the screening question 'Would you like some help for low mood/depression?' in comparison to a self-report depression symptom questionnaire
- The findings of this study indicate that the screening question 'Would you like some help?' has the potential to substantially increase depressed adolescents' treatment access

Introduction

It is estimated that, at any given point, 2.6% of adolescents experience depression (Polanczyk, Salum, Sugaya, Caye, & Rohde, 2015). Depression in childhood and adolescence is associated with increased risk of substance misuse (Fergusson & Woodward, 2002), non-suicidal self-injury (Barrocas, Giletta, Hankin, Prinstein, & Abela, 2015), suicidal acts (Nrugham, Larsson, & Sund, 2008), and lower educational attainment (Wickersham et al., 2020). Depression in adolescence is also associated with adverse outcomes in adulthood including poorer health, poorer educational and employment outcomes (Clayborne, Varin, & Colman, 2019; Naicker, Galambos, Zeng, Senthilselvan, & Colman, 2013), and a significantly increased risk of depression in adulthood (Johnson, Dupuis, Piche, Clayborne, & Colman, 2018).

Many young people with depression or other mental health disorders do not seek or access support (Neufeld, Dunn, Jones, Croudace, & Goodyer, 2017; Sen, 2004). For example, over half of adolescents and young adults in the UK with a mental health issue do not receive treatment from mental health services (Knapp, et al., 2016). Adolescents may be reluctant to seek professional help (Corry & Leavey, 2017) and treatment access often depends on adults recognising young peoples' difficulties and facilitating their access to help (Wahlin & Deane, 2012). In addition, many young people perceive there to be significant barriers to service access (Radez et al., 2020). This perception is supported by evidence of long treatment waiting lists and high treatment thresholds in Child and Adolescent Mental Health Services (Frith, 2016), as well as estimates which suggest that up to 39% of secondary schools in England may not offer counselling (Cooper, 2013; Taggart, et al., 2014). Previous research has indicated that adolescents currently experiencing depression symptoms (Mariu, Merry, Robinson, & Watson, 2012) or retrospectively reporting depression symptoms (Gasquet, Chavance, Ledoux, &

Choquet, 1997) are more likely to have previously sought help from primary care. However, most adolescents report that they did not ask for help when they were depressed (Sen, 2004).

Universal screening of mental health in schools has been proposed as a way to increase identification of young people who are experiencing mental health difficulties (Humphrey & Wigelsworth, 2016). Universal screening in schools involves all students completing screening measures, regardless of perceived risk or vulnerability. Universal school-based screening could facilitate earlier identification of student difficulties (Eklund & Dowdy, 2014), and increase access to school or community-based mental health services (Gould et al., 2009). However, universal screening can be challenging for schools to implement due to limited resources, e.g. time and money (Graham, Phelps, Maddison, & Fitzgerald, 2011; Langley, Nadeem, Kataoka, Stein, & Jaycox, 2010). A survey of schools and colleges in England (Marshall, Wishart, Dunatchik, & Smith, 2017) showed that 24% of institutions undertook targeted screening for mental health difficulties and 15% undertook universal screening. Unsystematic identification of student mental health difficulties by teachers was the most frequent method used by schools and colleges, despite evidence that teachers find this difficult (Loades & Mastroyannopoulou, 2010; Shelemy, Harvey, & Waite, 2019; Splett et al., 2019).

If a simple question asking students whether they would like help for depression were to identify a substantial number with depression who are not receiving help, this would offer major opportunities for improving access to treatment. However, while this may be a simple method, it will only be efficient if it is sensitive and specific. In this study, sensitivity was conceptualised as the proportion of adolescents with elevated symptoms of depression who were receiving help or responded positively to being asked if they would like help for low mood or depression.

Specificity was conceptualised as the proportion of adolescents without elevated symptoms of depression who were not already receiving help nor asked for it.

We recruited adolescents aged 11 – 18 in English schools in order to address the following four questions:

Q 1: What is the sensitivity and specificity of existing referral pathways?

Q2: What is the sensitivity and specificity of a single screening question asking 'Would you like some help?' with low mood/depression?

Q3: What is the combined sensitivity and specificity of both existing referral pathways and asking students whether they would like help with low mood or depression?

Q4: What proportion of depressed adolescents are missed by both existing referral pathways and asking students whether they would like help with low mood/depression?

Method

Procedure

Data from 2,397 students were collected between March 2017 and May 2019 as part of a research project establishing a school-based mental health service in four secondary schools in south east England. It was agreed with each school's Senior Leadership Team which year groups would be surveyed, taking into consideration students' exam preparations and settling into secondary school. All eligible students were given an information sheet and a verbal explanation of the study. Written information about the study was sent to parents/guardians, and parents/guardians of students under the age of 16 were asked to give consent via 'opt-out'. This means that they were asked to indicate if they did not want their child to take part in the research. Multiple means of indicating opt-out were provided, including contact with researchers by email,

phone or letter, and contact with the school via email, phone or in-person. Students gave written assent or consent and they were told that their responses were confidential. Students were told that if they asked for help with depression, their name would be passed on to the school mental health service. Students were told that if they indicated that they wanted help, they would be identified to the school safeguarding lead and school mental health service but not to other staff.

A printed survey booklet containing self-report questionnaires (including some not used in this study) was presented to all students, except those who opted-out themselves or were opted-out by their parents. Participants completed screening questionnaires in tutor classes of around 20-30 students or during whole-year assemblies. Two booklet versions with different ordering of questionnaires were handed out to students sitting adjacent to each other.

Ethical issues

Ethical approval for the study was granted by the University Research Ethics Committee. Parental/guardian consent was obtained via opt-out to ensure that as many students as possible had the opportunity to take part in the survey and had access to the school mental health service. Previous studies have shown that requiring active parental consent results in lower participation rates and restricted demographic diversity when compared to opt-out consent (Liu, Cox Jr, Washburn, Croff, & Crethar, 2017). Therefore opt-in parental consent processes are likely to result in samples of young people who are economically advantaged and do not represent minority populations. Opt-out consent was also requested by schools to maximise representativeness of the sample, and to minimise their administrative burden.

Sample

Student participation rates were estimated based on student attendance figures on the survey days. Three hundred and eighty-six students from years 7-10 and 12 were surveyed in

school A, with an estimated participation rate of 59%. In school B, 1173 students from years 8-13 were surveyed (an estimated 90% participation rate). Six hundred and eighteen students in years 7-13 in school C were surveyed, with an estimated participation rate of 59%. Finally, in school D, 220 students in years 9 and 10 participated (an estimated 61% participation rate).

According to their OFSTED (Office for Standards in Education, Children's Services and Skills) reports, the proportion of students supported by student premium (a governmental grant designed to allow schools to help disadvantaged students) and the proportion of students who had Special Educational Needs (SEN) and/or disabilities in schools A and B were below the national average. In schools C and D, the proportion of students supported by student premium was similar to the national average. In school C the proportion of students who had SEN and/or disabilities was also similar to the national average, but the proportion in school D was not included in their OFSTED report.

Measures

Short Mood and Feelings Questionnaire (Angold, Costello, Messer, & Pickles, 1995)

Symptoms of depression were measured using the Short Mood and Feelings Questionnaire (SMFQ). The SMFQ was developed as a short, self-report depression symptom screening questionnaire for young people (Angold et al., 1995). The 13 items are rated on a three-point scale (Not true =0, Sometimes true =1, True =2), with higher scores indicating more severe depression symptoms. Mean imputation was used for missing items on the SMFQ when participants completed at least 75% of remaining items (n=73). The SMFQ has been shown to demonstrate good internal reliability (alpha of 0.85; (Costello, Benjamin, Angold, & Silver, 1991). In a small sample of adolescents in primary care, a SMFQ threshold of 12+ demonstrated a sensitivity of 84% and specificity of 68% in relation to clinician-rated Children's Depression

Rating Scale—Revised (Thabrew, Stasiak, Bavin, Frampton, & Merry, 2018). In the current study a SMFQ threshold score of 12+ was used to indicate students with high severity of depression and a SMFQ score of less than 12 was used to indicate students with low severity of depression.

'Would you like some help?' questionnaire

The '*Would you like some help?'* questionnaire was designed in collaboration with young people who were members of a Patient Public Involvement Group. The questionnaire asked respondents to indicate if they would like help or were already receiving help for: bullying, worry/anxiety, eating difficulties, keeping up with schoolwork, low mood/depression, self-harm, suicidal thoughts, sleep problems and drugs/alcohol (the latter two were added after the survey had already been conducted in school A). Participants could also ask for help with other problems not listed (by writing these in a free text box) or indicate that they did not want help with any of the issues listed (the latter tick box was added after the survey had been conducted in school A). The majority of participants who did not tick any of the boxes on the 'would you like some help?' questionnaire (including 'I don't want help with any of these') completed the rest of the survey, therefore it was assumed that these students did not want help with any of the issues listed. Students who asked for help while reporting that they were already receiving help (n= 4) were not included in the analysis of responses to 'would you like some help?'.

Demographic characteristics

Participants were asked to indicate their date of birth, school year, gender and ethnicity. For pupils who did not report their date of birth, the mean age of their school year was input in place.

Statistical analyses

SMFQ scores were positively skewed so for parametric analyses the transformed variable was used. Analyses of categorical dependent variables used chi-square.

Results

Mean depression symptoms for each student by key demographic variables are displayed in Table 1.

Table 1: Sample characteristics (n= 2337)

	n (%)	Mean SMFQ (SD)
Self-reported gender		
Female	1168 (49.98%)	6.39 (5.80)
Male	1064 (45.53%)	3.87 (4.40)
Other	13 (0.56%)	8.77 (7.35)
Missing	92 (3.94%)	5.36 (5.76)
Mean age (SD)	14.20 (1.67%)	-
School year		
7	182 (7.79%)	4.84 (5.23)
8	413 (17.67%)	4.45 (5.11)
9	499 (21.35%)	5.41 (5.64)
10	502 (21.48%)	5.27 (5.67)
11	259 (11.08%)	5.39 (5.19)
12	306 (13.09%)	5.82 (5.15)

13	176 (7.53%)	5.36 (4.79)
Ethnicity		
White	1382 (59.14%)	5.42 (5.48)
Asian	501 (21.44%)	4.76 (4.94)
Black	124 (5.31%)	4.27 (4.2775)
Mixed race	186 (7.96%)	5.38 (5.57)
Any other ethnic background	26 (1.11%)	4.69 (5.17)
Missing or declined to answer	118 (5.05%)	5.55 (5.79)

The overall mean SMFQ score was 5.23 (5.38) and 13.4% of students scored at or above the SMFQ cut-off of 12+. As shown in Table 1, female students reported significantly higher mean symptoms of depression than male students, $t(2234)= 12.30$, $p<.001$, 95% CI of mean difference in transformed scores [0.33, 0.46], and were significantly more likely than males to score 12+ on the SMFQ (18.49% vs 7.71%, $\chi^2= 55.97$, $p<.001$).

There was a small, significant, positive correlation between age and transformed SMFQ score, $r=.11$, $p<.001$. Depression symptoms also varied across school years 7 – 13. For a formal comparison, four school year categories were created with approximately similar numbers of students; years 7 – 8 (n= 596), year 9 (n= 501), year 10 (n=503) and years 11 – 13 (n=741). A one-way ANOVA with transformed SMFQ scores was highly significant ($F(3)= 5.44$, $p < .001$) and in pairwise comparisons, mean scores in year 9 (M= 5.41) were higher than those in years 7 – 8 (M= 4.57, $p = .019$), and those in years 11 – 13 (M= 5.56) were higher than those in year 10 (M= 5.27, $p = .012$).

Table 2: Numbers of participants with low and high depressive symptoms who were already receiving help and who asked for help in the survey

	Number (%) SMFQ <12 Low depressive symptoms	Number (%) SMFQ 12+ High depressive symptoms	Total number (%)
Did not ask for help	1905 (94.2%)	161 (51.3%)	2066 (88.4%)
Already receiving help	56 (2.8%)	45 (14.3 %)	101 (4.3%)
Asked for help	62 (3.1)	108 (34.4 %)	170 (7.3%)

Q1: What is the sensitivity and specificity of existing referral pathways?

As shown in Table 2, of the 314 adolescent participants who reported high depressive symptoms, only 45 were already receiving help, giving a sensitivity of existing referral pathways of 14.3%. Among the 2023 adolescents with low depressive symptoms, the vast majority (1967) were not receiving help, giving a specificity of 97.2%.

Q2: What is the sensitivity and specificity of a single screening question asking 'Would you like some help?' with low mood/depression?

Also shown in Table 2, of the 269 participants with high depressive symptoms who were not already receiving help, 108 requested help in the survey giving a sensitivity of 40.1%. Among the 1967 with low depressive symptoms and not already receiving help, 1905 did not request help, yielding a specificity of 96.8%.

Q3: What is the combined sensitivity and specificity of both existing referral pathways and asking students whether they would like help with low mood or depression?

Of the 314 students who reported depressive symptoms at or above the SMFQ cut-off, 153 either reported already receiving help or asked for help with low mood/depression. Therefore, the sensitivity of both pathways combined was 48.7% and the specificity was 94.3%.

Q4: What proportion of depressed adolescents are missed by both existing referral pathways and asking students whether they would like help with low mood/depression?

More than half (see Table 2) of adolescents who reported high depressive symptoms did not ask for help or report already receiving help. As an initial exploration of possible differences between help-seeking and non-help-seeking adolescents with high depressive symptoms, we compared mean depression symptoms in the two groups. Those who asked for help and were not already receiving help had a higher mean SMFQ score (M= 17.4) than those who did not ask for help (M= 15.2), $t(312)= 3.86$, $p<.001$).

Discussion

Many young people with elevated depression symptoms do not access support or professional help (Neufeld et al., 2017) and therefore the adverse impacts of depression on a range of educational, social and health outcomes are likely extended and amplified. It has been suggested that identifying student mental health difficulties at school may help increase access to mental health interventions (Humphrey & Wigelsworth, 2016) and reduce these adverse outcomes. However, no previous study has examined whether offering young people an opportunity to ask for help at school could increase access to support for those young people experiencing significant depressive symptoms.

To investigate the effectiveness of using the screening question ‘Would you like some help?’, we surveyed a large sample of English secondary school students. The findings indicate that fewer than 1 in 6 of those students who reported high depressive symptoms were already receiving help for low mood or depression and when given the opportunity to ask for help over one third of students with high symptoms of depression who were not already receiving help asked for this. This finding suggests that existing referral pathways are leaving many adolescent who want support for depression or low mood without it and that asking adolescent students whether they would like help has the potential to substantially increase identification and access. While loss of motivation is a symptom of adolescent depression (Watson, Harvey, McCabe & Reynolds, 2020), the results of this study indicate that loss of motivation does not necessarily act as a barrier to help seeking among adolescents. In addition, the willingness of adolescent students to ask for help with depression at school offers support for the suitability of school as a setting for identifying adolescents’ mental health needs (Humphrey & Wigelsworth, 2016).

In this study, sensitivity and specificity were conceptualised as the proportion of adolescents with and without high depression symptoms who were receiving help via existing referral pathways and/or asked for help with low mood/depression. Our main finding is that the sensitivity of current referral pathways in relation to high levels of depression is very low and that asking the single question ‘Would you like some help?’ has a much higher sensitivity. Crucially, the specificity of asking ‘Would you like some help?’ is less than one percent lower when compared to existing referral pathways. This means that asking adolescent whether they would like help for low mood or depression does not lead to larger numbers of inappropriate requests for help. Overall, these findings indicate that asking a single question is an efficient way

of increasing the identification of depressed adolescents and thus potentially increasing young people's access to help.

However, even after being directly invited to ask for help, more than 50% of students who had elevated symptoms of depression did not indicate that they would welcome support. This is a very important group for future research, which should aim to investigate why they did not ask for help. This study was not designed to investigate this systematically, however comparison of mean SMFQ scores between those who did and did request help may provide some clues. While both groups, by virtue of being in the high depressive symptoms group, had very high mean scores, those who requested help were significantly more depressed than those who did not. This suggests that adolescents are likely aware of the severity of their symptoms and ask for help when the severity of their symptoms exceeds their ability to cope. Nevertheless, possible reasons why a greater number of student did not request help may include mistrust of offers of help, perceived stigma, or viewing help-seeking to be a sign of personal weakness (Radez et al., 2020; Sharp & Vanwoerden, 2015). Barriers associated with the school context may also have influenced students requesting help, such as the presence of peers and concerns about teacher involvement.

A strength of this study is that we surveyed adolescent students across all school years in four schools with contrasting demographic characteristics, yielding a sample that was ethnically diverse. Levels of participation were high. The representativeness of our sample is also indicated by rates of elevated depression and of help-seeking that are comparable to those reported in existing epidemiological studies (e.g. Patalay and Gage , 2019; Sen, 2004).

The survey used in this study included measures not used in this paper, such as the Strengths and Difficulties Questionnaire, and young people were also given the opportunity to

ask for help with issues other than low mood/depression, such as anxiety and eating issues. These measures were not used in this study as the focus was on depression symptoms and asking for help with depression or low mood specifically. An avenue not explored in this study was the relationship between asking for help with low mood/depression and these other issues. Similarly, this study did not investigate the relationship between depression symptoms and asking for help with issues other than low mood/depression. Based on the high comorbidity between depression and other mental health disorders (Avenevoli, Swendsen, He, Burstein & Merikangas, 2015), it may be expected that young people with high depressive symptoms would also ask for help with issues other than depression, and that many of the young people who asked for help with low mood/depression also asked for help with other issues. It is possible that one of the reasons that a substantive proportion of students with high depressive symptoms did not ask for help with low mood or depression was that they did not feel this was their main problem and they wanted help for another issue. Future research exploring this premise could help develop our understanding of why many young people with high depressive symptoms do not ask for help.

A potential limitation of this study is that it is not known what sources of help those young people who reported already receiving help for low mood/depression were receiving. These students may have been receiving professional help, however others may have been receiving help from friends or family only. A further limitation is that we were not able to determine how many of those students who said they would like help then accessed the services that were offered. Previous studies have shown that students who are identified via symptom screening do not always go on to access services (Gould et al., 2009) and thus this is likely to be similar when asking ‘Would you like some help?’.

It is also a limitation that our sample were not recruited from areas of high deprivation. Young people with backgrounds of high deprivation are more likely to reported mental health difficulties (Deighton et al., 2019) and have more limited access to mental health services (Reiss, 2013) than young people from more privileged backgrounds. Nonetheless, two of the schools in this study had a higher proportion of pupils receiving pupil premium than the national average, so our sample was not overly privileged.

In this study a SMFQ threshold score of 12+ was used to indicate young people reporting high depressive symptoms. However, previous studies using the SMFQ have applied a variety of threshold scores to indicate elevated symptoms of depression. For example, Katon, Russo, Richardson, McCauley and Lozano (2008) used a threshold score of 6 in a sample of adolescents with and without asthma and found a sensitivity of 80% and a specificity of 81% to a C-DISC diagnosis of major depression. By contrast, Angold, Costello, Messer and Pickles (1995) demonstrated that a threshold score of 8 in a sample of children and adolescent psychiatric outpatients and primary care paediatric clinic attendees yielded a sensitivity of 60% and a specificity of 85% to a DISC depression diagnosis. Using a higher threshold score is likely to increase specificity in relation to sensitivity (i.e. few young people without depression are likely to be identified as having high depressive symptoms, while some young people with depression may be missed), whereas using a lower SMFQ threshold is likely to decrease specificity in relation to sensitivity (i.e. few young people with depression will be missed but there may be many young people without depression identified as having high depressive symptoms). The aim of using a threshold score of 12 in this study was to focus on those young people with more severe depression symptoms and therefore those most likely to ‘need’ or benefit from targeted intervention. However, it is acknowledged that using a different SMFQ threshold score to

indicate those young people with high depressive symptoms would have an impact on the proportion of these young people who asked for help or did not ask for help with low mood/depression.

To our knowledge, this was the first study to explore asking for help with depression by adolescents in the context of school-based treatment provision being available. Our findings suggest that simply asking one question could substantially improve access to treatment, and that this would not identify a large number with low levels of need. More research is needed to establish how often this translates into engagement in treatment among students who otherwise would not have received treatment. Future research should also examine whether treatment outcomes vary by responses to an offer of help. It may be that those who respond positively to the offer of help will also be those who are most motivated to change, leading to higher treatment effectiveness in this group (Ryan, Lynch, Vansteenkiste, & Deci, 2011).

Conclusions

This study found that giving adolescent students the opportunity to ask for help with low mood or depression at school could substantially increase their access to support. This study also provides evidence that few students without elevated depressive symptoms are likely to ask for help. Therefore, routinely offering students the opportunity to ask for help with low mood or depression at school could provide an effective and efficient method of helping to increase access to support for depressed adolescents.

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Chapter 3. Paper 2:

Publication status: published in Clinical Child Psychology and Psychiatry. Article first published online: October 19, 2020; Issue published: January 1, 2021.

How adolescents understand their values: A qualitative study.

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Abstract:

An important component of some psychological therapies is the use of clients' values to motivate behaviour change. Values are understood to be developed during childhood and adolescence but there has been limited exploration of how young people experience values and their function across contexts. This study aimed to explore adolescents' understanding of the concept of 'values' and to elicit their experiences of values. Semi-structured, individual interviews were conducted with 11 adolescents aged 12-17 years. Thematic analysis was used to identify themes. Young people were readily able to discuss the meaning of 'values' and their own personal values. Three main themes were identified: 1) what values are (in general, and specific to themselves), 2) where values come from (relationships, education, growing up), and 3) why

values are important (prioritising/decision making, reflecting on values is helpful). The adolescents in this study demonstrated an in-depth understanding of the meaning, origins and functions of values. The results suggest young people may welcome and benefit from opportunities to discuss their values, including in therapy.

Keywords: Values, Adolescents, Development, Qualitative, Behavioral Activation for the Treatment of Depression (BATD), Acceptance and Commitment Therapy (ACT).

Acknowledgements:

Thank you to the participating school and pupils. The authors are grateful for support of the Charlie Waller Memorial Trust and the Titcomb Foundation Charitable Trust, who funded the doctoral studentship of IL-S that made this research possible.

Introduction

"... you know your values, but it's only when you talk about it that you understand where it comes from, how it's changed" [Millie, 17].

Values are often assumed to influence the development and expression of attitudes, beliefs, behaviour and wellbeing. Given the breath of their assumed role, research on human values has been conducted across a range of disciplines including sociology, psychology and anthropology. Perhaps unsurprisingly therefore, conceptual definitions of the term 'values' are varied (Rohan, 2000). Most psychological research on individuals' values is based on Schwartz (1992), who suggested that values are "transsituational goals, varying in importance, that serve as guiding principles in the life of a person or other social entity" (Schwartz, 1994, p.21).

Schwartz proposed that individuals' values are derived from three fundamental needs: biological, social, and group survival. He further argued that all human values sit within a circular structure and can be classified using four broad categories: conservation, self-enhancement, openness to change, and self-transcendence (Schwartz et al., 2012).

Values are thought to guide behaviours and remain relatively consistent during adulthood (Bardi & Schwartz, 2003; Vecchione et al., 2016), although they can change in response to events or experiences (e.g. Sortheix, Parker, Lechner, & Schwartz, 2019). There is evidence that values develop throughout childhood and adolescence and that the likelihood of value change decreases with age (Cieciuch, Davidov, & Algesheimer, 2016; Daniel & Benish-Weisman, 2019). Young people often have similar values to their family (Boehnke, Hadjar & Baier, 2007) and value similarity between adolescent friends also suggests that peer relationships influence value development (Solomon & Knafo, 2007).

The Schwartz value structure can be observed in children as young as five (Lee, Ye, Sneddon, Collins, & Daniel, 2017). However, although childhood and adolescence appear to be critical periods in the development of values, there is very little research focussing on the consequences and significance of values in young peoples' lives. Qualitative methods are well suited to exploration of the personal significance and experience of values but, similarly, there has been very limited qualitative research on values. Thus, a comprehensive understanding of values during adolescence and young people's experiences of values across contexts is currently missing.

Despite the limited research on how values develop or are experienced, the concept of individual values is central to some psychotherapeutic approaches. For example, in Acceptance and Commitment Therapy (ACT: Hayes, Strosahl, & Wilson, 2011), Behavioral Activation for

the Treatment of Depression (BATD: Lejuez, Hopko, Acierno, Daughters, & Pagoto, 2011; Lejuez, Hopko, & Hopko, 2001), Narrative Therapy (Freedman & Combs, 1996) and Meaning Therapy (Wong, 2010) it is proposed that values are fundamental to psychological wellbeing and functioning.

Adolescence is an important period in the development of identity and autonomy (Fleming, 2005; Kroger, Martinussen, & Marcia, 2010) and a period when mental health problems often emerge for the first time (Kessler et al., 2005). Both ACT and BATD have been adapted for adolescents and these adaptations incorporate identifying adolescents' values to form the basis of behavioural intervention (Hayes & Ciarrochi, 2015; Pass, Brisco, & Reynolds, 2015). However, although these psychological therapies assume that values are developmentally relevant and important to young people, no research has provided a direct understanding of how young people experience their values and how they understand their function across contexts. Thus, knowing how adolescents conceptualise their values would provide new insights beyond the existing quantitative explorations of values, as well as informing psychotherapeutic approaches that use individuals' values to enhance psychological wellbeing. Therefore the aim of this study was to gain rich, detailed data on values in the lives of adolescents.

Method

Study design

One-to-one, semi-structured interviews were conducted with young people by the first author. Qualitative thematic analysis methodology (Braun & Clarke, 2006) was used to analyse the interview content. This study adopted a predominately linear-sequential approach to analysis (Kennedy & Thornburg, 2018) because most interviews were conducted before data analysis began; however, field notes from previous interviews were considered when conducting each

subsequent interview. Data analysis was heavily data-driven, as opposed to theory-driven, given the paucity of existing qualitative and quantitative examinations of adolescents' values.

Participants and recruitment

Forty-one adolescents from year 8 and year 12 in a co-educational secondary school with sixth form in Berkshire, UK, were invited to take part in this study. They were contacted following their participation in a school survey conducted by the research team, where students provided consent to receive communications about future research studies. According to the school's most recent Ofsted report, the majority of pupils at the school were White British and only a small number did not speak English as their first language. There were no exclusion criteria for the study and all participants who opted-in were interviewed. Participants were given an information sheet explaining the study and the need for them (or a parent) to give consent to the research. Parental consent was gained for those participants under the age of 16. Students aged 16 and above provided their own informed consent. All participants consented for their demographics and Short Mood and Feelings Questionnaire (SMFQ; Angold, Costello, Messer, & Pickles, 1995) responses collected in the school survey to be used in this study. Ethical approval for the study was obtained from the University of Reading's School of Psychology and Clinical Language Science Research Ethics Committee.

Eight year 12 students (2 males, 6 females, all White British, average age 16.75 years) and three year 8 students (all female, all White British, average age 12.33 years) took part. Participant demographics and scores on the SMFQ are presented in Table 1. Pseudonyms have been used to protect participant confidentiality. Participants' SMFQ scores ranged from 1 to 13 with a mean score of 6.5.

Table 1. Participant demographics and SMFQ scores.

Pseudonym	Gender	Age	SMFQ score
Charlotte	Female	12	8
Erin	Female	13	3
Isabelle	Female	16	6
Jessica	Female	12	1
Joshua	Male	17	4
Leo	Male	17	3
Millie	Female	17	13
Olivia	Female	17	6
Poppy	Female	16	11
Sophie	Female	17	6
Zara	Female	17	10

SMFQ = short mood and feelings questionnaire.

Measures

The SMFQ assessed participants' symptoms of depression, to contextualise the sample in relation to adolescents that psychological therapists may work with. The SMFQ consists of 13 items (e.g. 'I felt miserable or unhappy') that are scored as 0 = 'Not true', 1 = 'Sometimes true', and 2 = 'True'. Scores on the SMFQ range from 0 to 26, with higher scores indicating more depression symptoms. In a sample of 11-17 year old primary care attendees, a SMFQ criterion score of 6 had a 80% sensitivity and 81% specificity to a diagnosis of depression (Katon, Russo, Richardson, McCauley, & Lozano, 2008) and in a community sample of 8-16 year olds, a criterion score of 8 had a sensitivity of 75% and a specificity of 74% (Thapar & McGuffin, 1998).

For demographic information, participants were asked to report their date of birth, gender, school year and ethnicity.

Procedure

Interview procedure

Semi-structured interviews with participants were conducted using a topic guide to facilitate responses, while allowing the direction and content of each interview to be determined by each participant. The interview topic guide included questions that aimed to elicit participants' understanding of values as a concept (e.g. *What does the word 'values' mean to you?*), what their values meant for them (e.g. *What do your values mean for your life?*) and how they thought about and expressed their values (e.g. *Tell me how you think about your values? How do you express your values?*).

All interviews were conducted at school during the school day. At the start of the interview, the interviewer explained the purpose of the interview, the terms of confidentiality, the format of the interview and expected length. All participants consented for their interview to be audio recorded and for the researcher to take brief notes during the interview. Interviews lasted between 20 to 60 minutes. One participant asked for the interviewer to define the term 'values', for which the interviewer used a description of values adapted from Brief Behavioural Activation (Brief BA; Pass et al., 2015) to form the basis of her answer, as this used language intended to be developmentally appropriate for adolescents. Apart from using the description of values from Brief BA for one participant, the first author tried to remain aware of and minimise the bias from her own understanding of values.

Data analysis procedure

Data analysis was undertaken following the thematic analysis procedures described by Braun and Clarke (2006). All interviews were transcribed verbatim by the first author using Nvivo 11 software, before repeated re-reading to familiarise her with the young peoples'

responses. Two cycles of line-by-line coding were used with the aim of interpreting and capturing the essence of the data (Saldaña, 2015). The first author then grouped the codes into semantically-related categories, determined by perceived patterns in the codes. Grouping of codes into potential themes was an iterative process, with the aim of refining categories and moving from concrete to more abstract categorisations (Saldaña, 2015). Next, the second and third authors coded a transcript blind to the themes identified by the first author and a discussion between the researchers was used to refine the themes. An iterative process of deciding appropriate labels for themes and their definition was then conducted by all three authors, after which the first author compared the final themes against the audio-recordings to check that all themes accurately reflected the content and meaning of the interviews. Throughout data analysis, the authors reflected on the influence of their assumptions and biases, including their understanding of values from the perspective of psychological therapies and their understanding of adolescent development.

Results

Overview of themes

Participants' discussions of values were captured in three main themes: (1) what values are, (2) where values come from and (3) why values are important.

Theme 1 – 'What values are':

This theme encompasses what the young people understood values to be as an abstract concept and also what they understood their personal values to be.

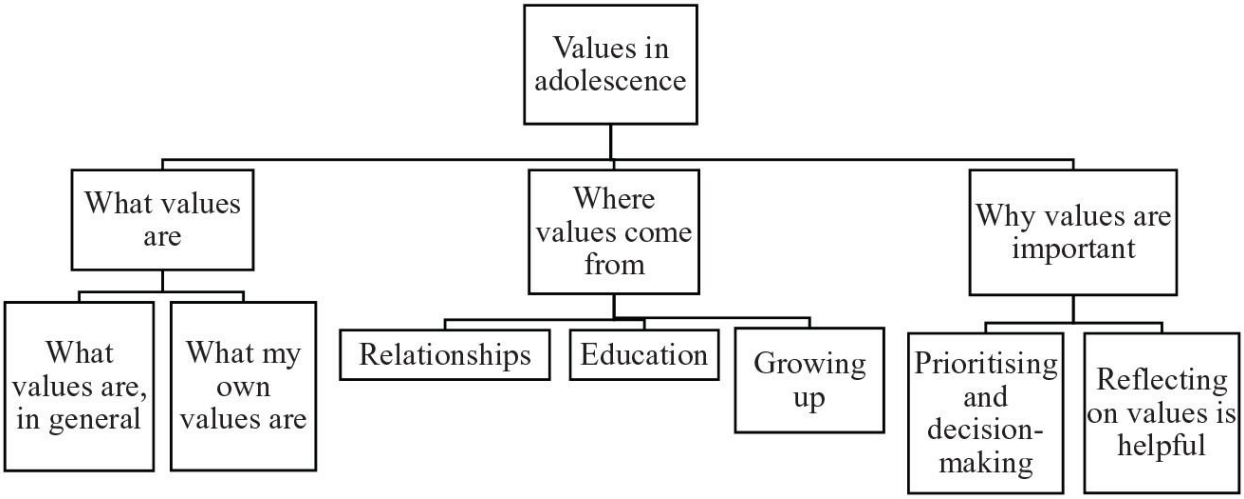

Figure 1. Thematic map showing the interview topic (level 1), themes (level 2) and subthemes (level 3).

Subtheme: 'What values are, in general'

All but one participant easily described what the term 'values' meant. Participants used a range of related concepts to explain what they understood values to be. These included "*morals*", "*what you believe in*", "a*spirations*" and "*traits*". Some participants also highlighted a link between values and the concept of the self, in other words, values *"make you, kind of, the person you are"*. Most participants were able to view values as an abstract concept, for example, Joshua explained *"[values are] less sort of physical things, more links you've made with people or various other aspects of life"*. The only participant who was unsure of what 'values' were, Zara, said she thought values were beliefs but she was not confident in this description. After asking the interviewer to explain their understanding of the term, she was reassured and continued to talk about them with ease.

Subtheme: 'What my own values are'

Most participants spoke about their own values as being *"good*" or *"right*" and participants spontaneously described their values. These frequently included: relationships and the quality of relationships (e.g. "*my family", "trust"*); education, learning and working hard

(e.g. *"I think important to me the most is probably my education"*); self-improvement and best self (e.g. *"be the best I can be"*); enjoyment and happiness (e.g. *"what's the most important is just to be happy"*); independence (e.g. *"I'd like to be able to just sort of go out in the world and sort of do my own thing"*); and responsibility (e.g. *"being responsible"*).

Theme 2 – 'Where values come from':

Young people talked fluently about how their values developed and what had influenced them.

Subtheme: 'Relationships'

All participants stated that their values had been influenced by their family. Some participants said that adult family members had taught them their values through praise, punishment or by modelling value-congruent behaviour. For example, Isabelle said:

"my aunty works for a charity which helps children who have disabilities, or have lost relatives, I think. And they kind of, that's what's kind of helped guide me into thinking I wanna help someone make a difference".

The majority of participants also mentioned the influence of peers on value development. Participants described the bi-directional association between friendships and values – some friendships were formed because of shared values and some values were formed through friendships. Highlighting the causal link between friendships and value similarity, Leo said "*if I had a different friend group, yeah, I think my value of working hard could definitely have changed, 100 percent".* On the other hand, Millie talked about how her friendship group were drawn to each other because of their shared values:

"I think that is kinda how friendship groups work, cos it's like another friendship group who like who are quite like bitchy, talk about each other and stuff, like we wouldn't

really do that and they would. But like that's why they're a group of friends and we're a group of friends. Like we might be friends with each other, but you do kind of gravitate towards the people that are gonna be similar to you".

Although most participants discussed how values developed through supportive peer relationships, Poppy described how being bullied by her peers had reinforced her value of 'kindness towards others':

"when I was younger maybe like being picked on a little bit probably makes you think like "I never want anyone else to go through what I went through"... just be like kind to everyone all the time so that no one ever has to like feel upset".

All participants recognised that, in addition to their own values being influenced by their relationships, other peoples' values were dependent upon "*how they were brought up*". Leo emphasised this point by saying "*our socialisation, I think, is key to everything*". The extent to which participants accepted others' individual differences, which they attributed to their different social environments, was varied. For example, Olivia reflected on how learning about her peers' different backgrounds had informed her own values by making her "*realise how like lucky [she is]*". However, she was also clear about her appreciation for peoples' different values and priorities:

"I value like people's personalities. And like I value other people's values almost. I like how everyone has different things that they're so like courageous about, and like I love how other people who are ambitious do different things, and how people find other things like so important that I sometimes don't".

By contrast, some participants described how other peoples' different values might cause them to behave in ways they considered *"just not important at all"* or *"really strange"* and that

they "*would try [their] best to influence them".* Despite this, most participants shared the sentiment that they would just have to accept peoples' differences, even if this was sometimes difficult. Leo summarised this by saying: *"I don't agree with what you say but I'll defend the right for you to say it"*. Participants therefore demonstrated that, alongside understanding how their own values developed, they critically evaluated where other peoples' values came from and understood how this influenced the way they related to them.

Subtheme: 'Education'

A few participants explained that they had been made aware of the concept of values at primary school, with Jessica reporting that "*in primary school we were really big on values*". Participants also said they talked about and developed their values in certain school classes, including English, Politics, and Personal, Social, Health and Economic Education. Olivia highlighted the significance of school in personal development by saying that by going to school each day she "*might find something out that like completely alters the way that [she] think[s]*". She reflected on how, when she was younger, she had *"less knowledge of the world"* but as she has learned more about the world, she has *"become interested in like the world [she] live[s] in"* and *"that's where a lot of [her] values have come from"*. Leo talked a lot about the effect of education on his values. He said that he valued *"working hard*" in order to *"achieve*" at school and that *"the results at the end"* of his hard work reinforced this value for him. Studying politics, in particular, seemed to have a big influence on Leo, as he explained it made him look at "*the bigger picture*" and thus lead to him to feel that *"[knowing] how the world works is a big value*. He reflected overall that "*I value school in a sense of its important in developing you as a person"*.

Subtheme: 'Growing up'

Some participants talked about their value development as aided or enabled by the development of other cognitive or psychological processes. For example, Erin referred to how developments in inhibitory control altered peoples' ability to behave in line with their values:

> *"if you wanted to be honest, except you really wanted that chocolate cake that you weren't allowed to have, then you'd take it and you'd lie. Whereas, now I wouldn't steal and then lie, I would rather just badger the other person for it until they said yes".*

Three participants – Poppy, Zara and Millie – talked about how they thought their ability to realise and enact their values was enabled by increasing independence in thought and action as they got older. Poppy described how she had come to value standing up for what she believes in:

> "*when I was younger… I would never like really stand up… and like never really say anything if something was going on that I didn't agree with and then I started thinking like "no, why am I doing that? Like it's something that I believe in, if like something's happening that I don't want to be happening, then I should say something"… I think that's like really important".*

Millie echoed this idea when she described how, as she matured, she learned to follow her own values, as opposed to following others:

> *"as you grew up, you're like "this isn't right for me, it might be alright for you, but that's ok, I'm not going to do it" kind of thing. And just like, yeah, definitely, I think just like maturing over the situations to be honest".*

Other participants talked about learning to be less "*selfish*" with age, as well as accruing knowledge from applying their values, learning from mistakes and seeing that "*values will*

change slightly after". Isabelle noted how becoming more conscious of the consequences of her behaviour with age made her aware of her values:

> *"when I was little, I just did things that I enjoyed. I never really took much notice. I kinda just did it but now I kind of realise that I do those things for a reason and I kind of think that other people do certain things for a reason".*

Overall, participants acknowledged the importance of general developmental processes associated with growing up on the development, awareness and implementation of their values.

Theme 3 – 'Why values are important':

Young people in this study had clear views about the importance of values to them personally and in general. Their views highlighted two distinct functions for their values.

Subtheme: 'Prioritising and decision-making'

All participants talked about their values as being an important factor in making decisions and prioritising. Through knowing their values, participants said that they were able to decide what actions or outcomes were most important to them, both in the short-term and long-term. For example, Joshua was very clear about valuing his friendships above everything else, therefore he saw the importance of working hard to do well in his exams so he could go to university, as this would allow him to stay in close contact with his friends:

> "*I don't want to end up redoing, um, my sixth form, because if I end up with bad grades at the end of it and have to redo it, but all my friends end up going off to uni, then it's gonna be weaker connections with them, and maybe break quite a few of them".*

Sophie also indicated that she was doing a "*lot of work towards*" her future exams so she could "*get to where [she] want[s] to be*" and that this was to train as an occupational therapist because she valued "*helping people*".

Most participants mentioned the need to find a "*balance"* between priorities and to decide the "*right value*" to enact in a given situation. They also talked about situations where prioritising goals based on their values had been difficult and less rewarding in the short-term than simply emulating the behaviour of others, following their impulse, or satisfying their immediate desires. For example, Millie really valued learning and working hard, however, she talked about how it was sometimes difficult to follow these values:

> "*I should be revising but I wanna sit and watch TV. Like you know, you have to be, take responsibility for your education and stuff but you're like "nah, I can't really be bothered" kind of thing".*

Despite acknowledging times when behaving in line with values could be difficult, a few participants also highlighted that their values provided hope and motivation, as opportunities for behavioural expression of their values allowed them to access a sense of fulfilment. Isabelle summarised this idea by saying:

> *"I would say that [values], kind of, like kind of gets you up in the morning, in a way. So, cos I kind of think it's quite nice that you wake up and then you finish the day realising that you kind of helped someone, or you made someone feel confident or you expressed an emotion, or helped them express emotion as well. I kind of think that's a good thing".*

Zara - the only participant to express any uncertainty about what her values were - said that her uncertainty about what was most important to her made decision making difficult and reduced her motivation to invest effort in her schoolwork. She said:

"*I think I need to do well [in my exams], but it's just finding the motivation to actually revise, and to actually like do something about it. Like I think because my heads like quite up, like it's all quite confused*".

By highlighting the difficulties she experienced making decisions without clear values to guide her, Zara's account further highlights how important values were in helping guide and motivate the young peoples' behaviours.

Despite reflecting during the interviews on the role of values in directing their actions, all participants said that integrating their values in day-to-day decision-making was something they did automatically. Millie summarised this idea by saying, in relation to living according to her values, that:

"it is my decisions, like what is right and wrong and I've lived with that for, you know, like 17 years and it's what I do without necessarily thinking about it".

Subtheme: 'Reflecting on values is helpful'

Despite indicating that thinking about and behaving according to their values was an automatic process, at the end of the interview most participants also commented that having had the opportunity to consciously think and talk about their values had been a positive, helpful experience. For example, Millie said that talking about values could aid self-awareness and growth and, consequently, it should be encouraged:

"it is good to talk about it, because I feel like you get much more of an awareness about actually where you've come from and the journey that you've taken and, actually, like reflecting on yourself. So like you know, if you did find something, like you could think "oh, I need to change that" kind of thing. Like I think it is good, like I think it should be encouraged, kind of, more than it is".

Other participants said that, although values were something they'd *"never really talked about before"*, being "*open*" and "*honest*" about them during the interview felt *"good"*, *"nice*" and Jessica said she "*quite enjoyed it*". Over half of the participants also conveyed that values were *"personal"* and therefore would not be something they would discuss with everyone but would be happy to talk about with some people "*depending on what the reasoning behind talking"* about them was. For example, Charlotte said she'd be comfortable talking about her values with "*family and… my closest friend",* a sentiment which Jessica echoed when she said of discussing her values: *"most friends I would be fine talking to".*

Discussion

This is the first study to explore how adolescents think, feel and talk about their values. This was achieved through thematic analysis of semi-structured interviews with young people at their school. The results demonstrate that almost all participants were readily able to access and communicate their values and that they saw their values as playing an instrumental role in their lives.

Abstract thinking and the self-concept further develop during adolescence (Dumontheil, 2014; Sebastian, Burnett, & Blakemore, 2008), thus it might be expected that adolescents would struggle to think and talk about values. However, all participants in this study (those 12-13 and 16-17 years old) could reflect on and communicate the content, meaning and purpose of their values. This suggests using the concept of values to support psychological therapies with young people is very likely to be achievable.

The young people had a strong sense of where their values came from and identified the main sources of influence as their relationships with family and friends. Participants described bidirectional associations between their values and friendships, whereby shared values drew

them to build friendships, and their friendships influenced and reinforced their values. Giordano (2003) suggests that adolescents are attracted to others they perceive as similar to themselves and are more open to influence from those they want to befriend. The role of family influence was also acknowledged; despite the pervasive myth that young people reject the influence of parental relationships during adolescence, parents continue to play an instrumental role in providing support and guidance throughout adolescence (Smetana, Campione-Barr, & Metzger, 2006). Overall, participants' perceptions of the origins of their values are consistent with findings from other research, which indicate that children often attribute some of their values to their parents (Whitbeck & Gecas, 1988) and that peoples' values tend to be similar to those of their friends (Lea & Duck, 1982).

In addition to discussing the role of relationships in value development, the participants discussed maturing and the role of formal education. Nurturing the development of values is a part of school curricula in the UK and other countries (Lovat, 2011) and teachers consider the instruction and modelling of values to be an important aspect of their role (Thornberg, 2013). It is encouraging that, for the participants in this study, these efforts made an impact and it suggests that professionals working with adolescents can and do make a positive contribution to the development of young peoples' values.

The significance of values in prioritising and decision-making was discussed. Participants saw their values as important in motivating behaviour and helping them to prioritise and make decisions. Studies have shown there are significant associations between values and reported behaviour (Bardi & Schwartz, 2003), and that priming self-transcendence values (such as benevolence) can increase prosocial behaviour (Arieli, Grant, & Sagiv, 2014). It is significant that the participants in this study perceived an association between their values and behaviour,

since this supports the theoretical propositions of BATD and ACT that values, motivation and behaviour can be causally and consciously linked.

Although the adolescents in this study indicated they did not often talk about their values, they also reported that discussing their values in the interview was a positive or worthwhile experience. This suggests adolescents may appreciate opportunities to articulate and develop their understanding of their values with people and in settings they feel comfortable with, which could include therapy.

While the purpose of this qualitative study was not to generalise to all adolescents, nevertheless it is a limitation that all participants were White British and the majority of were female, sixth form pupils from the same school. While the process of value content and structure development during adolescence does not substantially differ according to gender or ethnicity (Daniel & Benish-Weisman, 2019), adolescents' experiences of value development may be associated with demographic factors. Furthermore, while some participants reported moderate levels of depression symptoms, therapists may find that adolescents experiencing Major Depressive Disorder or other mental health disorders might struggle with the cognitive demands of exploring their values in depth. The authors considered and reflected on their pre-existing ideas about adolescent values throughout the study, however it is acknowledged that the authors' subjective perspectives will have necessarily influenced the research process. Further research is needed to address the potential cultural, ethnic, gender or age differences in adolescents' experiences of values, as well as the impact of mental disorder on adolescents' ability to access and articulate their values.

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Chapter 4: Paper 3

Publication status: published in Psychotherapy Research. Received 15 Oct 2020, Accepted 25 Feb 2021, Published online: 12 Mar 2021.

"…it shows that if I care about stuff, then other people care about me.": Adolescents' experiences of helpful and unhelpful aspects of Brief Behavioural Activation therapy (Brief BA) for depression.

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Abstract:

Brief Behavioural Activation (Brief BA) is a time limited psychological therapy for the treatment of depression symptoms in adolescents (Pass & Reynolds, 2020). Research on clients' experiences of the helpful and unhelpful aspects of psychological therapies is important for developing an understanding of the therapeutic process, and for helping to improve interventions and therapists' skills. The aim of this study was to explore 12-19 year old's experiences of the helpful and unhelpful aspects of Brief BA through thematic analysis of one-to-one interviews

with nine adolescents who had completed Brief BA at school. Three main themes relating to the helpful aspects were identified: ‘self-discovery’; ‘given the tools to cope and make progress’; ‘having someone to talk to’. One main theme relating to the unhelpful aspects of Brief BA, ‘discontinuation and maintenance’, was also identified. Findings indicated that the participants found behavioural activation strategies, identifying values and valued activities, and therapist support to be helpful. The duration of therapy and difficulties in maintaining improvements were identified as unhelpful aspects. Future research is needed to investigate the impact of the timing of the end of therapy and how improvements can be more easily maintained after the end of Brief BA.

Keywords: Brief Behavioural Activation (Brief BA), Adolescents, Qualitative, Values, Helpful and unhelpful aspects.

Acknowledgements:

Thank you to the young people who participated in this research and to the schools that were involved in the study. The authors are grateful for support of the Charlie Waller Memorial Trust and the Titcomb Foundation Charitable Trust, who funded the doctoral studentship of IL-S that made this research possible.

Clinical or methodological significance of this article:

This paper is the first to explore young peoples’ experiences of the helpful and unhelpful aspects of Brief Behavioural Activation therapy at school and their views on the unique aspects of this approach, i.e. identifying values and valued activities.

Abstract

Brief Behavioural Activation (Brief BA) is a time limited psychological therapy for the treatment of depression symptoms in adolescents (Pass & Reynolds, 2020). Research on clients' experiences of the helpful and unhelpful aspects of psychological therapies is important for developing an understanding of the therapeutic process, and for helping to improve interventions and therapists' skills. The aim of this study was to explore 12-19 year old's experiences of the helpful and unhelpful aspects of Brief BA through thematic analysis of one-to-one interviews with nine adolescents who had completed Brief BA at school. Three main themes relating to the helpful aspects were identified: 'self-discovery'; 'given the tools to cope and make progress'; 'having someone to talk to'. One main theme relating to the unhelpful aspects of Brief BA, 'discontinuation and maintenance', was also identified. Findings indicated that the participants found behavioural activation strategies, identifying values and valued activities, and therapist support to be helpful. The duration of therapy and difficulties in maintaining improvements were identified as unhelpful aspects. Future research is needed to investigate the impact of the timing of the end of therapy and how improvements can be more easily maintained after the end of Brief BA.

Introduction

Adolescent depression is a serious health condition experienced by 4 to 7% of adolescents each year (Costello et al., 2002). Offering acceptable and effective treatments is important for reducing the risks associated with adolescent depression, such as poor educational attainment (Wickersham et al., 2021), substance misuse (Fergusson & Woodward, 2002), self-injury (Barrocas, Giletta, Hankin, Prinstein, & Abela, 2015) and suicide (Nrugham, Larsson, & Sund, 2008). A crucial element in assessing the effectiveness of psychological therapies for adolescent depression is to explore young people's lived experience of them. Identifying young

people's experiences of the helpful and hindering aspects of psychological therapies can help develop an understanding of the processes of change they experience during and after therapy (Elliott, 2008). Moreover, gaining insight about young people's experiences of the therapeutic process can help shape and refine interventions and therapists' skills (Elliott & James, 1989).

A meta-synthesis of the qualitative literature relating to adults' experiences of helpful events and positive impacts associated with psychological therapies identified nine prevailing themes (Timulak, 2007): awareness, insight and self-understanding; behavioural change and problem solution; empowerment; relief and experiential relaxation; exploring feelings and emotional experiencing; feeling understood; client involvement; reassurance, support and safety; and personal contact. In studies of adolescent experiences of manualised treatments for depression, similar themes reflecting the helpful aspects of therapy have been illustrated, especially the importance of the therapeutic relationship (Dhanak et al., 2020; Donnellan, Murray, & Harrison, 2013; Wilmots, Midgley, Thackeray, Reynolds, & Loades, 2020). While the majority of research has focused on the helpful aspects of therapy and/or the experience of clients who demonstrate clinically significant change following therapy (Timulak & Keogh, 2017), a qualitative meta-synthesis by Levitt, Pomerville, and Surace (2016) identified several common experiences across a range of psychotherapeutic approaches that adults may not find to be helpful. These included: fearing sadness and vulnerability, which could lead to disengagement; therapist over-involvement, which could limit clients' sense of agency; feeling unheard, misunderstood or unappreciated, which may challenge the therapeutic relationship; and the professional status of the therapist, which could foster a sense of power imbalance and thus undermine the therapeutic relationship, make therapy seem inaccessible, or enable dependence.

While research has highlighted adults' experiences of psychological therapies, little is currently known about adolescents' experiences of unhelpful aspects of psychological therapies. Furthermore, the existing research has mainly focused on young people who have reported symptomatic improvements following therapy (e.g. McArthur, Cooper, & Berdondini, 2016). Investigating young people's experiences of both the helpful and unhelpful aspects of psychological therapy could help inform the development of strategies to increase young people's engagement across interventions, as youth dropout rates across psychological therapies can often be high (O'Keeffe et al., 2018). In addition, exploring adolescents' experiences of therapy may help highlight the elements of therapy responsible for change: both those factors which are common across psychological therapies and those which may be specific to one approach. It is important to listen to the views and opinions of young people when developing and evaluating psychological therapies for this population but their 'voice' has been largely excluded in previous research (Duncan, Sparks, Miller, Bohanske, & Claud, 2006; Trawick, Aber, Allen, & Fitts, 2019). Therefore, the key aim of this study was to explore young people's experiences of the helpful and unhelpful factors of Brief Behavioural Activation therapy in relation to how these facilitated or hindered change.

Behavioural activation describes a set of therapeutic techniques which place importance on the role of reinforcement (in other words, environmental consequences) in the development and maintenance of behaviour (Kanter, Bush, & Rusch, 2009). Behavioural activation forms a substantial component of cognitive behavioural therapy (CBT), which evidence shows is effective in the treatment of depression and other mental health difficulties (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012). However, research has also highlighted the effectiveness of behavioural activation as a standalone treatment for depression, both for adults (Richards et al.,

2016) and adolescents (Tindall et al., 2017). It has been suggested that one of the advantages of behavioural activation in comparison to CBT is that it is potentially simpler, easier and cheaper to train therapists in its delivery (Veale, 2008). Therefore behavioural activation may offer a simple and effective alternative to other psychological therapies, such as CBT, in the treatment of adolescent depression.

Brief Behavioural Activation (Brief BA) is a manualised treatment for depression symptoms in adolescents (Pass & Reynolds, 2020) and is an adaptation of Brief Behavioral Activation for the Treatment of Depression ([BATD]; Lejuez, Hopko, Acierno, Daughters, & Pagoto, 2011; Lejuez, Hopko, & Hopko, 2001; Pass, Brisco, & Reynolds, 2015). BATD is based on the theory that depression arises when a) positive reinforcement of non-depressed behaviours is reduced and these behaviours therefore decrease in frequency, and/or when b) positive reinforcement for depressed behaviours increases and therefore depressed behaviours increase in frequency (Lejuez et al., 2001; McDowell, 1982). Consequently, BATD aims to increase positive reinforcement of non-depressed behaviour and thus increase the frequency of non-depressed behaviours, and decrease the frequency of depressed behaviour.

Brief BA includes the key components of BATD, i.e. activity monitoring and scheduling, consideration of values and important life areas, increasing valued behaviours, and contracting support from others. Other components of Brief BA, which are not found in BATD, are: psycho-education about adolescent depression in the context of adolescent development, a greater focus on collaboration and engagement of the young person in therapy, adolescent case examples, a manual for young people, involvement of parents/carers in treatment (including a treatment manual for parents), and the addition of problem solving as a therapeutic technique (Pass & Reynolds, 2020; Pass et al., 2015). Brief BA is delivered across 6-8 sessions (BATD is typically

delivered over 5-10 sessions; Lejuez et al., 2011), followed by a review session one month after the end of treatment (for full treatment manual see Pass & Reynolds, 2020). Brief BA has been piloted in both Child and Adolescent Mental Health Services (CAMHS) and schools, with outcome measures among a small adolescent sample in CAMHS indicating a large pre-post treatment effect size and treatment adherence in schools (over 90% completed treatment) indicating the acceptability of Brief BA in this setting (Pass, Lejuez, & Reynolds, 2018; Pass, Sancho, Brett, Jones, & Reynolds, 2018). However, young people's experiences of the helpful and unhelpful elements of Brief BA have yet to be studied.

One of the elements which makes Brief BA and BATD distinct from other behavioural activation approaches is the explicit and substantial focus on identifying values and increasing valued behaviours. The purpose of identifying idiosyncratic values and valued activities in Brief BA and BATD is to find activities that are most likely to offer consistent positive reinforcement of non-depressed behaviour, and to maximise the likelihood of engagement in helpful activities (Lejuez et al., 2011; Pass & Reynolds, 2020). Identifying and using individuals' values is also a key component of other psychological therapies used to treat adolescents, such as Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 2012), and recent qualitative research suggests that adolescents see values as instrumentally important in their own lives and the lives of others (Lewis-Smith, Pass, & Reynolds, 2020). In Brief BA, consideration of a young person's values is also deemed important for engagement and the therapeutic relationship. There is explicit recognition that adolescents do not always have autonomy over their activities, but by identifying what is important to them they can spend a greater proportion of their time doing things that personally matter. To date, no research has explored adolescents' views about identifying their values and increasing valued behaviour as part of behavioural psychotherapy,

thus this study will offer the first exploration of young people's lived experiences of these activities.

Schools are increasingly positioned as an important setting for universal and targeted mental health care. For example, in 2017 the Department of Health and Department of Education in England published their plans to provide mental health treatments in education settings (Department of Health and Department for Education, 2017). However, little is known about school students' experiences of and opinions on school-based mental health treatments. While the delivery of Brief BA in schools is feasible and acceptable to students, parents and teachers (Pass, Sancho, Brett, Jones, & Reynolds, 2018; Brett, Reynolds, Totman, & Pass, 2020), this study will be the first to investigate students' specific views on school as a setting for Brief BA.

Method

Study design

This study used semi-structured interviews to facilitate in-depth exploration of participants' individual experiences of Brief BA delivered in their school. Semantic thematic analysis methodology (Braun & Clarke, 2006) was used to analyse the interviews. This study was undertaken from the position of critical realism, thus the authors assumed that participants 'true' experiences were accessible, while still recognising the influence of the research context. Throughout the research process, the authors reflected on sources of bias and the potential influence of their own experiences (including working with adolescents in prior research and mental health services) and assumptions. A predominately linear-sequential approach to analysis was used (Kennedy & Thornburg, 2018) since interviews were conducted before formal data analysis began; however, field notes from previous interviews were considered when conducting each subsequent interview.

Participants and recruitment

Ethical approval for the study was obtained from the University Research Ethics Committee. Thirty-nine adolescents (aged 12-19) from four co-educational secondary schools in the south of England who had received Brief BA therapy at school were invited to take part in this study. Inclusion criteria for students' participation in Brief BA therapy were 1) the presence of elevated symptoms of depression as indicated by self-report (RCADS depression subscale or Short Mood and Feelings Questionnaire) or diagnostic interview (Kiddie-Schedule for Affective Disorders Schedule) and 2) help-seeking (identified by school staff or self-report) and 3) young person and parental consent and contact details for parents. Exclusion criteria were 1) currently receiving psychological or psychiatric treatment and/or 2) diagnosis of autism spectrum disorder, attention deficit hyperactivity disorder, eating disorder, oppositional defiant disorder/conduct disorder, psychotic symptoms or learning difficulties (young people were referred to services where targeted treatments for these difficulties were provided). Brief BA was delivered in the same format in each of the schools, by a team of Psychological Wellbeing Practitioners and Child Wellbeing Practitioners supervised by a clinical psychologist (the second author).

The only inclusion criterion for participation in this embedded qualitative study was completing at least one session of Brief BA. Significant effort was made to recruit as many young people to participate as possible, as well as to include participants with diverse outcomes and experiences of Brief BA. Thirty-nine adolescents were given information about the study and invited to take part via phone, email, post and/or by their therapist. Of these 39 young people, three had dropped out of therapy, three did not attend their review session and 33 completed all Brief BA sessions. Ten young people agreed to take part in an interview, however, during the interview one participant was reluctant and/or unable to answer many of the questions

and so their responses were not included in the thematic analysis. The final sample included nine adolescents, whose demographics, therapists, and pre- and post-Brief BA Revised Children's Anxiety and Depression Scale depression *T* scores are shown in Table 1. All the young people interviewed completed 8 sessions of Brief BA and attended a follow-up review session. Most participants (8/9) were female, 14-15 years old (5/9) and White British (5/9). These demographics are representative of the wider sample who completed Brief BA. The majority of participants reported a reduction in depression symptoms following Brief BA (7/9), however, one participant reported an increase in depression symptoms, and one reported no change. Participant and therapist pseudonyms have been used to protect confidentiality.

Measures

Interview schedule

This study used an adapted version of the Client Change Interview for Young People (Lynass, Pykhtina, & Cooper, 2012), which was developed to investigate clients' understandings of change, as well as the reasons for and barriers to change following psychological therapy. Additional questions related to the unique aspects of Brief BA, e.g. young people's experiences of the focus on identifying values and increasing valued behaviours, and their experiences of therapy taking place at school. The interview schedule is presented in Table 2. The schedule was used flexibly, allowing the direction and focus of the interviews to be established collaboratively with the participants.

Table 1: Participants' demographics, therapists, and pre- and post-Brief BA symptom scores.

Participant pseudonym	Age (years)	Gender	Ethnicity	Therapist pseudonym	Time (days) between end of Brief BA and interview	Pre-Brief BA RCADS depression *T* score	Post-Brief BA RCADS depression *T* score
Aisha	14	Female	African	Deborah	54	84	84
Ben	14	Male	White British	Deborah	35	80	50
Eleanor	15	Female	White British	Abigail	28	92	100
Lucy	15	Female	White British	Abigail	84	67	54
Naomi	19	Female	Afro-Caribbean	Manju	124	51	36
Samantha	14	Female	White British	Sarah	81	61	53
Shivani	14	Female	Mixed race: White and Asian	Manju	55	58	43
Rita	15	Female	Asian	Manju	34	73	59
Victoria	14	Female	White British	Abigail	92	61	55

Revised Child Anxiety and Depression Scale (RCADS; Chorpita, Yim, Moffitt, Umemoto, & Francis, 2000)

To assess the severity of their symptoms all participants completed the RCADS before therapy and at the end of therapy. The RCADS is a 47 item self-report measure of anxiety and depression symptoms in children and adolescents. Items on the RCADS are scored 0= 'Never', 1= 'Sometimes', 2= 'Often' and 3= 'Always' and generate sub-scale scores for generalised anxiety disorder, separation anxiety disorder, social anxiety, panic disorder, obsessive-compulsive disorder and major depressive disorder. Depression subscale *T* scores were used. Depression *T* scores are based on a gender and school grade normed distribution with a mean of 50 and can be generated from raw scores using *T* tables available at Child First (www.childfirst.ucla.edu).

Procedures

Interview procedure

An information sheet describing the aim of and procedure for the study was given to all participants and their parents. Written parental consent was gained for those participants under the age of 16 and those aged 16 or above provided their own written consent. Participants were interviewed between March and August 2019, within six months of their final session of Brief BA. The interviews took place at the university, on school premises at the end of the school day or at the participants' homes. On the day of the interview, the interviewer (the first author) verbally explained the study to the participants, offered them the opportunity to ask questions and explained the terms of confidentiality. All participants consented for their interview to be audio-recorded.

Table 2: Interview schedule (adapted from Lynass, Pykhtina, & Cooper (2012))

Question topics	Specific questions
General questions	How are you doing now in general?
	What was Brief BA like for you? How did it feel to do Brief BA?
Changes	What changes, if any, have you noticed in yourself since you did Brief BA? (behaviour, thoughts, feelings, events) Has anything changed for the better for you since you did Brief BA? Has anything changed for the worse for you since you did Brief BA? Is there anything that you wanted to change that hasn't since you did Brief BA? How important or significant to you personally do you think that these changes have been? How likely it would be for you to have had these changes without Brief BA?
Attributions	In general, what do you think has caused the various changes you described? In other words, what do you think might have brought them about (including things both outside of therapy and in therapy)? *Prompts (if needed): things about family, school, relationships, ways of thinking and feeling.* Are there things you think have helped or got in the way of making the changes you wanted to?
Helpful aspects	Can you sum up what has been helpful about doing Brief BA? Please give examples. (For example, general aspects, specific events.)
Problematic aspects	What kinds of things about Brief BA were unhelpful, negative or disappointing for you? (For example, general aspects, specific events.) Were there things in Brief BA which were difficult but still OK or perhaps helpful? What were they? Do you think anything was missing from Brief BA? (What would have made Brief BA more effective or helpful?)
Your values	Do you remember talking about your values in Brief BA? What kind of things did you discuss about your values? How did you find working with your values in Brief BA? Did you find working with your values helpful or unhelpful?

	What did you find helpful about working with your values during Brief BA? What did you find unhelpful about working with your values during Brief BA?
	Was it difficult or easy to think and talk about your values? What was difficult about thinking and talking about your values?
	How did you find doing activities related to your values? Was there anything helpful about doing activities related to your values? Was there anything unhelpful about doing activities related to your values?
	Can you remember the values you talked about during Brief BA?
	If so, are these still your values? Are any of these not a value for you now?
	Do you think you have realised any new values since you finished BA?
	Do you still do activities related to your values? If not, why not?
	If you do still do activities related to your values, what is helpful about this?
Therapy at school	How did you find having Brief BA take place at school?
	Were there any good things about having the sessions take place at school?
	Were there any bad things about having the sessions take place at school?
	How did you feel about the ways in which your parents were involved in Brief BA?
Suggestions	Do you have any suggestions for us, regarding the research or the Brief BA?
	Do you have anything else that you want to tell me? Is there anything that I should have asked in this interview that I have left out?

Data analysis procedure

Data analysis was undertaken following the six key phases of thematic analysis described by Braun and Clarke (2006). All interviews were transcribed verbatim. Two interviews were transcribed by a research assistant and then checked against the original recording for accuracy by the first author. All other interviews were transcribed and then checked by the first author. In accordance with Braun and Clarke's (2006) phase one, repeated re-reading was used to familiarise the first author with the interview content. Initial codes were generated via line-by-line inductive coding, first using printed copies of the anonymised transcripts and then using Nvivo 11 software. Following the two cycles of line-by-line coding, searching for themes involved iteratively grouping codes into categories based on patterns evident from the data. To minimise the potential bias associated with the first author's familiarity with Brief BA, coding was undertaken by the first and third author separately. Potential themes were explored through collaborative discussions between all authors, which helped foster in-depth consideration of alternative interpretations of the data before a consensus on the final themes was reach. The final theme labels were then selected collaboratively by all authors.

Reflexive statement

The first author had previous experience of conducting qualitative interviews with adolescents and using thematic analysis. The first author also had an understanding of adolescent depression from her experience conducting diagnostic assessments with school students and, while she had never delivered Brief BA, she had observed its delivery in schools. The first author had lived experience of mental illness in adolescence and depression in adulthood, however, she had not experienced depression or received therapy as an adolescent. The first, second and fourth authors had conducted previous qualitative research on adolescents' experiences of values. The

second and fourth authors were clinical psychologists and had extensive knowledge of adolescent development and depression, as well as using Brief BA in schools and in child and adolescent mental health services. The third author was an academic psychologist with experience of conducting qualitative research, but no prior knowledge about Brief BA. He was not involved in the other authors' research on adolescent values. Throughout the research process, all authors aimed to remain aware of and reflect on the effect of these prior understandings and experiences to minimise their influence on the interviews and their interpretations of them.

Results

Figure 1 provides an overview of the four main themes which encompass participants' experiences of the helpful and unhelpful aspects of Brief BA. These were: 'self-discovery'; 'given tools to cope and make progress'; 'having someone to talk to'; 'discontinuation and maintenance'. To describe the frequency with which experiences and views were shared between participants, the term 'few' refers to 1-2 participants, 'some' refers to 3-4 participants, 'many' refers to 5-7 participants and 'most' refers to 8-9 participants.

Theme 1 – 'Self-discovery' "...*you think you know yourself when you don't"* [Lucy]

A key, overarching theme in young people's descriptions of the helpful aspects of Brief BA was self-discovery, which was fostered through Brief BA stimulating self-reflection. This process of self-discovery encompassed participants' increased self-awareness, especially increased awareness of their emotions, values and behaviours.

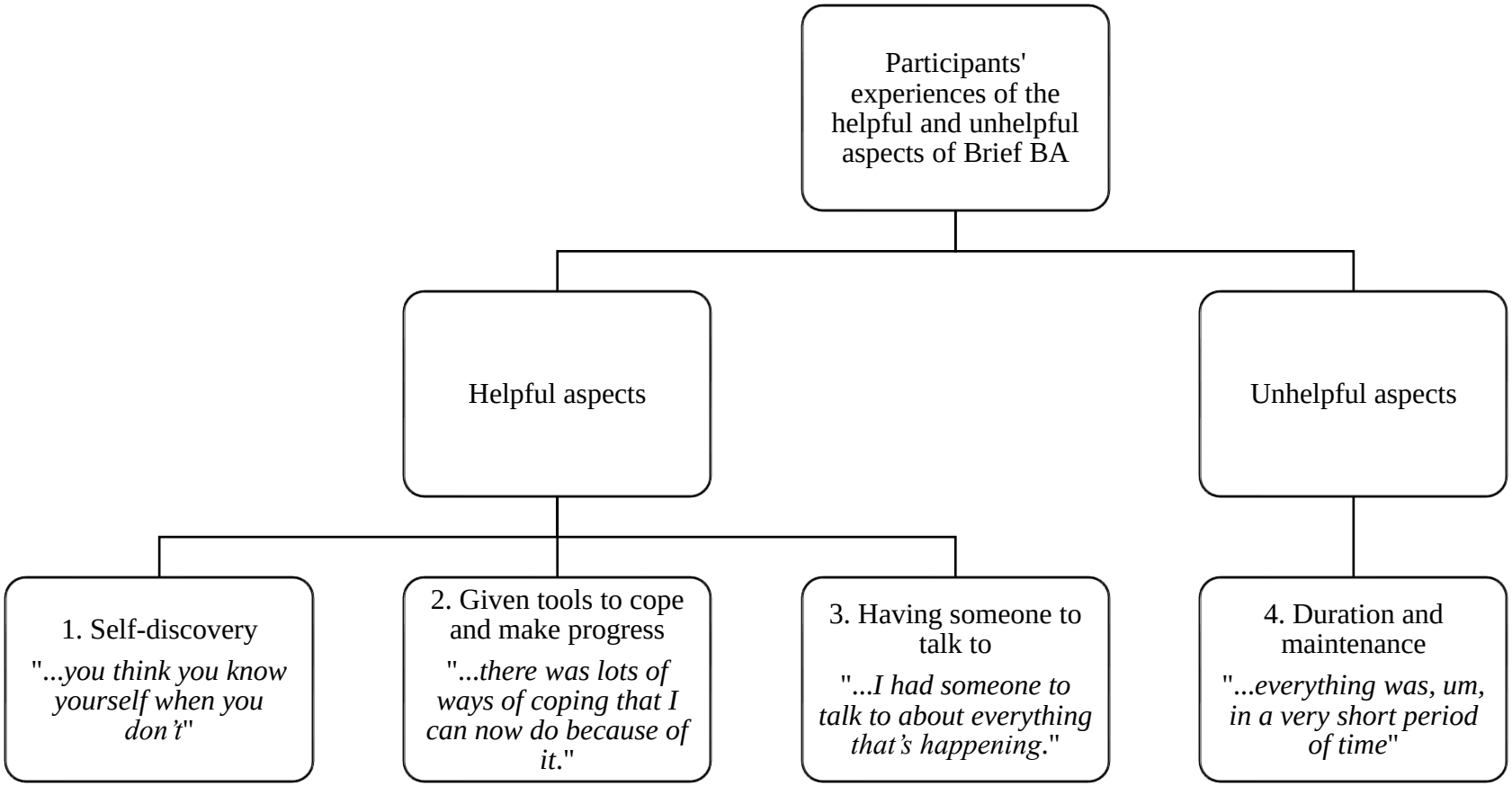

Figure 1: Overview of themes relating to participants' experiences of the helpful and unhelpful aspects of Brief BA

All participants indicated that Brief BA had initiated an increased awareness of their emotions. Samantha, Lucy and Naomi indicated that they had found it difficult to recognise, confront and manage their emotions before they started Brief BA. For example, Samantha said she tended to bottle up her feelings and Naomi said she was less open to her emotions. Lucy indicated that managing her emotions had been difficult because she didn't really know what she was feeling. However, completing daily mood diaries as part of Brief BA helped her become more aware of how low she had been feeling: "*I was doing the charts about how I was feeling every day, how low they were, and I thought, well I thought I was happy, but then I realised I wasn't.*" Through completing mood diaries, Lucy was also able to notice how her mood improved over the course of Brief BA. She explained that her mood "*went up slowly every time and then at the end [of Brief BA], it was, like, really high*". Eleanor described how, as well as increasing her awareness of her feelings, Brief BA aided her in developing her understanding of the causes or origins of her emotions. She said: "*... [Brief BA] helped me understand more of, like, maybe either why I feel certain, like, why I feel certain feelings, I guess.*"

When asked about their experiences of identifying their values and increasing valued activities, most participants talked about the process of 'discovering' their values. For instance, Samantha said she didn't have any idea what her values were before Brief BA, whereas Aisha, Naomi and Victoria said they had thought about their values before but not in a detailed way, as they did in Brief BA. Naomi expressed how novel and useful it was to reflect on and learn about her values:

"*It was actually really helpful. Um, because I don't think anyone really pointed out what was valuable to me. That actually sounds really sad [laughs]. How you don't really think about, well I didn't really think about that. I don't think many people do, actually*."

Lucy said that, before Brief BA, she hadn't realised that she valued anything. Through discovering her values, Lucy said that she was able to realise her own worth: *"…it shows that if I care about stuff, then other people care about me*."

Whilst talking about and identifying their values had been helpful, Samantha, Aisha, Lucy and Naomi expressed how thinking about and working with their values was initially difficult because doing so was unfamiliar. However, they also indicated that it became easier, as reflecting on their values went from being a conscious to an automatic process.

Many participants discussed how linking their values to their behaviours helped them to notice how they were spending their time and to consider to what extent this allocation of time reflected their priorities. Through reflecting on their behaviour in the context of their personal values, participants felt that they could behave more authentically. Victoria described how, by completing activity logs, she was made aware of how often her activities revolved around the same things, such as work or family. Thus, Victoria realised that the activities she found most valuable and helped with improving her mood were not what she was spending her time on. This awareness then allowed her to critically evaluate her actions: "*I just see like "oh, that doesn't actually, why, that isn't important to me so why am I, sort of, putting so much effort into it? When the end result isn't, like, that great*".

Some participants also described how Brief BA increased their awareness of their behaviour towards others. For example, Eleanor expressed how, since having been introduced to Brief BA, she was able to observe when her emotions were causing her to behave poorly towards others and then do something about it:

"*…if I get really angry I can now see it and I don't just carrying on? I can, like, I can see I'm being more angry and being more rude so I can be, like, 'ok, well now I need to, like, go somewhere else'. So I'm kinda more, like, self-aware of what, like, I'm actually doing?*"

Similarly, Aisha described how she had experienced difficulty getting along with her peers, but that Brief BA had helped her to recognise that she didn't need to hold grudges and could instead start just forgiving and forgetting. Overall, participants' experience of self-discovery helped foster their sense of autonomy and independence. Samantha summarised this point by saying: "*I just, like, understand my, like, me more than, like, I can just do things more independently than having to, like, ask other people to do things and, yeah*."

Theme 2 – 'Given tools to cope and make progress' "...there was lots of ways of coping that I can now do because of it." [Samantha]

Participants described Brief BA as having provided them with a broad range of coping tools and strategies to help manage their mood and increase their engagement in activities. A few of the coping tools participants described were not directly linked to the Brief BA content, for example, Samantha said she had learned new ways of coping with anxiety and panic attacks, such as through controlling her breathing. Ben described how, in collaboration with his therapist, he established a strategy for thinking more positively:

"…[the therapist] helped me set a reminder on my phone that said, uh, think of three positive things of the day and also fill out, um, activity log. And, um, the positive things, I think, like, mum would help me with that sometimes and think of the positive things of the day, which probably made me feel a bit more positive."

Nevertheless, the majority of coping tools participants discussed were related to methodically planning and/or writing down their valued behaviours/activities. For instance, Ben described how planning his time and activities help improve his mood:

"*I could also plan when I was gonna have, like, like, for example, do a piece of homework and then have fun time. So it was almost, so it, it was balanced and it wasn't all play, it wasn't all work, so I was happier*".

Shivani and Victoria also attributed improvements in their mood and functioning to learning behavioural activation techniques, such as setting goals and building a routine. Likewise, Lucy said that completing the activity logs helped motivate her to make meaningful behavioural changes:

"*I was more active, like when I had to do the activity logs, and I set the goals to like say, do a run in the morning – I didn't do the run, but like I pushed myself to like try and like be more active and like do stuff that really mattered to me but whereas like before, I didn't really like do that 'cause I didn't really bother 'cause it wasn't really written down for me to do.*"

In this way, Brief BA provided participants with tools they could use to motivate behaviour change, which helped improve their sense of self-efficacy and mood. For instance, Naomi said that learning to write down her valued activities made them seem more achievable to her. Similarly, Victoria said:

"…doing the, sort of, more valued things. Um [brief pause]. Like if I don't, um, oh, I don't know how to describe it, like if I can't do something, instead of just being like 'oh, I just won't do any of it' then, sort of, just thinking 'I can do that and I can do that'".

Theme 3 – 'Having someone to talk to' "*Being able to talk to someone and, like, getting the feelings out, and you know that no-one else will know."* [Rita]

All participants reflected on how having someone to talk to in Brief BA was helpful. Samantha and Naomi explained that being able to talk to a professional who they felt knew how to help them was important. Lucy and Eleanor said it was helpful to speak to someone they saw as non-judgmental, with Eleanor adding this meant that Brief BA felt like a safe space for her. Confidentiality was an important aspect of the therapeutic relationship for some participants, for instance Rita said she found it helpful to have someone checking how she was doing, whilst being assured that no-one else would know. There were, however, limits to confidentiality since clinicians shared risk information with key adults (e.g. parents/carers, school safeguarding leads) as needed. Participants demonstrated a range of responses to this sharing of risk information, for example Samantha indicated that she didn't mind this procedure because the therapist had clearly explained the terms of confidentiality so she was comfortable with it. However, Lucy indicated some reserve about information sharing but understood why it was necessary:

"*…it kind of got annoying 'cause like I wanted it to keep to myself but then like, I understood why 'cause it was to do with my safety and like I just learned over time that they [parents] need to know*".

Thus, while some participants found the sharing of risk information challenging at first, all participants who discussed the issue acknowledged that it was part of the therapists' role to help keep them safe.

Although participants expressed how important it was that they were able to talk to someone who they felt knew how to help, Naomi and Aisha also highlighted the importance of talking to and being heard by someone they felt cared about them. Aisha emphasised this point

by saying: "*…if I was telling her something that I felt was quite meaningful to me and was quite upsetting to me, you could tell that it meant something to her… I feel like that really does have an effect*".

Rita expressed how the safety of speaking to her therapist in Brief BA allowed her to subsequently open up to other people in her life. She said:

"My friends and, like, people at school… and my family, 'cause I wouldn't, like, talk to them much. Or, like, tell them if I, like, something's wrong, but now I do... Feeling like, 'cause talking in, like, doing BA and talking to someone and it was ok, talking to someone else would be ok as well."

Many participants reflected on how having Brief BA at school facilitated their opening up in therapy. Around half of participants talked about the advantages of the setting being familiar to them, which were principally that it felt comfortable and thus made it easier for them to talk. Lucy and Eleanor highlighted that since many of their difficulties were about or originated from school, having Brief BA take place within the same context made it easier for them to remember and talk about these issues.

Theme 4 – 'Discontinuation and maintenance' "*…everything was, um, in a very short period of time*" [Naomi]

One main theme emerged that was related to participants' experiences of the unhelpful aspects of Brief BA. This theme encompassed insufficiencies in the duration of Brief BA and the maintenance of progress post-treatment.

Naomi expressed gratitude that she got the help she felt she needed, but she also expressed how she thought that Brief BA was too short and felt a bit rushed. Similarly, Aisha said of the length of the Brief BA sessions:

"...you'll jump from talking about how your week was to, I dunno, like, self-harm or suicide, then to doing a leaflet and then pretty much saying 'ok, goodbye, I've got to go to another lesson now!'... 'cause we only had an hour to do it"

Victoria and Aisha also indicated that they felt the number of Brief BA sessions were too few to build the relationship they wanted with the therapist or see a greater improvement because, as Victoria said, "*that's gonna take, like, more than however many weeks to change*".

A few participants struggled to maintain the changes in symptoms and functioning they had experienced over the course of Brief BA after their eight sessions had come to an end. They expressed that this was a consequence of losing motivation. For example, Lucy indicated that she had felt low since Brief BA had come to an end and that she had returned to the way she was before therapy, for instance she had stopped engaging in most activities. When asked why she had stopped doing things, Lucy said "*'Cause I haven't really like said I was gonna do it, so I'm not*".

In this manner, Lucy expressed how, without the Brief BA sessions and therapist, she had lacked the accountability that had motivated her. Because of this, Lucy had stopped doing the activities which had helped to improve her mood and thus it was even harder for her to maintain motivation. She said:

"*So, like, even if I planned it I just wouldn't 'cause I wou- [pause] I wouldn't be bothered and, like, I wouldn't have any like motivation to do it 'cause I wouldn't [pause] I just like [pause] when I'm low, I give up on everything so I'd have no like energy to do anything*."

Shivani and Aisha reported that since they no longer had the Brief BA therapist to talk to, they struggled to share their difficulties with others, which was a coping strategy they had found helpful during therapy. Shivani said that talking to someone had been the most helpful aspect of

Brief BA for her, but since it ended she had not talked to anyone. Similarly, Aisha said that, since the end of Brief BA, she had kept things to herself.

Discussion

The aim of this qualitative study was to explore adolescents' experiences of the helpful and unhelpful aspects of Brief BA. Four main themes were identified from interviews with participants, three relating to the helpful aspects of Brief BA and one relating to the unhelpful aspects of Brief BA. The themes which encompassed the helpful aspects of Brief BA were 'self-discovery', 'given the tools to cope and make progress' and 'having someone to talk to'. The theme which encompassed the unhelpful aspects of the therapy was 'discontinuation and maintenance'. Participants also expressed positive experiences of the values component in Brief BA and having the therapy take place at school. The helpful aspects of Brief BA identified by the adolescents in this study closely reflect many of those found by Timulak (2007) in their meta-synthesis of adult experiences of psychological therapies, i.e., increase in awareness/insight/self-understanding, behavioural change/problem solving, feeling understood, reassurance/support/safety, and personal contact. In keeping with the latter three of these helpful elements, the adolescents in this study made reference to the importance of the therapists' competence, attention and care. Previous research on adolescents' experiences of therapy have likewise found that it is important to young people that they feel heard and understood by the therapist, and they have confidence in their competence (Dhanak et al., 2020; Donnellan et al., 2013; Wilmots et al., 2020). The therapeutic relationship is often proposed as a particularly important common therapeutic factor across psychological therapies, however, further research is required to establish the causal role of the therapeutic relationship in the process of therapy (Cuijpers, Reijnders, & Huibers, 2019).

participants described their self-discovery as encompassing increased awareness of their emotions, behaviour and values. In particular, participants discussed how the intervention helped them discover what their own values were, which some participants said they had never consciously considered before. Previous research has demonstrated that adolescents perceive their values to be important for prioritising and decision making, and that reflecting on their values may facilitate personal growth and self-awareness (Lewis-Smith et al., 2020). In accordance with these findings, and the findings of Stein et al. (2020) in their study of adult experiences of group BATD, the adolescents in this study described how Brief BA increased their awareness of their values, and how this was instrumental in helping them to reflect on (i.e. step back from) and evaluate their behaviour. This 'stepping back' helped participants see ways they could make positive, meaningful behavioural changes, and enabled them to do more that mattered to them.

Participants' reflections on the helpful aspects of Brief BA expressed in the themes of self-discovery and being given the tools to cope and make progress appear to be consistent with the proposed mechanisms of the therapy. For example, the purpose of completing activity logs in Brief BA is to increase adolescents' awareness of the links between their behaviour and mood, and the adolescents in this study reflected on how these helped increase their awareness of their feelings and motivated their behaviour. However, some participants also referred to positive outcomes, such as coping with anxiety, that are not specific targets of Brief BA. The cause of, or mechanism for, these changes is unclear, thus in light of participants' emphasis on the role of the therapeutic relationship, these findings may point to the importance of 'common' therapeutic factors as opposed to the 'specific ingredients' of Brief BA (Laska, Gurman, & Wampold, 2014).

Interestingly, although Brief BA involves some level of parental involvement for all young people, participants did not mention this except in relation to risk information sharing. It is possible that parental involvement may feel more important when they are directly attending therapy sessions, which happens for clinic-based but not school-based sessions.

With regard to adolescents' experiences of the unhelpful aspects of Brief BA, one main theme emerged that related to the brevity of treatment and problems with maintaining therapeutic strategies and changes after treatment had ended. Some participants indicated that they felt the duration of treatment was insufficient and some struggled to maintain the improvements they had made. In accordance with the experiences of participants in this study, in the Treatment for Adolescents with Depression Study, it was found that response to psychological therapy improved substantially from week 6 to week 18 of treatment (March et al., 2007). By contrast, in Improving Mood with Psychoanalytic And Cognitive Therapies Study (Goodyer et al., 2017), adolescents attended an average of 8 sessions of Cognitive Behavioural Therapy, despite being offered more. It is therefore possible that adolescents may benefit from a more flexible treatment end-point, for instance Løvgren, Røssberg, Nilsen, Engebretsen and Ulberg (2019) found that depressed adolescents who received psychodynamic therapy expressed how the flexible and extendable duration of therapy (which was initially 28 weeks) was helpful. Further research should aim to explore how adolescents' motivation to maintain behaviour changes can be sustained post-treatment.

Strengths and limitations

A key strength of this study was the flexibility afforded by the use of qualitative interviewing. The study used an established interview schedule – the Client Change Interview for Young People (Lynass et al., 2012) – which was amended to include questions specific to the

content and context of Brief BA. The interview schedule was used flexibly, allowing the direction of each interview to be determined in collaboration with the participant. In accordance with the TACT framework for ensuring rigour in qualitative research (Daniel, 2019) the trustworthiness and auditability of this study were fostered through the authors' consideration of their positionality and through a systematic data analysis process. The credibility of the findings were also enhanced by the inclusion of the third author, who had no prior knowledge of or experience with Brief BA, in data analysis.

However, transferability of the study is limited by the homogeneity of the participants: all but one of the participants were female and most were between the ages of 14-15 years. Including more boys and young people from a wider age range would have been helpful in describing and understanding a range of different adolescents' experiences. However the majority demographic of this study is likely to be representative of those young people most frequently treated for depression in routine mental health services (e.g. Goodyer, et al., 2017).

Participants in this study reported varied outcomes shown by the differing pattern of change on depression symptom scores. Despite some participants reporting little or no improvement on depression symptom scores, all participants described Brief BA as a positive experience and reflected on helpful strategies or skills they had gained from the intervention. However, it is possible that adolescents who did not find Brief BA to be helpful may have been less likely respond to the recruitment information. Therefore the sample may over-represent helpful aspects of therapy and positive experiences. To better understand the impact of Brief BA on adolescents with depression is it important to explore the experiences of adolescents who found Brief BA unhelpful or unacceptable and who did not experience a reduction in symptoms or an improvement in functioning.

Conclusions

The findings of this study demonstrate adolescents' positive experiences of exploring their values and using them to motivate behaviour change as part of Brief BA, and suggest the suitability of including adolescents' individual values in psychological therapy. The experiences of the adolescents in this study also indicate that students appreciated being able to talk about their emotional difficulties at school within a supportive and safe therapeutic space. Learning about themselves and how to cope with their difficulties was perceived by adolescents to be key for experiencing positive change as a result of Brief BA. However, some participants struggled to maintain improvements following the end of treatment and indicated that they thought the intervention was perhaps too brief. Future research should aim to investigate the impact of the timing of the end of therapy and how improvements can be more easily maintained.

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Chapter 5: General discussion

The aim of this thesis was to explore requesting and receiving treatment for adolescent depression in secondary school. This aim was addressed through research that comprised three papers, which together investigated: a) whether offering adolescent students the opportunity to ask for help with low mood/depression at school has the potential to substantially increase treatment access for depressed adolescents b) how adolescents' experience their values, to evaluate the practicability of exploring adolescents' values in psychological therapies; c) what adolescents found to be the helpful and unhelpful aspects of Brief Behavioural Activation therapy at school. The main findings from each paper are discussed below. This is followed by a

synthesis of the implications for identifying and treating depression in secondary school students, as well as the implications for future research.

5.1 Overview of findings from each paper

Paper 1

The key finding of paper 1 was that offering adolescent students an opportunity to ask for help with low mood or depression at school has the potential to substantially increase treatment access for depressed young people. Among students with high depressive symptoms, the proportion who asked for help was higher than the proportion who reported already receiving help, therefore indicating an unmet need for support among adolescent students. It was found that very few students with low depressive symptoms asked for help, however a substantial proportion of students with moderate or high depressive symptoms did not ask for help. This suggests that, while offering pupils the opportunity to ask for help with low mood or depression will not risk offering schools' limited support or interventions to those who are least in need, it may risk leaving a considerable number of depressed young people without support.

Paper 2

Paper 2 explored adolescents' experiences of values through thematic analysis of one-to-one interviews with eleven young people aged 12 to 17 years. The themes that arose from the interviews revealed that most of the participants had an understanding of values, both as an abstract concept and in reference to their own lives. Furthermore, the adolescents reflected on the origin of their personal values, including the role of relationships and education, and expressed the importance of their values in terms of prioritising and decision-making. Significantly, the majority of the interviewees also indicated that talking about and exploring their values during the interview was a positive, beneficial experience. The findings of paper 2 suggest the

developmental appropriateness and potential acceptability of offering adolescents opportunities to explore their values in supportive settings, such as in therapy.

Paper 3

Paper 3 described a qualitative study of adolescents' experiences of the helpful and unhelpful aspects of Brief Behavioural Activation for the treatment of adolescent depression at school. Thematic analysis of one-to-one, semi-structured interviews with nine young people aged 14-19 years identified four main themes: self-discovery; given tools to cope and make progress; having someone to talk to; discontinuation and maintenance. These themes highlighted the importance of increasing self-awareness, identifying values and valued activities, and the therapeutic relationship as helpful elements of Brief BA. However, young people also suggested that insufficient treatment duration and finding it difficult to maintain positive changes after the end of treatment were unhelpful aspects of the therapy. These findings demonstrate adolescents' positive experiences of Brief BA and supports the inclusion of adolescents' own values as a core component of therapy, while highlighting the need for further research on the impact of the timing of the end of Brief BA and maintaining progress post-therapy.

5.2 Synthesis of study findings and implications for school as a primary mental health care setting

The findings across this thesis provide insights relating to the identification and treatment of adolescents experiencing depression symptoms at school (see Table 1). The UK's National Institute for Health and Care Excellence asserts that adolescent depression should be detected, assessed and treated at a primary care level whenever possible (NICE, 2019), and the Department of Health and Department for Education aim to expand access to community-based mental health services through embedding support in educational settings (Department of Health

and Department for Education, 2017). In line with these aims, the research presented in this thesis suggests the suitability of school as a setting for the identification and treatment of adolescent depression. For instance, the high survey participation rates and willingness of students to ask for help in paper 1 suggests that many young people are willing to engage in depression symptom screening and many students will seek support for low mood or depression at school when given the opportunity to. The findings of paper 3 suggest that young people experiencing symptoms of depression are likely to appreciate the familiarity of school as a setting for psychological therapy and the results of paper 2 indicate that young people believe schools can play an important role in the development and discovery of their values.

Table 1: An overview of the implications of the papers presented in this thesis.

	Identifying depressed adolescents at school	Using adolescents' values to support their mental health	Offering Brief BA for depression at school
Paper 1	Offering students the opportunity to ask for help with depression has the potential to substantially increase young peoples' access to support.	-	There is an unmet need for support with low mood/depression among adolescent students.
Paper 2	-	Adolescents are likely to be aware of their values and perceive them to be an important motivating factor in their lives.	Adolescents may appreciate the opportunity to explore their individual values in a supportive environment.
Paper 3	-	Adolescents may perceive identifying values and valued activities as instrumentally helpful in improving their mental health.	Students report positive experiences of receiving Brief BA for depression at school and expressed how the school environment facilitated the therapeutic relationship.

With respect to the school-based identification of depression symptoms in adolescents, paper 1 supports the findings of existing research which has highlighted the prevalence of significant depressive symptoms among adolescents (Patalay & Gage, 2019). The findings of paper 1 also suggest there is an unmet need for support with low mood/depression among adolescent students, as only a modest proportion of those with high depressive symptoms reported already receiving help. Paper 1 provides evidence to suggest that by offering young people the opportunity to ask for help with low mood/depression at school, the identification and treatment of depressed students could be substantially increased. While existing research evidences the benefits of school-based mental health symptom screening (e.g. Eklund & Dowdy, 2014), a recent qualitative study has highlighted that young people themselves indicate that, in the context of symptom screening at school, they would like to have the opportunity to ask for help or share issues with their teachers (Demkowicz, et al., 2020). Moreover, asking adolescents whether they want help could facilitate the identification of students most likely to engage in treatment. Engaging adolescents in psychological therapy can be difficult; for example, some treatment trials have found a significant level of drop-out among adolescents (Goodyer, et al., 2017). Therefore asking adolescent whether they would like help for low mood or depression could help ensure that available treatments are offered first to those who are ready to engage.

While the findings of paper 1 demonstrate that many secondary school students are willing to ask for help with low mood/depression, the majority of those experiencing elevated symptoms of depression did not ask for help. Research suggests there are numerous and significant barriers to young people seeking help for mental health difficulties, such as limited mental health literacy, stigma associated with help-seeking and a preference for self-reliance (Radez, et al., 2020). Therefore the finding of paper 1 that many depressed adolescents did not

ask for help with low mood or depression is likely to indicated the influence of significant barriers to young people seeking help.

Regarding the implications of the research presented in this thesis for the treatment of adolescent depression at school, the finding of paper 3 that adolescents who participated in Brief BA were appreciative of the convenience of receiving treatment at school lends support to the acceptability of school as a primary mental health care setting. Previous research has similarly found that young people respond positively to receiving mental health interventions at school, for example, McKeague, Morant, Blackshaw, & Brown (2018) found that over one third of sixth form students who were interviewed about their participation in a school-based psycho-educational CBT workshop described school as a convenient, familiar or safe setting. Uptake and engagement of adolescents in school-based Brief BA has been shown to be high (Pass, Sancho, et al., 2018), thus school is likely to be an acceptable setting for psychological therapies.

Not only do the findings of paper 3 suggest the potential acceptability of school as a setting for psychological therapy, but the finding of paper 2 that young people perceive education as uniquely influencing the development of their values suggests that schools can and do play an important role in nurturing the holistic development and wellbeing of students. Existing research has discussed the importance of 'values education' in schools, which aims to influence young peoples' value development through the school curriculum and 'moral climate' (Likona, 1991). Veugelers (2000) proposed that nurturing young peoples' ability to critically analyse and communicate their values is essential for enabling young people to develop and choose their personal values. In accordance with this theory, the young people interviewed in paper 3 expressed how being given the opportunity to explore their values as part of Brief BA was helpful for developing their understanding of themselves and for helping them to change their

behaviour. Previous research had indicated that valued living (in other words, how closely an individuals' behaviour reflects their values) is associated with wellbeing (Ostermann, et al., 2017) and quality of life (Grau, McDonald, Clark, & Wetterneck, 2020), thus the findings of paper 2 suggest that schools might support students' wellbeing through scaffolding the development of their values. This indication that allowing all young people the opportunity to identify and reflect on their values might be developmentally beneficial is supported by previous research which has found that meaning-centred interventions (interventions which focus on fostering individuals' sense of purpose) are effective for 'healthy' adolescents as well as those with mental health problems (Lim & Kang, 2008).

With reference to adolescents' understanding of values as a concept, the young people interviewed in paper 2 used a variety of related constructs to explain what the term 'values' meant to them. Thus, the adolescents interviewed conceptualised values through their relation to these other constructs as opposed to any conceptual distinctiveness. The implication of this is that the use of the term 'values' in some psychological therapies, such as Brief BA, and the use of the term 'meaning' in others, e.g. Frankl's Logotherapy (Frankl, 1959), represents a difference in terminology and parsing that is likely functionally unimportant to adolescents. Nevertheless, future research might explore adolescents' understanding of concepts related to values, such as meaning or goals, in order to build a clearer picture of the importance and interpretation of these terms.

5.3 Implications for clinical practice

Several psychological therapies – including ACT (Hayes et al., 2012), BATD (Lejuez et al., 2011), Brief BA (Pass, et al., 2015), Narrative Therapy (Freedman & Combs, 1996), and Meaning Therapy (Wong, 2010) – are based on the theory that by exploring, identifying and

committing to value-congruent behaviour, individuals can overcome psychological distress and live more fulfilling lives. The findings of paper 3 suggest that using adolescents' individual values as part of behavioural activation therapy for depression is developmentally appropriate and likely to be perceived as instrumentally helpful by adolescent clients. The findings also support the theoretical position of Brief BA that increasing value-congruent behaviour may help increase non-depressed, personally meaningful behaviour and thus improve depression symptoms.

A further implication of the research presented in this thesis for clinical practice is the that orienting towards individuals' unique, positive inner experiences is potentially as important for personal growth and healing as focusing on 'problematic' aspects of an individuals' behaviour or internal experience. Psychological therapies are often designed to 'treat' behaviours, cognitions or emotional states that are perceived as undesirable or 'disordered'. However, as demonstrated in papers 2 and 3, offering young people the opportunity to explore and develop positive, constructive aspects of their 'self' increases self-awareness and thus promotes authentic, healthful behaviours and internal states. This therefore supports the premise that moving away from treating 'problems' and instead promoting self-sustaining states of being in psychological therapies might lead to equal, if not greater, outcomes.

An interesting finding of paper 3 was that some young people described learning strategies and experiencing changes not explicitly targeted in the Brief *Behavioural* Activation intervention, such as thinking more positively. This finding implies that the assumed or theorised mechanisms of change in a given psychological therapy may not always be entirely responsible for the changes experience by an individual. For example, having someone to talk to (a helpful aspect of Brief BA highlighted in paper 3) may have been responsible for the majority of positive

change experienced by an individual as a result of Brief BA, as opposed to participating in more valued activities, which is one of the principle theorised mechanisms of change associated with this therapy. The relative contributions of 'specific techniques' and 'common factors' in psychological therapies has been debated widely (e.g. Brown, 2015). The findings of this thesis provide further support for the role of 'common factors' in bringing about change during and/or following therapy. Furthermore, it is possible that participating in more valued activities would lead young people to feel more positive about themselves and the world around them, which may in turn lead to more positive thinking. In this way, theorised mechanisms of change in therapy could lead to cascades of positive changes across a wide variety of behaviours, cognitions, and emotional states that are not explicitly targeted by the content of the psychological therapy. The implications of this are that behavioural therapies may lead to positive cognitive and emotional changes without specifically targeting these. This is in accordance with the 'hot cross bun' model in cognitive-behavioural therapies (Greenberger & Padesky, 1995), where bidirectional relationships between cognitions, behaviours, physiological sensations and emotions are believed to explain and maintain mental health problems.

While the findings of this thesis point towards the advantages of Brief Behavioural Activation as a strategy for precipitating positive change in young people experiencing symptoms of depression, in paper 3 it was found that some participants experienced Brief BA as too short and some struggled to maintain positive changes after the end of therapy. This represents a challenge to the assertion that brief therapies can be as effective, and more cost-effective, than their 'full-length' counterparts (Nieuwsma et. al., 2013). It also raises the question as to whether quantitative analysis of treatment effectiveness obscures peoples' experience of its effect on their lives. In other words, perhaps brief therapies are more effect in

bringing about change according to quantitative outcome measures, but simultaneously not experienced or perceived as being as effective by individuals. Further mixed-methods research is needed to address this hypothesis and to investigate when and how 'brief' becomes too brief.

5.4 Limitations and suggestions for future research

There are some overarching limitations to the research presented in this thesis, and these limitations suggest areas and questions for future research. For example, a potential limitation of papers 1 and 3 in relation to the identification and treatment of adolescent depression is the focus on depression symptoms, as opposed to depression diagnosis. Given the prevalence of diagnosable depression among adolescents is substantially lower than the prevalence of elevated symptoms of depression (Costello et al., 2006; Patalay & Gage, 2019), it is likely that some of the young people who reported high depressive symptoms in Paper 1 were not clinically depressed. Similarly, as suggested by some participants' sub-clinical depression symptom scores, it is unlikely all participants in Paper 3 would have met threshold for clinical diagnosis. Nevertheless, subthreshold depression in adolescents is associated with reduced quality of life and increased risk of later development of major depressive disorder (Bertha & Balázs, 2013). Psychological treatments for subclinical depression in adolescents can reduce depression symptoms and may also reduce the incidence of major depression (Cuijpers, Smit, & Van Straten, 2007). Consequently, while further research is needed to examine the association between diagnosed depression in adolescence and asking for help with low mood/depression at school, the focus on depression symptoms in Paper 1 is still relevant to the identification of adolescents who may benefit from support with low mood or depression. Similarly, Brief BA is an intervention for young people with depression symptoms which cause significant impairment, and not exclusively for those with clinical depression (Pass & Reynolds, 2020). However, future

research might explore whether young peoples' experiences of Brief BA vary depending on whether they are experiencing clinical or subthreshold depression.

A potentially important line of enquiry that was not explored in this thesis was whether the survey in paper 1 increased young peoples' access to mental health services and whether offering young people Brief BA at school decreased the need for specialist mental health services. In view of the current demand for child and adolescent mental health services, the UK's National Health Service's long term plan for mental health aims to increase young peoples' access to mental health services through increasing support offered in schools and colleges (National Health Service, 2019). Students who reported moderate or high depressive symptoms and who asked for help with low mood or depression in paper 1 (in addition to meeting the inclusion criteria for Brief BA) were offered treatment. However, paper 1 did not investigate how many of these students accessed or engaged in Brief BA or whether those students who did not meet the Brief BA inclusion criteria accessed appropriate support. In order to understand whether offering young people support with their mental health at school really does increase access to early intervention, further research which investigates the flow of young people identified via symptom screening and/or asking for help through to treatment is needed. Similarly, in order to better understand whether offering school-based mental health interventions does decrease demand for specialist mental health services, future research should explore whether taking part in Brief BA therapy at school reduces the likelihood that young people will require support from other child and adolescent mental health services.

A shared limitation of papers 2 and 3 is the homogeneity of the participant samples. In paper 2, all participants were recruited from a pool of adolescents from one secondary school who had participated in the school survey reported in paper 1. In paper 3, all the young people

who took part in an interview had completed eight sessions of Brief BA, despite efforts to recruit participants who had completed fewer sessions or had dropped out. The aim of paper 2 was to explore adolescents' experiences of their values and paper 3 aimed to explore young peoples' experiences of the helpful and unhelpful aspects of Brief BA. Therefore more diverse participant samples would have enabled the analysis of a greater range of experiences and so provided more unique and nuanced perspectives on each topic. For example, it is likely that young people who had completed fewer than eight sessions of Brief BA or had dropped out of the therapy would have identified more or different unhelpful aspects than those who completed eight sessions of Brief BA. Likewise, those adolescents who were less aware of their values or believed them to be less important to their lives may have been less likely to agree to be interviewed about them. Consequently, future research should aim to explore whether some adolescents are less aware of their values or believe them to be less important, and future research should also explore the experiences of those young people who did not complete Brief BA.

5.5 Reflection on the interaction between the researcher and the research

As stated in the introduction to this thesis, the author (ILS) endeavoured to remain aware of and reflect on how her prior experiences, ideas and learning may have influenced the direction and outcome of her research. ILS may have had assumptions about the importance and utility of psychological therapy through her knowledge of psychological theory and through her positive and negative experiences of receiving psychological treatment for mental illness. Similarly, due to her experience of using ACT with young people, ILS may have been predisposed to assume the importance of personal values to adolescents. Together these assumptions and predispositions may have influenced her interpretation of the interviews she conducted in papers 2 and 3. Furthermore, ILS's awareness of the attitudes towards values expressed by the young people she

interviewed in paper 2 may have influenced her expectations (and therefore interpretation) of the attitudes towards values in Brief BA expressed by participants in paper 3. The inclusion of and collaboration between ILS and her co-authors on each paper was invaluable in helping ILS to consider and minimise the influence of her preconceptions throughout the research process.

5.6 Conclusions

This thesis aimed to explore the identification and treatment of adolescents experiencing symptoms of depression in the school setting. This aim was achieved through three empirical research studies. The first study explored adolescents asking for help with low mood/depression in the context of universal school-based screening. The second study explored adolescents' understanding and experience of values and the third study examined young peoples' experiences of the helpful and unhelpful aspects of Brief BA therapy for depression. The findings across this thesis provide insights relating to requesting and receiving treatment for adolescent depression at school. For example, there is evidence of an unmet need for depression treatment among adolescent students in England and that by offering students the opportunity to ask for help with depression we could substantially increase access to support. Furthermore, the research presented in this thesis indicates that adolescents are likely to be aware of and appreciate the importance of their personal values, and may welcome opportunities to explore their values in a supportive environment, such as in therapy. Moreover, adolescents may perceive identifying values and valued activities as instrumentally helpful in improving their mental health and students report positive experiences of using their individual values in Brief BA therapy. Young people who have taken part in Brief BA for depression also express how the school environment facilitated the therapeutic relationship, thus providing evidence for the suitability of school as a setting for psychological therapy.

There are a few factors that limit the implications of this thesis for the identification and treatment of adolescents experiencing depression symptoms at school. For example, the research presented in this thesis did not provide specific evidence of whether offering students the opportunity to ask for help with low mood/depression lead to an increase in the number of young people accessing or receiving treatment, or whether offering young people Brief BA at school decreased their need for specialist mental health services. Furthermore, a lack of diversity of experiences among the adolescents sampled in papers 2 and 3 limits the implications for a wider range of young people. As a result, the findings of this thesis highlight areas in which future research is needed. For example, investigating whether offering adolescent students an opportunity to ask for help and providing school-based treatment for depression symptoms increases young peoples' access to treatment and decreases the demand on specialist mental health services. Further research focusing on adolescents who may be less aware of their values or believe them to be less important, and those who did not complete Brief BA or who did not find it helpful, would help develop our understanding of how Brief BA therapy might meet the needs of more young people.

5.7 References

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Appendices

Appendix 1: for Paper 1

Appendix 1.1: Ethical approval

University of Reading

Coordinator for Quality Assurance in Research
Dr Mike Proven, BSc(Hons), PhD

Academic and Governance Services

Whiteknights House
Whiteknights, PO Box 217
Reading RG6 6AH

phone
fax
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Professor Shirley Reynolds
School of Psychology and Clinical Language Studies
University of Reading

10 February 2017

Dear Shirley

UREC 17/14: Theale Green School survey of emotional health.
Favourable opinion

Thank you for your application (email, dated 23 January 2017 and including attachments, from Laura Pass refers) for review of the above project which was considered by a UREC Sub-committee on Wednesday 1 February 2017. I can confirm that the Chair is pleased to confirm a favourable ethical opinion on the basis of the information that was reviewed by the sub-committee.

Separately (and not as a specific condition), we'd like to ask Shirley to consider the recent advice – from UREC and the University's Research Data Manager, and given via Heads of Schools – to include a statement in the Consent form that would facilitate the 'downstream' sharing of data. The advice was that the researcher should check that:

"The consent form asks the research participant for permission to preserve some or all of the data they provide over the long term, and to make the data available, in anonymised form if required, either openly or subject to appropriate safeguards, so that they can be consulted and re-used by others, in accordance with the University's Research Data Management Policy."

Please note that the Committee will monitor the progress of projects to which it has given favourable ethical opinion approximately one year after such agreement, and then on a regular basis until its completion.

Please also find attached Safety Note 59: Incident Reporting in Human Interventional Studies at the University of Reading, to be followed should there be an incident arising from the conduct of this research.

The University Board for Research and Innovation has also asked that recipients of favourable ethical opinions from UREC be reminded of the provisions of the University Code of Good Practice in Research. A copy is attached and further information may be obtained here: http://www.reading.ac.uk/internal/res/QualityAssuranceInResearch/reas-RSqar.aspx.

Yours sincerely

Dr M J Proven
Coordinator for Quality Assurance in Research (UREC Secretary)

cc: Dr John Wright (Chair); Professor Laurie Butler (Head of Department)

University of Reading

Coordinator for Quality Assurance in Research
Dr Mike Proven, BSc(Hons), PhD

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Professor Shirley Reynolds
School of Psychology and Clinical
Language Studies
University of Reading
RG6 6AL

12 September 2017

Dear Shirley

UREC 17/14: Theale Green School survey of emotional health. *Amendment favourable opinion with condition.*

Thank you for your application (email dated 25 August 2017 from Dr Laura Pass, and including attachments refers) requesting and detailing amendments to the above project (*amendments to the information documents to make them school specific; addition of two items to one of the self-report measures*). I can confirm that the UREC Chair has reviewed that request and is happy for the project to continue on the condition that the information documents specify the school name and name of the person the participant's details may be shared with.

Yours sincerely

Dr M J Proven
Coordinator for Quality Assurance in Research (UREC Secretary)
cc: Dr John Wright (Chair); Professor Laurie Butler (Head of School); Dr Laura Pass (Researcher);

Appendix 1.2: Participant and parent information sheets

School of Psychology and Clinical Language Sciences
University of Reading
Harry Pitt Building
Whiteknights Campus
Reading
RG6 6AL

Project Title: The 'How are you doing?' School survey

INFORMATION FOR 11-15 YEAR OLDS

Hello, we are inviting you to take part in a research project.

Why is this project being done?

We want to understand the emotional health of students at your school, so the right kind of support can be offered in the school.

Why have I been asked to take part?

You have been asked to take part because your school has agreed to be part of this project. We are inviting you because you are aged between 11 and 18 years old.

Do I have to take part?

No. Because you are under 16, your parent has been asked if they are happy for you to take part, and they will have had the choice to opt you out of the study. But even if your parents have agreed, you still do not have to take part- it is **completely up to you**.

Also, if you decide to take part and then change your mind, this won't matter at all. You won't have to give us a reason.

What will happen if I take part in the project?

We would like you to complete some brief questionnaires about your feelings, behaviour, and how you like to spend your time. They will take about 15 minutes. We will also ask if you want any help with a particular issue, and if so we will be in contact after the study to find out more.

Might anything about the research upset me?

Some of the questions ask about how you have been feeling recently, and sometimes this makes people feel good, or upset, depending on whether they can relate to the questions. This is very normal so if you need to take a break at any point or want to stop then that is completely fine. We can talk about this or you might want to talk to your friends or a teacher or parent about it.

Will my information be kept private if I take part? Will anyone else know I'm doing this?

Everything you tell us as part of this project is treated as confidential; this means that nobody other than us will ever know what you have told us. You will be assigned a research ID number so no one will know who has filled out the questionnaires. Your answers will be kept in locked cabinets and nothing will have your name on it. Once we have finished the project the questionnaires will be destroyed.

We would not be able to keep information confidential if you tell us something which makes us worried about you or someone else, puts someone else at risk or we are worried about your safety. If this were to happen we would pass on this information to a school staff member who can help you.

Also, if you tell us you would like help with a particular issue, we will pass this on to a relevant member of staff so they can get you the right support.

Did anyone else check the project is okay to do?

Before any research is allowed, it has to be checked by the University Ethics Committee. They make sure the research is safe and they are happy for the research to go ahead. Everyone working on this study has been through the formal Disclosure Barring Service (DBS) checks and has been approved by the School of Psychology, University of Reading to work with young people.

What if I have more questions?

If you have any questions about our study, either now or later, please feel free to email us or phone to speak to us. You have a right to know everything and we will be happy to tell you everything. Also please feel free to talk about this study with your friends, parents and/or teachers.

Thank you very much,

Dr Laura Pass (Researcher) email: L.S.Pass@reading.ac.uk Tel:

Prof Shirley Reynolds (Principal Investigator) email: S.A.Reynolds@reading.ac.uk Tel:

Website: www.andyresearchclinic.com

School of Psychology and Clinical Language Sciences
University of Reading
Harry Pitt Building
Whiteknights Campus
Reading
RG6 6AL

Project Title: The 'How are you doing?' school survey
INFORMATION FOR 16-18 YEAR OLDS

Hello, we are inviting you to take part in a research project.

Why is this project being done?

We want to understand the emotional health of students at your school, so the right kind of support can be offered in the school.

Why have I been asked to take part?

You have been asked to take part because your school has agreed to be part of this project. We are inviting you because you are aged between 11 and 18 years old. Because you are 16 or older you do not need parental consent, therefore the decision to take part is completely up to you.

Do I have to take part?

No. You do not have to take part unless you want to. Also, if you decide to take part and then change your mind, this won't matter at all: You can withdraw from the study and you won't have to give us a reason.

What will happen if I take part in the project?

We would like you to complete some brief questionnaires about your feelings, behaviour, and how you like to spend your time. They will take about 15 minutes. We will also ask if you want any help with a particular issue, and if so we will be in contact after the study to find out more.

Might anything about the research upset me?

Some of the questions ask about how you have been feeling recently, and sometimes this makes people feel good, or upset, depending on whether they can relate to the questions. This is very normal so if you need to take a break at any point or want to stop then that is completely fine. We can talk about this or you might want to talk to your friends or a teacher or parent about it.

Will my information be kept private if I take part? Will anyone else know I'm doing this?

Everything you tell us as part of this project is treated as confidential; this means that nobody other than us will ever know what you have told us. You will be assigned a research ID number so no one will know who has filled out the questionnaires. Your answers will be kept in locked cabinets and nothing will have your name on it. Once we have finished the project the questionnaires will be destroyed.

We would not be able to keep information confidential if you tell us something which makes us worried about you or someone else, puts someone else at risk or we are worried about your safety. If this were to happen we would pass on this information to a school staff member who can help you. Also, if you tell us you would like help with a particular issue, we will pass this on to a relevant member of staff so they can get you the right support.

Did anyone else check the project is okay to do?

Before any research is allowed, it has to be checked by the University Ethics Committee. They make sure the research is safe and they are happy for the research to go ahead. Everyone working on this study has been through the formal Disclosure Barring Service (DBS) checks and has been approved by the School of Psychology, University of Reading to work with young people.

What if I have more questions?

If you have any questions about our study, either now or later, please feel free to email us or phone to speak to us. You have a right to know everything and we will be happy to tell you everything. Also please feel free to talk about this study with your friends, parents and/or teachers.

Thank you very much,

Dr Laura Pass (Researcher): Email: L.S.Pass@reading.ac.uk Tel:

Professor Shirley Reynolds (Principal Investigator): Email: S.A.Reynolds@reading.ac.uk
Tel:

Website: www.andyresearchclinic.com

School of Psychology and Clinical Language Sciences
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RESEARCH INFORMATION FOR PARENTS
Project Title: The 'How are you doing?' School Survey

What is the purpose of the study?

We want to find out more about the emotional health of students at your child's school.

Why are we inviting your son/daughter to take part?

We work at the Anxiety and Depression in Young people (AnDY) research clinic at the University of Reading. We are working in partnership with your child's school to deliver high quality research at the school. The first step is a student emotional health check: that is what this survey is about. The survey will help us tailor practical support for students at school.

Your son/daughter has been invited to take part because their school has agreed to be part of this research project and their class is involved. They have not been individually selected.

Does my child have to take part?

No, the study is completely voluntary for students to take part.

11-15 year olds

This is an opt-out study. This means that if your child is under 16 and you **DO NOT** want them to take part, please sign and return the attached 'opt-out' form. If you do not return this form (or tell the school in another way) we will assume that you are happy for your child to take part in this research. Your child will also be asked if they are happy to take part and are free to opt out themselves. Either you or your child can withdraw your child from the study at any time without giving a reason.

16 years and above

If your child is aged 16 or over they do not need parental consent. They will be asked if they are happy to take part and they are free to opt-out themselves. If they agree to take part, they are still free to withdraw at any time without giving a reason.

What will happen if my child takes part?

Your son/daughter will complete some short questionnaires during a brief slot in the school day, at a time agreed with the school (e.g. at tutor time). The questions will ask about feelings, behaviour and how they like to spend their free time.

What are the possible disadvantages and risks of taking part?

We do not expect there to be any disadvantages or risks involved in taking part in this research. Some of the questions ask about feelings, and it is possible that some adolescents may find this upsetting if they are having particular emotional difficulties. Many of these questions are unlikely to be relevant to the young person, however if they are, it is important for us to know this. If anyone

was upset by any of the questions we would offer to stop the research immediately (and your child can choose not to answer questions if they wish). During the research we will follow all school safeguarding and child protection policies. Additionally, all students will be given a support sheet to keep. The list contains helpful resources for those who want to learn more about emotional health, who want to get involved in volunteering opportunities or would like to seek advice.

As the research will be carried out in school we do not require you or your child to come to the University at any point. The study will be carried out in whole classes/tutor groups so your child will not miss any teaching.

What are the possible benefits?

Taking part will help us gain a greater understanding of the emotional health of students at your child's school. We hope to use this information to consider what interventions may be most suitable and could be offered in the school setting. We will also ask students to let us know if they would like help with any specific issues, and if they do we will put them in touch with the relevant member of staff. We think some young people may find this an easier way to ask for help.

What if there is a problem?

If you have any concern about any aspect of the study, you should ask to speak to Laura Pass, the lead researcher on the project (email: L.S.Pass@reading.ac.uk). If you remain unhappy and wish to complain formally, you can contact your child's Headteacher or Deputy Head.

Will our taking part in the study be kept confidential?

All the information provided will be kept confidential. The information we collect (questionnaire answers) will not have any names on and will be kept in locked cabinets in locked offices at the University. Consent forms with names on will be kept in a separate locked cabinet. All the information collected for the project will be destroyed as soon as they are no longer needed. The consent forms, however, will be kept for 5 years before disposal.

The only exception to this is if your child tells us something which puts them, or someone else, at risk. If this happens we will inform the school who will follow their risk and safeguarding policies. We are asking students about their emotional health, and if we feel any student is at risk of harm we will alert a nominated member of the school staff who will then follow school procedures.

What will happen to the results of the research study?

We hope to write these results up for publication in a scientific journal and at professional academic conferences. No personal information will be given and any material used will be anonymous and not be traceable to a particular person. If you would like a report of the findings of our study, we will be happy to provide it. Please note that the publication may take a year or more after the completion of the study.

Who has reviewed the study?

All research at the University of Reading is reviewed by an independent group of people, called a Research Ethics Committee, to protect your interests. This application has been reviewed and given a favourable opinion by the University of Reading Research Ethics Committee. Everyone working on this study has been through the formal Criminal Records Bureau Disclosure process and has been approved by the School of Psychology of the University of Reading to work with young people.

Does my child have to take part?

No: Participation in this research is entirely voluntary. If you or your child has any questions please do not hesitate to contact us by phone or email. We will be happy to tell you more about the research and to discuss any questions or concerns you might have.

Will there be any further studies?

We would like to give students who take part in this study the opportunity to take part in future studies we will be running at their school. We would send you information about this separately, so in this study we are just asking students to let us know if they are happy to be contacted in future- they are not signing up to anything else.

Thank you very much,

Dr Laura Pass (Researcher) email: L.S.Pass@reading.ac.uk Tel:

Prof Shirley Reynolds (Principal Investigator) email: S.A.Reynolds@reading.ac.uk Tel:

Website: www.andyresearchclinic.com

Appendix 1.3: Participant assent/consent and parent consent forms

School of Psychology and Clinical Language Sciences
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University of Reading

ASSENT FORM FOR ADOLESCENTS aged 11-15

The 'How are you doing?' school survey

Please circle all you agree with:

Have you read (or had read to you) the information about this project?	YES / NO
Has somebody explained this project to you?	YES / NO
Do you understand what this project is about?	YES / NO
Have you asked all the questions you want?	YES / NO
Have you had your questions answered in a way you understand?	YES / NO
Do you understand it's OK to stop taking part at any time?	YES / NO
Are you happy to take part?	YES / NO

If any answers are 'no' or you **don't** want to take part, **don't** sign your name! If you **do** want to take part, please write your name and today's date:

Your name: _____ Date: _____

Are you happy to be contacted about a future study? (This just means you will be asked, you do not have to take part!) YES / NO

If yes, please write your email address here:_____

If you don't have an email address, can we contact you through school? YES / NO

This project has been reviewed by the University Research Ethics Committee and has been given a favourable ethical opinion for conduct

School of Psychology and Clinical Language Sciences
University of Reading
Harry Pitt Building
Whiteknights Road
Reading
RG6 6AL

University of Reading

CONSENT FORM FOR ADOLESCENTS
16-18 year olds
The 'How are you doing?' School Survey

If your answer is YES to each question, please put your initials in each box:

Have you read (or had read to you) the information about this project?	
Has somebody explained this project to you?	
Do you understand what this project is about?	
Have you asked all the questions you want?	
Have you had your questions answered in a way you understand?	
Do you understand it is okay to stop taking part at any time?	
Are you happy to take part?	

If any answer are 'no' or you **don't** want to take part, then don't sign! If you **do** want to take part, please write your name and today's date:

Your name_____Date: _____

Are you happy to be contacted about a future study? (This just means you will be asked, you do not have to take part!) Please circle: **YES/ NO**

If yes, please write your email address here: _____

If you don't have an email address, can we contact you through school? **YES/ NO**

The person who explained this project to you needs to sign too:

Researcher name _____ Date _____

Sign_____

This project has been reviewed by the University Research Ethics Committee and has been given a favourable ethical opinion for conduct

School of Psychology and Clinical Language Sciences
University of Reading
Harry Pitt Building
Whiteknights Campus
Reading
RG6 6AL

OPT-OUT FORM

Project Title: The 'How are you doing?' school survey
Researchers: Laura Pass & Shirley Reynolds

Please only complete and return this form if you DO NOT want your child to take part in this research.

I **do not** agree to my child participating in this research.

Your child's name: _____

Your child's tutor group (if known): _____

Your Name: _____

Signature:_____

Date: _____

Appendix 1.4: Debriefing sheet

University of Reading

ADOLESCENT DEBRIEF SHEET

The 'How are you doing?' school survey

Thank you for taking part in our school survey! The aim of this study was to check in on the emotional health of students at your school, to find out in what areas students are doing well, and where they might need more help. We also wanted to find out more about activities young people enjoy in their free time.

Your results will be anonymously compared with those of other participants taking part in the study. If at any point you wish to withdraw your results or ask any questions about this study please email Laura Pass (L.S.Pass@Reading.ac.uk).

The survey questionnaires tell us about how you have been feeling and behaving. Everyone's feelings go up and down from time to time. This is perfectly normal and nothing to worry about.

Sometimes we do go through times when we feel upset or down for quite a while. Usually people you already know can help; for example, parents, other family, a member of staff at school, or a friend. Sometimes it's useful to talk to someone else or read some information so we have links to useful resources that you can download here:

https://tinyurl.com/y7qdpvyx

Thank you very much for helping us with this research. We hope you have found it interesting. We will be feeding back what we've found to the school once we have the results!

Appendix 1.5 Useful resources sheet (available via link on debriefing sheet)

School of Psychology and Clinical Language Sciences
University of Reading
Harry-Pitt Building
Whiteknights Campus
Reading

RG6 6AL

University of Reading

Useful Resources sheet

Feelings and behaviour can be difficult things to manage for everyone at some time. We are giving this leaflet to everyone who has taken part in our research at your school. It includes information about different types of support that you and/or your friends might find useful.

Support & Advice

Staff at your school

If you are having problems at school, whether it's keeping up in lessons, managing your homework, or getting on with others in your class, your Head of Year can help. They will talk to you about what you're finding difficult, and think about what could help. You can also speak to any staff member at school who can point you in the right direction.

Your General Practitioner (GP) (contact details vary)

Your GP will be able to offer support and advice on possible treatment options for any mental health difficulties. It can be helpful to take someone with you if you are not used to talking to them.

Time to Talk Counselling Service

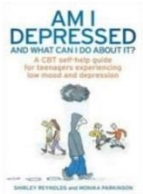
This is a counselling service available in various locations in Reading and Newbury. To find out more, go to http://t2twb.org/ **Tel:** 0118 903 5151, **Email:** office@t2twb.org

Time to Talk Reading

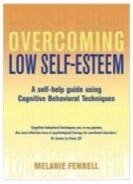
Number 5 Counselling Service

This is another counselling service available in Reading town centre. To find out more, go to: http://no5.org.uk/ Tel: 0118 901 5668.

Books



Am I depressed? And what can I do about it? A CBT self-help guide for teenagers experiencing low mood and depression. Authors: Shirley Reynolds, & Monika Parkinson (2015). Publishers: Constable & Robinson. This book is written for teenagers, and is available from your library and on Amazon.



Overcoming Low Self-Esteem: A self-help guide using cognitive behavioural techniques. Author: Melanie Fennell (1999). Publisher: Constable & Robinson.

This book is a really easy to read guide on how to overcome difficulties with low self-esteem, a common problem for many young people.

Websites

Google UK

YOUNGMINDS
The voice for young people's mental health and wellbeing

Young Minds:
www.youngminds.org.uk/

YoungMinds is a charity committed to improving the mental health of young people. The website has information leaflets and ways to get support.

Northumberland self-help: https://www.ntw.nhs.uk/pic/selfhelp/

This website has some great free to download self-help leaflets, including ones on anxiety, depression, anger, and self-harm.

MOODJUICE

Mood Juice: http://www.moodjuice.scot.nhs.uk/

A self-help site full of resources for dealing with depression, anxiety and other difficulties.

MoodGYM
TRAINING PROGRAM

Mood Gym: https://moodgym.anu.edu.au

Free web-based Cognitive-Behaviour Therapy (CBT) programme.

Childline: www.childline.org.uk

Lots of useful information. You can also email or speak to a counsellor online: http://www.childline.org.uk/talk/chat/pages/onlinechat.aspx

http://www.papyrus-uk.org Advice and support for young people dealing with self-harm and emotional distress and for those who are worried about them.

Helplines

ChildLine
0800 1111

Childline: 0800 11 11

Free confidential 24hr helpline for young people up to 19yrs old.

Samaritans: 08457 90 90 90

Free confidential 24 hour helpline.

Papyrus HOPELineUK 0800 068 41 41

Free confidential helpline for anyone concerned about a young person at risk of harming themselves. Open weekdays 10am – 5pm, 7pm – 10pm; weekends 2pm – 5pm.

Get Connected: 0808 808 4994

Free, confidential help for a wide range of issues for young people under 25.They also have a website: http://www.getconnected.org.uk/

Appendix 2: for Paper 2

Appendix 2.1: Ethical approval

From: Claire Williams [mailto:claire.williams@reading.ac.uk]
Sent: 06 June 2017 09:04
To: PCLS Ethics
Cc: s.a.reynolds@reading.ac.uk
Subject: RE: SREC application: values in adolescence 2017-064-SR

Hi Liz,
I am content for SREC to approve this study.
Many thanks,
Claire

From: PCLS Ethics [mailto:pclsethics@reading.ac.uk]
Sent: 23 May 2017 15:42
To: Claire Williams <claire.williams@reading.ac.uk>
Subject: FW: SREC application: values in adolescence 2017-064-SR

Hi Claire
Please find attached a new ethics application for you to review please.
Many thanks
Liz

Liz White
Ethics
Executive Support Administrator to Professors Cathy Creswell and Jonathan Hill
SPCLS, University of Reading, 3 Earley Gate, Reading RG6 6AL

Please note I work Monday - Thursday

From: Iona Lewis-Smith [mailto:i.lewis-smith@pgr.reading.ac.uk]
Sent: 23 May 2017 15:34
To: PCLSethics@reading.ac.uk
Cc: Shirley Reynolds
Subject: SREC application: values in adolescence

Hi,

Please find attached a new ethics application for the study 'Values in Adolescence', along with associated appendices. Please do not hesitate to contact me should you require any further information.
Many thanks,
Iona Lewis-Smith

Appendix 2.2: Participant and parent information sheets

School of Psychology and Clinical Language Sciences
University of Reading
Harry Pitt Building
Whiteknights Campus
Reading
RG6 6AL

PROJECT TITLE: VALUES IN ADOLESCENCE. INFORMATION FOR PARENTS

Hello, we are inviting your daughter/son to take part in a research project.

Why is this project being done?

We want to learn about young peoples' values – in other words, what young people feel are the most important things in their lives and how this helps guide their actions. Understanding what matters most to young people is important and may help us develop ways to improve their well-being and enjoyment.

Why has my daughter/son been asked to take part?

Your daughter/son has been asked to take part because they agreed to be contacted about future research with the University of Reading. Because your daughter/son is under the age of 16, we want to make sure you are happy for your daughter/son to take part. We will also ask your daughter/son if they want to take part.

Does my daughter/son have to take part?

No. Your daughter/son does not have to take part unless both you and they are happy to. Also, if either you or your daughter/son decide to take part and then change your mind, this won't matter at all: your daughter/son can withdraw from the study at any time and they won't have to give us a reason.

What will happen if my daughter/son takes part in the project?

We would like to have a chat with your daughter/son about their values in an informal interview. The interview will last between 30-60 minutes. We would like to hear their individual thoughts and opinions. To help us make sure we remember and understand their responses correctly, we would like to audio record the interview.

Might anything about the research upset my daughter/son?

Because your daughter/son will be guiding the discussion about their values, we don't expect for the interview to upset them. However, if they do feel uncomfortable, they will be free to stop the interview at any time, without giving a reason, and we will provide them with ways to get support if they would like it.

Will my daughter/son's information be kept private if they take part? Will anyone else know that my daughter/son is doing this?

Everything your daughter/son tells us as part of this project is treated as confidential; this means that nobody other than the researcher conducting the interview will ever know what they have told us. Your daughter/son will be assigned a research ID number so that any notes or audio recordings the researcher takes won't have your daughter/son's name on them.

We would not be able to keep information confidential if your daughter/son tells us something which makes us very worried about the safety of your daughter/son or someone else. If this were to happen, we would speak to a member of the school safeguarding team who could help them.

Did anyone else check the project is okay to do?

Before any research is allowed, it has to be checked by the University Ethics Committee. They make sure the research is safe and they are happy for the research to go ahead. The people working on this study have been through the formal Disclosure Barring Service (DBS) checks and have been approved by the School of Psychology, University of Reading to work with young people.

What if I have more questions?

If you have any questions about our study, either now or later, please feel free to email us or phone to speak to us. You have a right to know everything and we will be happy to tell you everything. Please feel free to talk about this study with your daughter/son and/or teachers.

Thank you very much,

Iona Lewis-Smith (Researcher): Email: i.lewis-smith@pgr.reading.ac.uk

Professor Shirley Reynolds (Principal Investigator): Email: S.A.Reynolds@reading.ac.uk Tel:

Website: www.andyresearchclinic.com

School of Psychology and Clinical Language Sciences
University of Reading
Harry Pitt Building
Whiteknights Campus
Reading
RG6 6AL

PROJECT TITLE: VALUES IN ADOLESCENCE. INFORMATION FOR PARTICIPANTS 11-15 YEARS OLD

Hello, we are inviting you to take part in a research project.

Why is this project being done?

We want to learn about young peoples' values – in other words, what young people feel are the most important things in their life, or what matters to them. Understanding what matters most to young people is important and may help us develop ways to improve their well-being and enjoyment.

Why have I been asked to take part?

You have been asked to take part because you agreed to be contacted about future research with the University of Reading.

Do I have to take part?

No. You do not have to take part unless you want to. Also, if you decide to take part and then change your mind, this won't matter at all: you can withdraw from the study at any time and you won't have to give us a reason. Because you are under 16, your parent will be asked if they are happy for you to take part and to give us written consent before you do take part.

What will happen if I take part in the project?

We would like to talk with you for about 30 -60 minutes. We would like to ask you about your values, what matters to you, what your care about. Everyone has different values and we would like to hear about your own thoughts and opinions. To help make sure we remember and understand your responses correctly, we will ask you for permission to audio record the interview.

Might anything about the research upset me?

Because you will be guiding the discussion about your values, we don't expect the interview to upset you. However, if you do feel uncomfortable, you can stop the interview at any time, without giving a reason.

Will my information be kept private if I take part? Will anyone else know I'm doing this?

Everything you tell us as part of this project is treated as confidential; this means that nobody other than the researcher conducting the interview will ever know what you have told us. We will use a research ID number on any notes or audio recordings, not your name.

The only time when information might be shared is if you tell us something which makes us very worried about the safety of yourself or someone else. If this were to happen we would tell you during the interview. We would then talk to a member of the school safeguarding team, who could help you.

Did anyone else check the project is okay to do?

Before any research is allowed, it has to be checked by the University Ethics Committee. They make sure the research is safe and they are happy for the research to go ahead. The people working on this study have been through the formal Disclosure Barring Service (DBS) checks and have been approved by the School of Psychology, University of Reading to work with young people.

What if I have more questions?

If you have any questions about our study, either now or later, please feel free to email or phone to speak to us. You have a right to know everything and we will be happy to tell you everything. Please feel free to talk about this study with your friends, parents and/or teachers.

Thank you very much,

Iona Lewis-Smith (Researcher): Email: i.lewis-smith@pgr.reading.ac.uk

Professor Shirley Reynolds (Principal Investigator): Email: S.A.Reynolds@reading.ac.uk Tel:

Website: www.andyresearchclinic.com

School of Psychology and Clinical Language Sciences
University of Reading
Harry Pitt Building
Whiteknights Campus
Reading
RG6 6AL

PROJECT TITLE: VALUES IN ADOLESCENCE. INFORMATION FOR PARTICIPANTS 16-18 YEARS OLD

Hello, we are inviting you to take part in a research project.

Why is this project being done?

We want to learn about young peoples' values – in other words, what young people feel are the most important things in their life and how these help guide their actions. Understanding what matters most to young people is important and may help us develop ways to improve their well-being and enjoyment.

Why have I been asked to take part?

You have been asked to take part because you agreed to be contacted about future research with the University of Reading.

Do I have to take part?

No. You do not have to take part unless you want to. Also, if you decide to take part and then change your mind, this won't matter at all: you can withdraw from the study at any time and you won't have to give us a reason. Because you are 16 or older you do not need parental consent, therefore the decision to take part is completely up to you.

What will happen if I take part in the project?

We would like to talk with you for about 30-60 minutes. We would like to ask you about your values, what matters to you, what your care about. Everyone has different values and we would like to hear about your own thoughts and opinions. To help make sure we remember and understand your responses correctly, we will ask you for permission to audio record the interview.

Might anything about the research upset me?

Because you will be guiding the discussion about your values, we don't expect the interview to upset you. However, if you do feel uncomfortable, you can stop the interview at any time, without giving a reason.

Will my information be kept private if I take part? Will anyone else know I'm doing this?

Everything you tell us as part of this project is treated as confidential; this means that nobody other than the researcher conducting the interview will ever know what you have told us. You will be assigned a research ID number so that any notes or audio recordings the researcher takes won't have your name on them.

The only time when information might be shared is if you tell us something which makes us very worried about the safety of yourself or someone else. If this were to happen we would tell you during the interview. We would then talk to a member of the school safeguarding team, who could help you.

Did anyone else check the project is okay to do?

Before any research is allowed, it has to be checked by the University Ethics Committee. They make sure the research is safe and they are happy for the research to go ahead. The people working on this study have been through the formal Disclosure Barring Service (DBS) checks and have been approved by the School of Psychology, University of Reading to work with young people.

What if I have more questions?

If you have any questions about our study, either now or later, please feel free to email or phone to speak to us. You have a right to know everything and we will be happy to tell you everything. Please feel free to talk about this study with your friends, parents and/or teachers.

Thank you very much,

Iona Lewis-Smith (Researcher): Email: i.lewis-smith@pgr.reading.ac.uk

Professor Shirley Reynolds (Principal Investigator): Email: S.A.Reynolds@reading.ac.uk Tel:

Website: www.andyresearchclinic.com

Appendix 2.3: Participant assent/consent and parent consent forms

School of Psychology and Clinical Language Sciences
University of Reading
Harry Pitt Building
Whiteknights Road
Reading
RG6 6AL

PROJECT TITLE: VALUES IN ADOLESCENCE. CONSENT FORM FOR PARENTS

(Please initial each box)

1. I confirm that I have read and understood the Information Sheet for this study and that I have had the opportunity to consider the information. ☐
2. I understand that my daughter/son's participation is voluntary and that we are free to withdraw at any time ☐
3. I agree that my daughter/son can be audio-recorded. I understand that this recording will be heard only by members of the research team and will be destroyed at the end of the research study. ☐
4. I agree for members of the research team to use information about my daughter/son that they have provided as part of other University of Reading research studies ☐
5. I agree for my son/daughter to take part in this study. ☐

Your child's name:
_____

Your name:
_____

Signature:
_____Date:_____

Name of Researcher:_____ Date: _____

Signature: _____

'This research study has been reviewed by the University Research Ethics Committee and has been given a favourable ethical opinion for conduct.'

School of Psychology and Clinical Language Sciences
University of Reading
Harry Pitt Building
Whiteknights Road
Reading
RG6 6AL

CONSENT FORM FOR PARTICIPANTS
Values in adolescence

If your answer is YES to each question, please put your initials in each box:

Have you read (or had read to you) the information about this project?	
Has somebody explained this project to you?	
Do you understand what this project is about?	
Have you asked all the questions you want?	
Have you had your questions answered in a way you understand?	
Do you understand it is okay to stop taking part at any time?	
Are you happy to take part?	
Are you happy for us to access your data from the Theale Green survey of emotional health?	
Are you willing for the interview to be audio recorded?	

If any answer is 'no' or you **don't** want to take part, then don't sign!

If you **do** want to take part, please write your name and today's date:

Your name_____Date: _____

The person who explained this project to you needs to sign too:

Researcher name _____ Date _____

Sign_____

'This research study has been reviewed by the University Research Ethics Committee and has been given a favourable ethical opinion for conduct.'

Appendix 2.4: Debriefing sheet

University of Reading

ADOLESCENT DEBRIEF SHEET

Values in adolescence

Thank you for taking part in the study and speaking to us about your values! The aim of this study was to learn more about what is most important to young people, and what this means for their lives. Understanding what young people value will help us better support those young peoples' mental health.

Your results will be anonymously analysed, to summarise the main things that came up during our discussion. If at any point you wish to withdraw your input, or ask any questions about this study, please email Iona Lewis-Smith (i.lewis-smith@pgr.reading.ac.uk).

We hope that taking part in our research was a positive experience for you. However, we have a link to some useful resources, if you would like some information for times when you might feel upset or distressed:

https://tinyurl.com/y7qdpvyx

Thank you very much for helping us with this research. We hope you have found it interesting!

Appendix 2.5: Interview topic guide

Introduction to interview:

- I will explain the purpose of the interview and what it is hoped to achieve during the session

The purpose of our discussion today is to find out about what you value. I hope that by the end of this interview, I will have a rich and detailed understanding of how you think and feel about your values.

- I will address terms of confidentiality

What we talk about today will be completely confidential. Only I will be listening to the recording of the interview, and in none of the data or analysis will I use your name. There is only one situation in which I might tell someone what you talked about today, and that would be if you said something that made me worried about your safety or the safety of someone else. In line with your school's safeguarding policy, I would pass this information on to a member of the safeguarding team. Does this make sense? Do you have any questions about this?

- I will explain the format of the interview and how long it will take

The interview should last no longer than an hour. If you want to stop at any point, you are completely free to do so and you do not need to give me a reason. Also, if you would like to take a break, then please just let me know.

- I will provide an information sheet with contact details for any questions after the interview

On the bottom of the information sheet is my contact details and the contact details of my supervisor, should you have any questions that occur to you after our discussion today.

- I will ask if the participant has any questions and if they're willing to continue

Do you have any questions just now? Are you happy for us to start?

Interview topics:

- What the young person understands by the term 'values'
- What values mean for their life as a whole
- What their values mean for their life day-to-day
- How their values are expressed

- Barriers to expressing or following values
- How values are prioritized or balanced
- Whether values ever conflict and how this is managed
- How values are thought about
- Whether they feel their values change or remain the same
- Where values comes from
- Who are values shared with and who has different values to them
- How they find the experience of talking about their values
- Whether their values have been talked about or explicitly thought about before
- What they value about/at school

Example questions:

I'd like to talk to you today about your values. What does the word 'values' mean to you?

Can you tell me about your values?

What do your values mean for your life?

How do you express your values?

Does anything get in the way of your values?

Do your values guide you day-to-day?

Tell me how you think about your values?

How do you prioritise or balance your values?

Do you values ever conflict with each other? How do you deal with this?

Do your values change or have they always been the same?

Where do you think your values comes from?

Who do you share your values with? What are they?

Who holds different values to you? What are they? How does this make you feel?

How do you find talking about your values?

Have you thought about or talked about your values before?

What do you value at or about school?

Is there anything else about your values that you want to tell me?

How have you found the interview? Do you have any questions?

Explanation of the term ‘values’:

Values are how you would like to approach each area of life, and what really matters to you. Values give you a sense of purpose and meaning. They are a bit like a compass- showing you the direction you want to go in, rather than the destination. So, for example, if you valued education, you might not enjoy doing your homework, but you would put a bit of effort into it so that you had a better chance of getting good grades. Does that make sense?

Appendix 3: for Paper 3

Appendix 3.1: Ethical approval

University of Reading

Coordinator for Quality Assurance in Research
Dr Mike Proven, BSc (Hons), PhD

Academic and Governance Services
Whiteknights House
Whiteknights, PO Box 217
Reading RG6 6AH

phone
email m.j.proven@reading.ac.uk

Dr Jonathan Totman
AnDY Research Unit
School of Psychology and Clinical Language Sciences
University of Reading
RG6 7BE

21 December 2018

Dear Jonathan,

UREC 18/54: Brief Behavioural Activation (BA) in schools: qualitative evaluation. *Favourable opinion*

Thank you for your application (email, dated 13 November 2018 and including attachments, from Liz White refers) for review of the above project which was considered by a UREC Sub-committee on Wednesday 5 December 2018. I can confirm that the Chair is pleased to confirm a favourable ethical opinion on the basis of the information that was reviewed by the sub-committee.

Separately (*and **not** as a condition of approval*), the Committee would like to ask you to consider the recent advice and example statements – from UREC and the University's Research Data Manager, and given via Heads of Schools – to include a statement in the Data Section of the Information Sheet and Consent form that would facilitate the 'downstream' sharing of data. The advice was that the researcher should check that:

"The consent form asks the research participant for permission to preserve some or all of the data they provide over the long term, and to make the data available, in anonymised form if required, either openly or subject to appropriate safeguards, so that they can be consulted and re-used by others, in accordance with the University's Research Data Management Policy."

Two examples of wording which can be used are below, one is anonymised data and the latter is not-anonymised:

> *'I understand that the data collected from me in this study will be preserved and made available in anonymised form, so that they can be consulted and re-used by others.'*
>
> OR
>
> *'I understand that the data collected from me in this study will be preserved, and will be made available to other authenticated researchers only if they agree to maintain the confidentiality of the information provided to them.'*

Please note that the Committee will monitor the progress of projects to which it has given favourable ethical opinion approximately one year after such agreement, and then on a regular basis until its completion.

Please also find attached Safety Note 59: Incident Reporting in Human Interventional Studies at the University of Reading, to be followed should there be an incident arising from the conduct of this research.

The University Board for Research and Innovation has also asked that recipients of favourable ethical opinions from UREC be reminded of the provisions of the University Code of Good Practice in Research. A copy is attached and further information may be obtained here: https://www.reading.ac.uk/internal/academic-and-governance-services/quality-assurance-in-research/reas-RSqar.aspx

Yours sincerely

Dr M J Proven
Coordinator for Quality Assurance in Research (UREC Secretary)

cc: Dr John Wright (Chair); Professor Laurie Butler (Head of School); Dr Laura Pass (Clinical Research Psychologist)

University of Reading

Coordinator for Quality Assurance in Research
Dr Mike Proven, BSc(Hons), PhD

Academic and Governance Services

Whiteknights House
Whiteknights, PO Box 217
Reading RG6 6AH

phone
email urec@reading.ac.uk

Dr Jonathan Totman
School of Psychology and Clinical
Language Sciences
University of Reading
RG6 6AL

25 June 2019

Dear Jonathan,

UREC 18/54: Brief Behavioural Activation (BA) in Schools: Qualitative Evaluation. *Amendment favourable opinion. AM021854*

Thank you for your application (email dated 24 June 2019 and including attachments refers) requesting and detailing amendments to the above project *(amendment to participant population to extend to include therapists)*. I can confirm that the UREC Chair has reviewed that request and is happy for the project to continue.

Yours sincerely,

Dr M J Proven
Coordinator for Quality Assurance in Research (UREC Secretary)
cc: Dr John Wright (Chair); Dr Laura Pass (Researcher)

Appendix 3.2: Participant and parent information sheets

University of Reading

School of Psychology and Clinical Language Sciences
University of Reading, Whiteknights Campus
Reading RG6 6AL

Experiences of Brief BA: Young Person Information sheet

Hi, we are inviting you to take part in a study we are doing.

Why is this study being done?

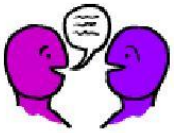
We would like to find out more about how you found taking part in the therapy 'Brief BA' (Behavioural Activation) in school. We would like to speak with you about any changes you've noticed since the end of therapy, and what in Brief BA you found most helpful and least helpful.

Why have I been asked to take part?

You have been asked to take part because you received Brief BA with one of our therapists in school.

Do I have to take part?

No: Whether or not you take part is **completely up to you**. Just because you took part in Brief BA does not mean that you have to take part in this study. If you decide to take part and then change your mind, that is completely fine – you can withdraw at any point.



What will happen to me if I take part in the study?

If you want to take part in this study, we will arrange a private interview to ask you about your experience of Brief BA. This might take place at school, home or at the University of Reading and will last for up to an hour – we will make arrangements that suit you best. The interview will be audio-recorded so we can remember what you tell us. We will also use some of the data you provided as part of Brief BA to help us understand your experiences.

Might anything about the study upset me?

Talking about your experience of Brief BA might bring up uncomfortable memories or emotions but you will not have to talk about anything you don't want to. The interviewer will check to make sure things feel OK for you, but you can take a break or stop altogether at any point.

Will my information be kept private if I take part? Will anyone else know I'm doing this?

Everything you tell us as part of this study is treated as confidential; that means that we won't tell anyone else what you said. The only time we would not be able to keep something to ourselves is if you told us that you or someone else was at risk of real danger. In this situation we would have to speak to another adult, like the person who looks after you or your GP. We will speak to a parent or caregiver about the study beforehand to check they're happy for us to have their contact details. If you are under 16, we also need to ask whether they're happy for you to take part.

We will give you an anonymous ID number and use this on all the information you give us in the study, rather than your name. All your study information will be kept in locked cabinets. Audio recordings will be kept on the computer and only our researchers will be able to access them. When we publish the findings of the study we might include quotes from what you tell us in our reports but we will make sure they are anonymous so can't be linked to you.

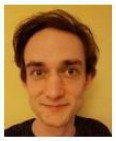
Did anyone else check the study is okay to do?

Before any research is allowed to happen, it has to be checked by a group of people called an Ethics Committee. They make sure the research is okay to do. This study has been looked at by the University of Reading School of Psychology Research Ethics Committee and they were happy for it to go ahead. Everyone working on this study has been checked and cleared to work with adolescents.

What if I have more questions?

If you have any questions about our projects, either now or later, please feel free to email us or phone to speak to us. We will be happy to tell you anything you want to know.

Thanks!



Research Lead: Dr Jonathan Totman
Email: j.w.totman@reading.ac.uk
Tel:

Study Researcher: Iona Lewis-Smith
Email: i.lewis-smith@pgr.reading.ac.uk

School of Psychology and Clinical Language Sciences
University of Reading
Harry Pitt Building
Whiteknights Campus
Reading
RG6 6AL

PROJECT TITLE: VALUES IN ADOLESCENCE. INFORMATION FOR PARENTS

Hello, we are inviting your daughter/son to take part in a research project.

Why is this project being done?

We want to learn about young peoples' values – in other words, what young people feel are the most important things in their lives and how this helps guide their actions. Understanding what matters most to young people is important and may help us develop ways to improve their well-being and enjoyment.

Why has my daughter/son been asked to take part?

Your daughter/son has been asked to take part because they agreed to be contacted about future research with the University of Reading. Because your daughter/son is under the age of 16, we want to make sure you are happy for your daughter/son to take part. We will also ask your daughter/son if they want to take part.

Does my daughter/son have to take part?

No. Your daughter/son does not have to take part unless both you and they are happy to. Also, if either you or your daughter/son decide to take part and then change your mind, this won't matter at all: your daughter/son can withdraw from the study at any time and they won't have to give us a reason.

What will happen if my daughter/son takes part in the project?

We would like to have a chat with your daughter/son about their values in an informal interview. The interview will last between 30-60 minutes. We would like to hear their individual thoughts and opinions. To help us make sure we remember and understand their responses correctly, we would like to audio record the interview.

Might anything about the research upset my daughter/son?

Because your daughter/son will be guiding the discussion about their values, we don't expect for the interview to upset them. However, if they do feel uncomfortable, they will be free to stop the interview at any time, without giving a reason, and we will provide them with ways to get support if they would like it.

Will my daughter/son's information be kept private if they take part? Will anyone else know that my daughter/son is doing this?

Everything your daughter/son tells us as part of this project is treated as confidential; this means that nobody other than the researcher conducting the interview will ever know what they have told us. Your daughter/son will be assigned a research ID number so that any notes or audio recordings the researcher takes won't have your daughter/son's name on them.

We would not be able to keep information confidential if your daughter/son tells us something which makes us very worried about the safety of your daughter/son or someone else. If this were to happen, we would speak to a member of the school safeguarding team who could help them.

Did anyone else check the project is okay to do?

Before any research is allowed, it has to be checked by the University Ethics Committee. They make sure the research is safe and they are happy for the research to go ahead. The people working on this study have been through the formal Disclosure Barring Service (DBS) checks and have been approved by the School of Psychology, University of Reading to work with young people.

What if I have more questions?

If you have any questions about our study, either now or later, please feel free to email us or phone to speak to us. You have a right to know everything and we will be happy to tell you everything. Please feel free to talk about this study with your daughter/son and/or teachers.

Thank you very much,

Iona Lewis-Smith (Researcher): Email: i.lewis-smith@pgr.reading.ac.uk

Professor Shirley Reynolds (Principal Investigator): Email: S.A.Reynolds@reading.ac.uk Tel:

Website: www.andyresearchclinic.com

Appendix 3.3: Participant assent/consent and parent consent forms

University of Reading

School of Psychology and Clinical Language Sciences
University of Reading, Whiteknights Campus
Reading RG6 6AL

ASSENT FORM FOR YOUNG PEOPLE (12-15)
Brief BA in schools study

Please circle YES or NO for each of these questions:

Have you read (or had read to you) the information about this project?	YES / NO
Has somebody explained this project to you?	YES / NO
Do you understand what this project is about?	YES / NO
Have you asked all the questions you want (or didn't have any questions)?	YES / NO
Have you had your questions answered in a way you understand (or didn't have any questions)?	YES / NO
Do you understand it's OK to stop taking part at any time?	YES / NO
Are you happy to be audio-recorded?	YES / NO
Are you happy for our research team to access the data you provided as part of Brief BA?	YES / NO
Are you happy to take part?	YES / NO

If any answers are 'no' or you **don't** want to take part, **don't** sign your name!
If you **do** want to take part, please write your name and today's date:

Your name _____ Date _____

The person who explained this project to you needs to sign too:

Print name _____
Sign _____
Date _____

Please tick this box if you would like to hear about the study's results in the future ☐
If you have ticked this box please provide us with your contact details e.g email address

……

School of Psychology and Clinical Language Sciences
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CONSENT FORM FOR YOUNG PEOPLE (16-18)
Experiences of Brief BA

Please initial each box if your answer is YES:

Have you read (or had read to you) the information about this project?	☐
Has somebody explained this project to you?	☐
Do you understand what this project is about?	☐
Have you asked all the questions you want (or don't have any questions)?	☐
Have you had your questions answered in a way you understand (or didn't have any questions)?	☐
Do you understand it's OK to stop taking part at any time?	☐
Are you happy to be audio-recorded?	☐
Are you happy for our research team to access the data you provided as part of Brief BA?	☐
Are you happy to take part?	☐

If any answers are 'no' or you **don't** want to take part, **don't** sign your name!
If you **do** want to take part, please write your name and today's date:

Your name _____ Date _____

The person who explained this project to you needs to sign too:

Print name _____
Sign _____
Date _____

Please tick this box if you would like to hear about the study's results in the future ☐
If you have ticked this box please provide us with your contact details e.g email address

……

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Reading RG6 6AL

CONSENT FORM FOR PARENTS

Experiences of Brief BA

Please initial each box if your answer is YES:

Have you read (or had read to you) the information about this project?	☐
Has somebody explained this project to you?	☐
Do you understand what this project is about?	☐
Have you asked all the questions you want (or didn't have any questions)?	☐
Have you had your questions answered in a way you understand (or didn't have any questions)?	☐
Do you understand it's OK for you and/or your child to stop taking part at any time?	☐
Are you happy for you and/or your child to be audio-recorded?	☐
Are you happy for our research team to access the data you and/or your child provided as part of Brief BA (including contact details if information needs to be shared)?	☐
Are you happy for your child to take part?	☐
Are you happy to take part yourself?	☐

If any answers are 'no' or if you **don't** want your to take part **and** you don't want your child to take part, **don't** sign your name!

If you **do** want to take part or for your child to take part, please write your name and today's date:

Your name: _____ Date:_____

Your child's name: _____

Please tick this box if you would like to hear about the study results in the future ☐
If you have ticked this box please provide us with your contact details e.g email address

……

Appendix 3.4: Interview schedule

Adapted version of the Client Change Interview for Young People (Lynass, et al., 2012)

1. General Questions:
    1a. How are you doing now in general?
    1b. What was Brief BA like for you? How did it feel to do Brief BA?

2. Changes:
    2a. What changes, if any, have you noticed in yourself since you did Brief BA? (behaviour, thoughts, feelings, events)
    2b. Has anything changed for the better for you since you did Brief BA?
    2c. Has anything changed for the worse for you since you did Brief BA?
    2d. Is there anything that you wanted to change that hasn't since you did Brief BA?
    2e. How important or significant to you personally do you think that these changes have been?
    2f. How likely it would be for you to have had these changes without Brief BA?

3. Attributions:
In general, what do you think has caused the various changes you described? In other words, what do you think might have brought them about?
(Including things both outside of therapy and in therapy).

Are there things about yourself that you think have helped or have been unhelpful?

Are there things in your life (family, school, relationships, home) that have helped or have been un-helpful?

4. Helpful Aspects:
Can you sum up what has been helpful about doing Brief BA? Please give examples.
(For example, general aspects, specific events)

5. Problematic Aspects:
    5a. What kinds of things about Brief BA were unhelpful, negative or disappointing for you?
    (For example, general aspects, specific events)
    5b. Were there things in Brief BA which were difficult but still OK or perhaps helpful? What were they?
    5c. Do you think anything was missing from Brief BA?
    (What would have made Brief BA more effective or helpful?)

6. Values:
    6a. How did you find working with your values in BA? Did you find working with your values helpful or unhelpful? Was it difficult or easy to think about and do activities related to your values?

6b. Here are some of the values you wrote down in Session 3. Do you remember these? Are these still your values? Are any of these not a value for you now? Do you think you have realised any new values since you finished BA?

6c. Do you still do activities related to your values? If not, why not? If so, do you find this helpful? In what ways do you find this helpful/unhelpful?

7. Therapy at school:
How did you find having the Brief BA take place at school? Were there any good things about having the sessions take place at school? Were there any bad things about having the sessions take place at school?

8. Suggestions:
Do you have any suggestions for us, regarding the research or the Brief BA? Do you have anything else that you want to tell me? Is there anything that I should have asked in this interview that I have left out?