Thesis Submitted in Partial Fulfilment of the degree of Doctor of Clinical Psychology (DClinPsych)



John Kerr

Oxford Institute of Clinical Psychology Training and Research

Green Templeton College

University of Oxford

Trinity Term 2025

Table of Contents

1. Word Count by Component *4*
2. Abstracts *5*
3. Systematic Review of the Literature *9*
Abstract *10*
Introduction *11*
Method *14*
Results *18*
Discussion *36*
4. Service Improvement Project *57*
Abstract *58*
Introduction *59*
Methods *62*
Results *65*
Discussion *77*
5. Theory-Driven Research Project *86*
Abstract *87*
Introduction *88*
Methods *93*
Results *100*
Discussion *107*
6. Executive Summary *126*
7. Connecting Narrative *129*
8. Acknowledgements *133*
9. Appendices *134*
Appendix 1.1: Instructions to Authors *134*
Appendix 1.2: Search Terms *143*
Appendix 2.1: Author Instructions *146*
Appendix 2.2: Survey & Interview Schedule *151*
Appendix 2.3: In-Service Project Approval *154*
Appendix 2.4: Participant Quotes *155*
Appendix 2.5: Published Service Improvement Project *165*
Appendix 2.6: SIP Lay Summary *180*
Appendix 3.1: Author Guidelines *182*
Appendix 3.2: CUREC Approval Letter *193*

Appendix 3.3: Child Assent Form *194*
Appendix 3.4: Anxiety Literacy Questionnaire *195*
Appendix 3.5: General Help Seeking Questionnaire *197*
Appendix 3.6: Stress Appraisal Measure for Adolescents *198*
Appendix 3.7: Mental Help Seeking Attitudes Scale *199*
Appendix 3.8: Generalised Anxiety Stigma Scale *200*
Appendix 3.9: Visual Analog Scale *203*
Appendix 3.10: Descriptive Statistics *204*
Appendix 3.11: Measure Baseline Characteristics *212*
Appendix 3.12: Participant Flow Diagram *213*
Appendix 3.13: Predictive odds of completing each study questionnaire. *214*
Appendix 3.14: Subgroup Analyses *215*
Appendix 3.15: ANOVAs of potential mediators *228*

1. Word Count by Component

Systematic Review of the Literature	6, 817
Service Improvement Project	4, 989
Theory-Driven Research Project	4, 500
Executive Summary	627
Connecting Narrative	979

2. Abstracts

Systematic Review of the Literature (SRL): Parents' experiences in accessing services for their autistic children in the United Kingdom: a meta-synthesis.

Background: Parents of autistic children support their children through additional challenges, often experiencing adversity as a result. Such parents report high support needs, yet service provision is often limited. Services often support children through providing various psychological interventions to parents. Quantitative evidence for such interventions is mixed, and qualitative evidence is sparse. This review therefore aimed to synthesise the perspectives of UK parents regarding interventions for their autistic child.

Method: The databases Scopus, Embase, Medline, PubMed, PsycInfo, CINAHL, Web of Science and ASSIA were searched in February 2025. Inclusion criteria constituted qualitative articles published in English from 2004 onwards exploring UK parents' perspectives of interventions aimed at supporting autistic children. Articles were evaluated using Kmet et al. (2004)'s Standard Quality Assessment Criteria. Thematic meta-synthesis as described by Lachal et al. (2017) was conducted.

Results: Fifteen papers were identified; eight high-quality, five medium-quality, and two low-quality. Interventions were psychoeducational, behavioural, communication-based, sensory-related or mental-health based in nature. Themes included change, relationship with help, parents' need to process and solidarity.

Conclusions: Facilitators of positive change included learning, empowerment, structure and rigour, while barriers included delivery issues and unhelpful information. Parents reported finding solidarity amongst similar parents helpful. Reflective space was deemed useful in facilitating new understanding of autistic lives. Methodological quality varied, with more reflexive and theoretically grounded research encouraged. Future research should also consider implementing embedding processes into qualitative designs.

Service Improvement Project (SIP): “You never know who you’re gonna speak to”: Exploring Psychological Wellbeing Practitioners' Experiences of Assessing Traumatic Events.

Background: Clinicians in NHS Talking Therapies for Anxiety and Depression (NHS-TT) services often assess people who have experience of traumatic events. Psychological Wellbeing Practitioners (PWPs) experience unique challenges in recognising and treating trauma. PWPs are recognised in literature as particularly vulnerable to burnout and emotional distress; such circumstances are pertinent when working with people reporting traumatic events. This study explored PWP experiences of assessments featuring traumatic events.

Method: Eleven PWPs from an NHS-TT service participated in semi-structured interviews and themes were identified through reflective thematic analysis.

Results: Participants discussed themes of ambiguity in distinguishing trauma problems, high levels of pressure, management of personal distress, appropriate training, and personal support in-service.

Conclusions: Findings corroborate previous research regarding challenges experienced by PWPs and offer novel insight into the challenges faced when assessing service-users' experiences of traumatic events. Recommendations regarding future training, service design and emotional outlets for PWPs were offered.

Theory Driven Research Project (TDRP): Examining the effectiveness of a single-session school-based outreach intervention to increase anxiety literacy and help-seeking intentions in adolescence.

Background: Mental health needs are at all-time highs in UK adolescents, and anxiety is one of the most commonly experienced difficulties. Many adolescents do not seek professional help for these difficulties or understand when their difficulties warrant support. Adaptations of Azjen's Theory of Planned Behaviour argue that increasing mental health literacy and addressing stigma, illness appraisal and attitudes towards help-seeking may lead to increased help-seeking intentions. The present study sought to i) develop a single-session, school-based intervention on anxiety and related help-seeking (ALHS), ii) test its' efficacy in improving anxiety literacy and help-seeking for anxiety and iii) explore the moderating influence of stigma, attitudes, and appraisal towards anxiety.

Methods: The ALHS' effectiveness was tested using a randomised, controlled experimental design at three timepoints (pre, post and one-month follow-up). Students (n=273) aged 12-13 were randomised at class level to either the ALHS or a control intervention about general mental wellbeing. Participants completed measures of anxiety literacy, help-seeking intentions, stigma, appraisal, help-seeking attitudes, and acceptability at each timepoint.

Results: 210 students completed primary outcome measures at pre- and post-intervention, with 104 completing both at three timepoints. The ALHS led to significantly higher anxiety literacy than the control post-intervention, with effects not sustained at follow-up. The ALHS did not lead to significantly greater help-seeking intentions for anxiety - help-seeking intentions in both groups increased significantly post-intervention, an effect sustained at follow-up.

Conclusions: While a single-session, school-based intervention can produce short-term improvements in anxiety literacy, more comprehensive intervention may be needed to produce lasting effects and encourage help-seeking.

3. Systematic Review of the Literature

Title: *Parents' experiences in accessing services for their autistic children in the United Kingdom: a meta-synthesis.*

John Kerr

Green Templeton College

University of Oxford

John.kerr@gtc.ox.ac.uk

Thesis submitted in partial fulfilment of the degree of Doctor of Clinical Psychology (DClinPsych)

Internal Supervisor: Dr Ciorsdan Anderson

Journal: Autism. This journal is a highly-regarded international journal seeking submissions regarding the improvement of quality of life for autistic people and their families.

Word Count: 6,817

Date: 2nd May 2025

Abstract

Background: Parents of autistic children support their children through additional challenges, often experiencing adversity as a result. Such parents report high support needs, yet service provision is often limited. Services often support children through providing various psychological interventions to parents. Quantitative evidence for such interventions is mixed, and qualitative evidence is sparse. This review therefore aimed to synthesise the perspectives of UK parents regarding interventions for their autistic child.

Method: The databases Scopus, Embase, Medline, PubMed, PsycInfo, CINAHL, Web of Science and ASSIA were searched in February 2025. Inclusion criteria constituted qualitative articles published in English from 2004 onwards exploring UK parents' perspectives of interventions aimed at supporting autistic children. Articles were evaluated using Kmet et al. (2004)'s Standard Quality Assessment Criteria. Thematic meta-synthesis as described by Lachal et al. (2017) was conducted.

Results: Fifteen papers were identified; eight high-quality, five medium-quality, and two low-quality. Interventions were psychoeducational behavioural, communication-based, sensory-related or mental-health based in nature. Themes included change, relationship with help, parents' need to process and solidarity.

Conclusions: Facilitators of positive change included learning, empowerment, structure and rigour, while barriers included delivery issues and unhelpful information. Parents reported finding solidarity amongst similar parents helpful. Reflective space was deemed useful in facilitating new understanding of autistic lives. Methodological quality varied, with more reflexive and theoretically grounded research encouraged. Future research should also consider implementing embedding processes into qualitative designs.

Introduction

Parents of autistic children love and cherish their children just as any parent (Aylaz et al., 2012) . However, research has long depicted the additional challenges in raising their children (Bonis, 2016). Such parents are often compelled by necessity to become passionate advocates for the needs of both their autistic child and their families', despite resultant/ensuing impact on their personal wellbeing, familial relationships, and careers (Lee et al., 2021; Smith-Young et al., 2022; Stoner & Stoner, 2016). Such effort can lead to increased risk of developing clinically significant mental health problems, including depression, anxiety and persistently elevated stress (Cachia et al., 2016; Falk et al., 2014; Machado Junior et al., 2016).

Literature regarding the difficulties children with autism, and their parents, face in accessing appropriate service support is widespread (Corcoran et al., 2015). Racial and socioeconomic disparities in service access exist for such families, relating to care access, referral frequency and proportion of unmet need (Smith et al., 2020). Fragmented service provision, inadequate service communication, and long waitlist periods are commonly reported by parents (Khanlou et al., 2017). Post-diagnostic support provision has been identified within United Kingdom (UK) services as a systemic limitation (Crane et al., 2018).

Brice et al. (2021) note that the UK's National Health Service (NHS), as a freely accessible provider, differs from service provision for autistic people in other countries, and that barriers to accessing such services duly differ. As Smółka (2022) notes, whilst the NHS is largely publicly funded, with the state and statutory agencies strongly involved in service planning and provision, other countries' healthcare systems are designed differently; for example, healthcare in the United States is largely market-based. Therefore, service design,

spending, cultural context and staffing contribute to varying international efficacy in supporting service users (Anandaciva, 2023).

The National Institute for Health and Care Excellence (NICE, 2013) recommends various forms of therapeutic support for autistic children and their families. These include behavioural approaches such as Applied Behaviour Analysis (ABA) and Early Intensive Behavioural Interventions (EIBI), communication therapies including Social Communication Therapy and Paediatric Autism Communication Therapy, sensory support interventions such as Sensory Integration Therapy, and a variety of psychologically therapeutic interventions including psychoeducational groups and various forms of psychological therapy for children and families (Cooper et al., 2018; Denne et al., 2017; Green et al., 2018; Pickles et al., 2016; Randell et al., 2019; Roughan et al., 2019).

Such interventions achieve optimal results when targeted and intensive (Nevill et al., 2018). However, logistical challenges on the part of parents and services, ranging from time limitations to long waitlists, create barriers to such intervention on the part of services (Jimenez et al., 2012). While parents are therefore well-placed mediators of such interventions, review and meta-analysis has identified that the efficacy of such interventions are inconclusive; for example, disparities between clinically relevant improvements in parent-rated adaptive functioning contrast with a lack of similar clinician-rated improvements (Conrad et al., 2021). The factors involved in successful parent-mediated interventions remain unclear (Trembath et al., 2019).,

Similarly, meta-analysis of psychosocial interventions for anxiety in autistic children showed significantly superior parent- and clinician-reported outcomes post treatment

compared to waitlist and treatment-as-usual controls; however, there was no significant difference in post-treatment self-reported outcomes (Kreslins et al., 2015). Similar results were found in meta-analysis by Wang et al. (2021) of Cognitive Behavioural Therapy (CBT) for a range of social-emotional problems, including depression. Recent meta-analysis of CBT and social-skills therapies for ASD populations illustrated reductions in child anxiety in the former, and both anxiety and depression in the latter (Wichers et al., 2023). While exposure (Guzick et al., 2022) and emotional regulation skills (Helland et al., 2023) represent potential mechanisms of change, Luo and McAloon (2021) note that research delineating components of effective psychological therapy for autistic children is limited.

To date, much of the qualitative evidence base regarding parents' interactions with UK services for autistic children has focused on either experience of the ASD diagnostic process (Legg & Tickle, 2019) or service access (Babalola et al., 2024). Similar trends are apparent globally (Boshoff et al., 2021; Naicker et al., 2023; Smith-Young et al., 2025), while parents' experiences of ASD assessment processes (Howes et al., 2021), stigma (Mitter et al., 2019), and providing care (Corcoran et al., 2015; DePape & Lindsay, 2014) have also been explored further afield. However, while the quality of support provided by relevant UK services has long been criticised (Read & Schofield, 2010; Tissot, 2011), no review to date has summarised parents' perspectives on interventions provided to their autistic children.

This review therefore seeks to capture UK parents' experiences of therapeutic interventions for their autistic children throughout the last two decades. It aims to, using a meta-synthetic approach, collate qualitative data of UK parents' perspectives regarding such interventions and describe overarching themes found in this literature.

Method

Given markedly increased rates of diagnosis and assessment in the twenty years preceding this study (NHS England, 2023), this review examines studies published from 2004 onwards to ensure that themes elucidated reflect the modern clinical context.

Reflexivity

Prior to establishing search criteria, a bracketing interview between the main researcher and their research supervisor was held. This interview explored potential biases, assumptions and beliefs held by both researchers. The main researcher contextualised themselves within this research as a sibling of an autistic young person with experience navigating support services, as an immigrant, and as a psychological practitioner with therapeutic relationships with autistic youths and published research in the subject area (Kerr et al., 2023).

Inclusion Criteria

Articles for inclusion comprised studies with qualitative data depicting the perspectives, experiences, or perceptions of UK-based parents of autistic children regarding interventions aimed at supporting the young person psychologically, whether parent-,child-, or family-focussed. Psychological support was deemed any support related to mental health, communication, behaviour or sensory integration. For the purposes of this study, autism was characterised in line with the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition; this included diagnoses of Autism Spectrum Condition, Asperger's Syndrome, autistic disorder and pervasive developmental disorder not otherwise specified. Studies using the International Classification of Diseases, 11th revision or parental confirmation of autism diagnosis were also deemed acceptable for inclusion.

Exclusion Criteria

Articles excluded were those not translated to English, those published before 2004, those based outside the United Kingdom, those with quantitative analysis only, those that focused on interventions received by autistic offspring in adulthood, those that mentioned neurodiversity or developmental disorder but did not specify autism, those with parents of young people solely with learning disabilities, and those solely featuring the perspectives of parents with regard to siblings of autistic children.

Search Strategy and Screening Process

This review was prospectively registered on Prospero by the main researcher (registration number CRD42023461840). Six databases were searched from 2004 up to 2025 for articles involving parents' perspectives on psychological interventions for their children with autism. Scopus, PubMed, PsychInfo and Ovid Medline were the databases outlined in Prospero registration from the dates 2000-2025; following consultation with an expert librarian, the databases EMBASE, Web of Science, Applied Social Sciences and CINAHL were also included (see Appendix 1.2 for search terms). The date range of included studies was also amended based on librarian advice. The main researcher also manually searched Google Scholar and relevant reference lists for additional potentially eligible articles. Following removal of article duplicates, titles and abstracts were screened by the main researcher.

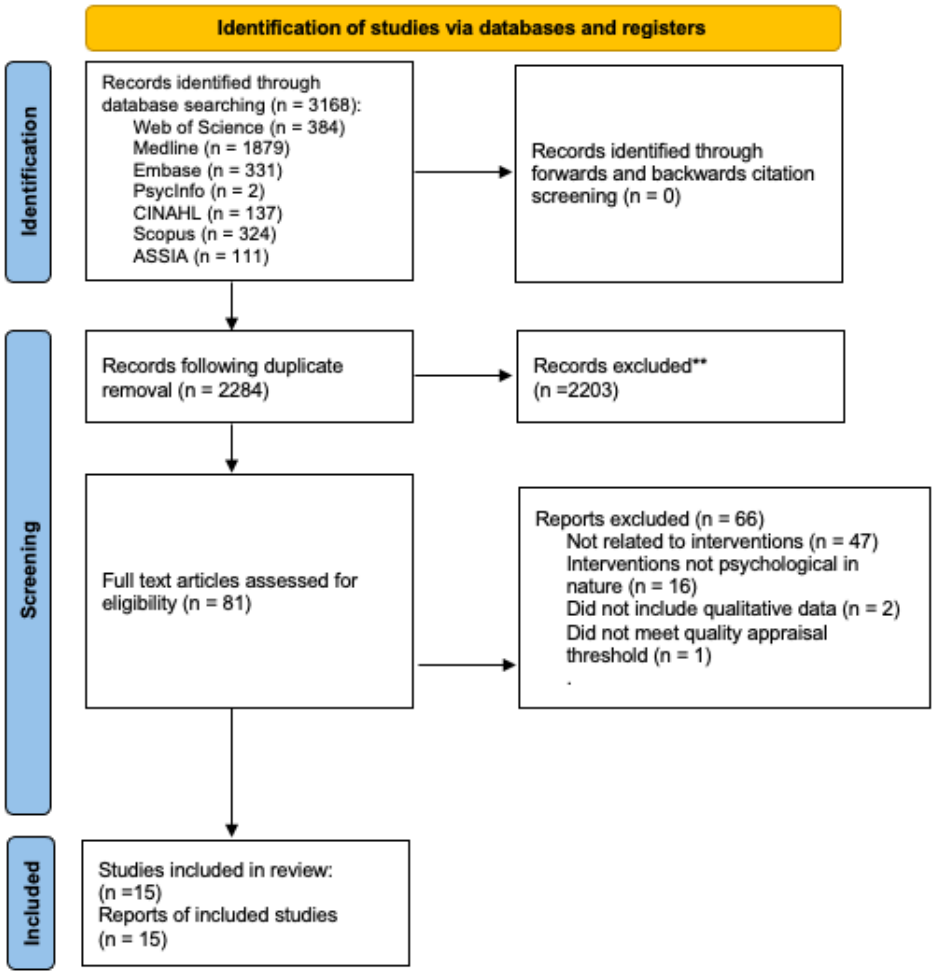
A Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) flowchart depicts the review process (see Figure 1). The combined electronic database searches retrieved 3168 results. Following removal of duplicates, 2284 papers remained. All titles and abstracts were reviewed by the first author. Of these, 20.77% (658 papers) were

also screened by a second reviewer (Cohen's k = 1). If papers did not meet inclusion criteria, they were excluded from further review. This excluded 2203 papers.

The full text of eighty-one papers was screened by the first author. Of these, 44.44% (36 papers) were screened by the second reviewer (k = 1). From full-text review, a further sixty-six were excluded. Another reviewer (a Clinical Psychologist experienced in working with parents of autistic children) reviewed the final fifteen papers to verify eligibility, ensure credibility and increase rigour.

Figure 1

Systematic Review Search and Screening Process based on the PRISMA 2020 Statement



Data Extraction

Relevant information extracted included title, author, publication year, origin country, type and length of intervention, sample size, methods of data collection and data analysis, and themes. Additionally, all qualitative data was extracted; this information served as data for this study's thematic synthesis.

Quality Assessment

Studies' methodological quality were established using the qualitative component of the Standard Quality Assessment Criteria for Evaluating Primary Research Papers from a Variety Of Fields, or 'QualSyst' (Kmet et al., 2004). This tool was chosen for its' applicability to a range of study designs and analytic approaches. Papers were individually evaluated against the tool's checklist to analyse risk of bias, and quality scores were attributed accordingly. First author and co-rater independently conducted quality appraisals for all included studies. Fair agreement between the two reviewers, k =0.34, 95% CI .059 to .619, p<.001, was initially found. The first author and co-rater then clarified interpretation of each criterion, discussed each study and collaboratively reviewed each criterion separately. Following this, perfect agreement (k =1) was found.

Data Synthesis

Fifteen papers were reviewed following a meta-synthetical approach, as described by Lachal et al. (2017). Meta-syntheses facilitate deep and broad explorations of phenomena by converging disparate findings on the subject matter (Hoon, 2013), supporting this study's aim to establish parents' overarching lived experiences of their autistic children's receipt of psychological intervention.

Each study was first actively read, before line-by-line coding was conducted on the full qualitative segments of each included study. These codes were then grouped into hierarchal structures before analytical themes were then generated. The first author discussed their perceptual biases and opinions in regular supervision.

Results

Study Information

Results included fifteen papers published between 2004-2025. Methods of data collection included semi-structured interviews (9), questionnaire items (3), and focus groups (3). Sample sizes varied from eight to 120. Type of interventions included psychoeducation (6), behavioural (2), communication (3), mental health (3) and sensory integration (1). They ranged from 3-26 weeks in length. Participants were predominantly recruited from the service in which research was being conducted.

Quality Appraisal

None of the studies included in this review achieved maximum scores using the Standard Quality Assessment Criteria for Evaluating Primary Research Papers from a Variety of Fields (Kmet et al., 2004). Table 1 displays item-by-item appraisal of each study.

Table 1

Item-by-item study appraisal.

Study	Objective Described	Design Evident	Context Clear	Literature Connection	Sampling Outlined	Data Collection Outlined	Analysis Described	Verification Procedures	Conclusions Supported	Reflexivity	Total
Trudgeon and Carr (2007)	2	1	2	1	0	1	2	2	2	0	13
Grindle et al. (2009)	2	1	1	1	1	2	2	2	2	0	14
McConachie et al. (2014)	2	2	2	1	1	1	1	2	0	0	12
Cutress and Muncer (2014)	2	1	2	1	2	1	2	2	2	1	16
McAleese et al. (2014)	2	2	1	1	2	2	2	0	2	0	14
Peckett et al. (2016)	2	1	1	1	1	2	1	2	2	2	15
Hodgson et al. (2018)	2	2	1	1	0	2	2	2	1	0	13
Jackson et al. (2020)	2	2	2	1	1	2	2	2	2	2	18
Leadbitter et al. (2020)	2	2	2	2	2	2	2	2	2	1	19
Palmer et al. (2020)	2	2	2	1	1	2	1	2	1	2	16
Rodgers et al. (2023)	2	2	1	1	1	1	1	2	1	0	12
Leadbitter et al. (2024)	2	2	2	2	1	1	2	2	1	0	15

Pettitt (2024)	2	2	2	1	2	2	2	2	2	2	19
Randell et al. (2024)	1	2	2	1	1	1	2	2	1	0	13
Ashworth et al. (2025)	2	2	2	1	1	2	2	0	2	1	15

Most studies featured sufficiently described objectives, while a majority featured evident and appropriate study designs and were contextualised clearly. All studies were at least partially connected to a wider body of knowledge; however, just two were deemed sufficiently connected to a theoretical framework. Descriptions and justifications of sampling strategy varied, and was completely absent in two studies. Data collection and analysis methods were described clearly and systematically in a majority of studies and was at least partially evident in all studies included. While a majority of studies described using verification procedures, there was none described in two. All studies at least partially offered conclusions substantiated in their results. Seven of fifteen studies were deemed to not offer reflexive accounts – of those remaining, a further three were deemed partially reflexive.

Eight studies were considered of high quality, five medium quality, and two low quality. One study - Roberts and Pickering (2010) – was excluded as it did not meet the minimum threshold of 55% suggested by Kmet et al. (2004). A summary of studies and their quality is included in Table 2.

Table 2

Characteristics of studies included

Author(s)	Year	Published	Intervention Type	Intervention Length	Sample Size (n)	Study Type	Data Collection Methods	Analytical Framework	Main Themes	Study Quality
Trudgeon & Carr	2007	Yes	Early Intensive Behavioural Interventions	Varied	16	Qualitative	Semi-structured interviews	Grounded Theory	Search for Treatment; Establishing ABA Programme; Insights; Impacts; Perceived Support Needs	13
Grindle, Kovshoff, Hastings et al	2009	Yes	Home-based ABA Programme	2 years	53	Qualitative	Semi-structured interviews	Content Analysis	Practical benefits; practical difficulties; impact of EIBI on family relationships; emotional impact of EIBI; overall evaluation of EIBI	14
McConachie et al.	2014	Yes	Group CBT for anxiety	7 sessions	10	Mixed-methods	Semi-structured interviews	Thematic Analysis	Acceptability of Intervention	12
Cuttress & Muncer	2014	Yes	Psychoeducational Parent Group	10 weeks	120	Qualitative	Questionnaire	Content Analysis	Learning about autism, learning about communication, learning about behaviour, messages for others	16
McAleese, Lavery & Dyer	2014	Yes	Psychoeducational Parent Group	3 sessions	83	Mixed-methods	Questionnaire	Thematic Analysis	General positive talk; felt security and support; timeframes; workshop content and application	14
Peckett, MacCallum & Knibbs	2016	Yes	Social Communication Therapy	6 sessions	15	Qualitative	Semi-structured interviews	Interpretive Phenomenological Analysis (IPA)	Communication; new perspectives; more appreciative/interactive sibling relationships; ASC and Lego Therapy fit; Child specific Developments/ barriers (time, ambivalence)	15

Hodgson, Grahame, Garland et al	2018	Yes	Psychoeducational Parent Group	8 weeks	14	Qualitative	Focus Groups	Framework Analysis	Experiences of participating in a RCT, opinions about the intervention and the impact of the intervention on the participants, their children and the family.	13
Jackson, Keville & Ludlow	2020	Yes	Child and Adolescent Mental Health Services	Varied	7	Qualitative	Semi-structured interviews	IPA	Psychological impact on caregiver, negative access experience, relationship breakdown with professionals	18
Leadbitter, Macdonald, Taylor et al	2020	Yes	Paediatric Autism Communication Therapy	18 sessions	18	Qualitative	Semi-structured interviews	Thematic Analysis	Backdrop to therapy, therapeutic process, practical challenges, therapeutic outcomes	19
Palmer, Cáceres, Tarver et al	2020	Yes	Psychoeducational Parent Group	8 sessions	17	Mixed-methods	Semi-structured interviews	Thematic Analysis	Increased knowledge; improvements in stress and wellbeing; supportive environments; changes in children; relevance of content; additional content; ideal group size; lack of time	15
Rodgers, Goodwin, Garland et al	2023	Yes	Parent-Supported Group Mental Health Intervention	8 weeks	50	Mixed-methods	Semi-structured interviews	Thematic Analysis	Acceptability; impact	12
Leadbitter, Harrison, Langhorne et al	2024	Yes	Psychoeducational Parent Group	5 weeks	24	Mixed-methods	Semi-structured interviews & Focus Group	Thematic Analysis	Broad acceptability, accessibility issues, perceived benefits	15
Pettitt	2024	No	Family-Based Treatment for Anorexia Nervosa	Varied	13	Qualitative	Semi-structured interviews	Abductive Framework Analysis	Interplay between ASC and current treatment methods; Relational aspects of treatment; Issues encountered during treatment and recovery	18

Randell, McNamara, Busse et al	2024	Yes	Sensory Integration Therapy	26 weeks	30	Mixed-methods	Semi-structured interviews	Framework Approach	Overall experience; trial info; completing measures/assessments	13
Ashworth, Bray, Hanlon et al	2025	Yes	Child and Adolescent Mental Health Services	Varied	300	Mixed-methods	Survey	Content Analysis	Experiencing mental health difficulties; seeking mental health support; first CAMHS appointment; provision of support	15

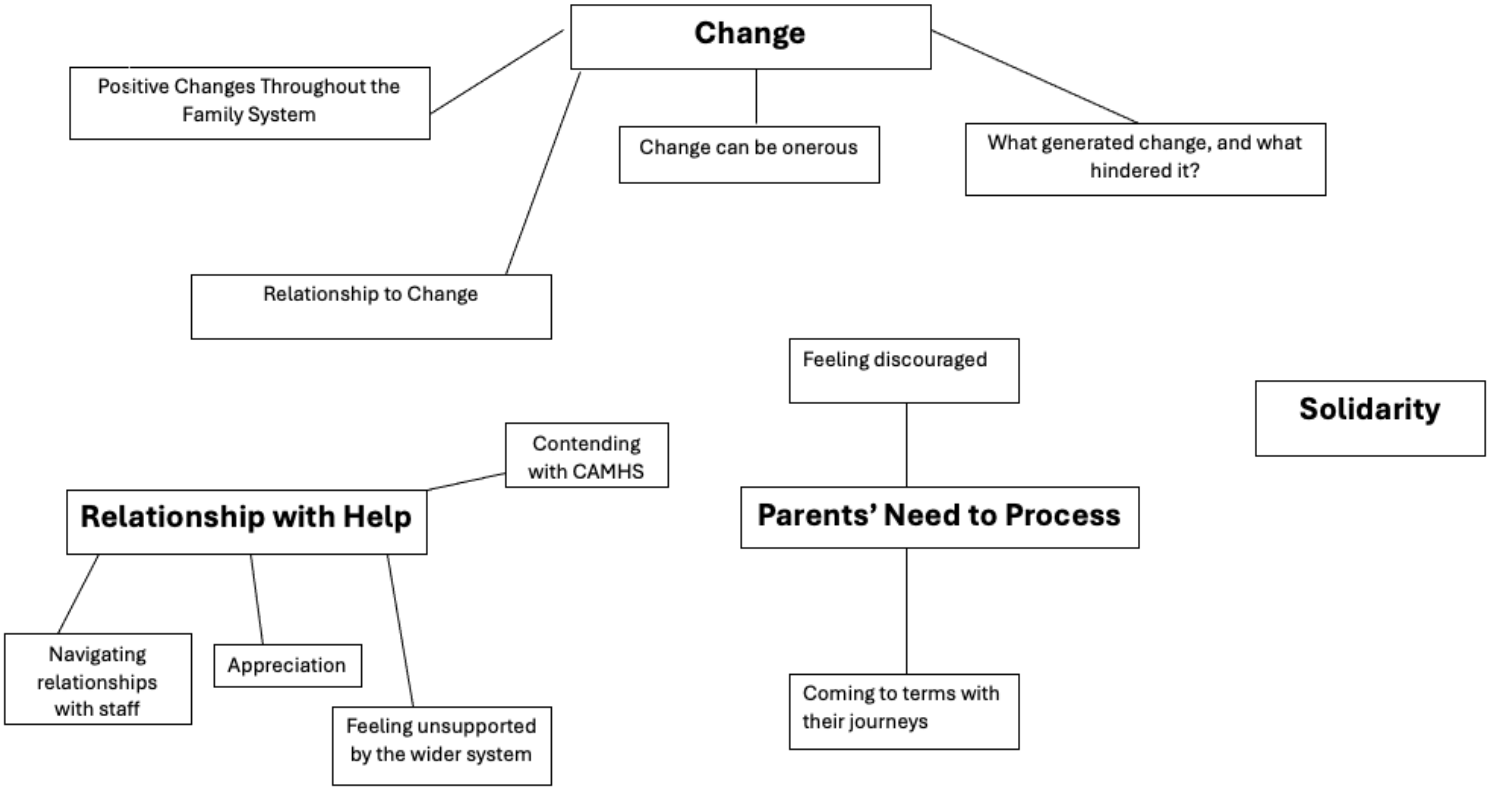
** One study was excluded as it did not meet minimum quality thresholds*

Meta-Synthesis

Four themes were developed through meta-synthesis; change, relationship with help, parents' need to process, and solidarity (see Figure 2).

Figure 2

Thematic Map



Theme 1 – Change

Eight of fifteen studies contributed to the development of this theme. Of these, four were deemed high quality (Cutress & Muncer, 2014; Leadbitter et al., 2020; Peckett et al., 2016; Pettitt, 2024), three medium quality (Hodgson et al., 2018; McAleese et al., 2014; Trudgeon & Carr, 2007), and one low quality (McConachie et al., 2014).

Positive Changes Throughout The Family System. Nearly all of the papers included in this review explored the variety of positive changes invoked through participation in the

interventions offered. Many of these were *positive changes for the autistic child*, including improved capacity to communicate with others, greater social integration, better awareness of their own behaviour and enhanced emotional regulation skills. As one parent reflected, "he has really been able to tell you what's going on. Before, his anxiety would have been massive" (McConachie et al., 2014). *Positive changes for parents* were also apparent throughout; they described increased optimism regarding their child's prospects, more confidence in supporting their child appropriately, having improved wellbeing and social connectivity, and better capacity to manage difficult emotions regarding parenthood. *Positive Changes in Family Relationships* were relayed by many parents. This could include relationships between siblings who were often typically developing; parents reported their children were "squabbling less", and the autistic child being seen "in a more positive way" (Peckett et al., 2016). Some parents described positive developments in their marriages; drawn "closer together as a couple", or by making partners "more aware of the way you speak and how you convey information" (Peckett et al., 2016; Trudgeon & Carr, 2007). An improved capacity to partake in endeavours as a familial unit was discussed in several papers (Peckett et al., 2016; Trudgeon & Carr, 2007); for example, improvements brought about by interventions facilitated relational activities ranging from play ("we tend to avoid confrontation and we tend to split them up, and I think doing this now, I realise that it's not always necessary."), to social outings ("now we are able to go out and do the things as a family that were so restricted in before."), to family holidays ("I think it's the autism that affects plans for a holiday. In the past he used to get so upset with change but now it's not such an issue"). Closer dyadic relationships between parents and autistic children were explored in many of the studies included; as one parent described it, "I have always loved my son… but I fell in love with him after this"(Leadbitter et al., 2020). Many studies attributed this greater closeness to a clearer understanding of their child; whether better recognising

their emotions and reacting appropriately ("I now realise I used to think X was being naughty and tell him off ... if he gets upset/anxious I react differently now."), greater capacity to take their child's perspective "I put my eyes behind [child's name]'s eyes and I just imagine for a minute that I am in [child's name]'s little head and try and look at it from his angle . . . and you probably react totally different to the way you would initially react, because you have looked at it from his point of view.") or having more constructive attitudes towards their child's difficulties ("he's always going to have these challenges, it's more how you adapt around him, how you deal with that, rather than making it go away.") (Cutress & Muncer, 2014; Hodgson et al., 2018; Leadbitter et al., 2020).

What Generated Change – and what hindered it? Most papers explored the components of interventions that acted as barriers and facilitators to change for the autistic child and their family. Various *facilitators of change* were discussed across the studies. Learning new things was commonly described as conducive to improvements; whether that was how to become more aware of one's own behaviour, using techniques such as Icebergs or social stories, developing greater understanding of non-verbal communication, or the importance of routine to their autistic child. Structure was another component parents viewed as beneficial in various elements of the interventions they participated in; this could entail receiving sufficient information regarding the intervention prior to beginning, knowing clear rules regarding homework, or being given clear explanations as to why a task may be beneficial. Relatedly, rigour was received positively across various studies; while the intensity of intervention workloads could be high, they were ultimately viewed positively for that very reason, as one parent explained: "It was like you was being analysed, everything you'd just done, was like she was like ripping it all to bits and putting it in little [chunks], and I didn't like that, but it was good in the end"(Leadbitter et al., 2020). Parents reflected that

their own high level of commitment was conducive to the change generated by interventions: “I think if we hadn’t have done that, I think the homework and stuff, that you wouldn’t have got very much out of the course”(Hodgson et al., 2018). *Empowerment* was also highlighted as an ingredient of success; knowing that you are taking a constructive approach can instil confidence, as a parent conducting EIBI explained: “I think parents who are involved in this type of programme are more empowered... and I think it takes a lot of the anxiety away”(Trudgeon & Carr, 2007). Conversely, various *delivery issues* were also identified. Factors such as therapist unavailability, or lack of clarity from intervention providers, caused issues for parents; studies featured setbacks such as participants not being told what group their child was in, not knowing what the role of involved professionals were, or professionals not attending all relevant meetings. While learning was viewed as important, parents were sometimes frustrated by low quality of learning material, such as the parent reporting that the “stuff we got was a bit late and it just, it just wasn’t that good… I found it a little bit airy fairy…”(Pettitt, 2024). Additionally, the issue of *biased selection* was raised by one parent, who mused “they can pick and choose whether they want children in their programme… maybe it's easier to choose easier children”(Pettitt, 2024).

Change can be onerous. Across each study, differing perspectives on the demands placed on parents by intervention participation were explored. *Intensive workloads* were sometimes reported by parents; these ranged from completing long questionnaires, to videotaping their child’s behaviours, to managing therapy teams during home-based treatments. As one parent summarised, “...as the weeks go on you need more and more things – copying the recording sheets, preparing for workshops, getting pictures together of things to teach the child, it can all take a lot of time.” (Trudgeon & Carr, 2007). *Logistical burdens,* such as time commitment and the travel required to access treatment, were also

commonplace across studies; these challenges were compounded by the additional needs of their children. One parent explained: “I just felt the sessions were a bit long… they could be an hour and a half. . . it’s just [child’s name] is very on the go, so it’s quite difficult” while another noted “He didn’t like the small [therapy] room . . . he started, like, screaming and not wanting to go in . . .” (Leadbitter et al., 2020). Some parents reported *implementation challenges* between sessions; these included children’s outbursts disrupting parents’ strategies, parents not having sufficient time to take notes required for future sessions, or finding homework emotionally difficult to complete as it involved focussing on aspects of their child they found negative. Furthermore, parents did not always appreciate the rigidity of treatment plans; as one mother remarked, “it's not one thing's gonna fit all. It's not gonna fit every single family” (Pettitt, 2024).

Relationship to Change. How participating parents viewed change varied across studies. Many parents wished that *change could have happened sooner*; as one parent noted, “when we heard the news, we were left to deal with it… this would have helped greatly”(McAleese et al., 2014). The entrenchment of unhelpful approaches to supporting their autistic child, the solitude parents felt in supporting their autistic child through their struggles, and the anxiety felt by their children without appropriate support were all offered as examples of challenges avoidable through quicker intervention. Throughout interventions, some parents *wanted change quicker*, frustrated when presenting problems were not rapidly resolved. One parent reflected they had believed “they’re going to give me some miracle potion or something”(Leadbitter et al., 2020). Some were *unsure whether change resulted from intervention*, noting that while their child was in a better place, it was unclear whether that development could be attributed to the intervention offered; for instance, one parent noted “he started to talk, so that was a big thing – but that could have been his age”, while

another engaging in Lego Therapy mused that positive change was "probably a combination of him being generally happier and… maybe the Lego"(Leadbitter et al., 2020; Peckett et al., 2016). Reflections on *maintaining change* arose in several papers; while some reported that change had been sustained following interventions' conclusion, others reported struggling to continue implementing strategies practiced during intervention. As one described, "it's just because you let things [go], whereas you were going there you had to keep doing like your little bits of things that you were doing, you sort of slide out of that a little bit now"(Leadbitter et al., 2020). Others found it difficult to maintain changes given the difficulties their children faced at the time of intervention; one parent reflected that "given the circumstances, if the circumstances had been different, and [name] hadn't been going through his issues, it probably would have had a bigger impact"(Peckett et al., 2016).

Theme 2 – Relationship with Help

Seven of fifteen studies contributed to this theme's development; of these, four were deemed high quality (Ashworth et al., 2025; Jackson et al., 2020; Leadbitter et al., 2020; Pettitt, 2024), two medium quality (Grindle et al., 2009; Trudgeon & Carr, 2007), and one low quality (Rodgers et al., 2019).

Navigating relationships with staff. Many papers explored the relationship between the parents receiving interventions and the staff delivering them. Some parents described resolute emotional support from therapists or facilitators. As one described, "the speech therapist, she was lovely, she was absolutely fantastic… it was difficult . . . and she saw how difficult it was." (Leadbitter et al., 2020). In several studies, parents celebrated affirmative, nurturing and supportive environments cultivated by staff, which for some, marked a change from previous experiences of supporting their child in solitude: "Initially it felt like a huge support as previously I had been left at home to manage him alone and there was so little you

could do with him"(Trudgeon & Carr, 2007). Some parents described positive relationships with staff, but struggled with their intensive nature in the context of the interventions. As one summarised, "We trust them implicitly, but at the same time, you don't want your best friend with you all the time do you?"(Trudgeon & Carr, 2007).

Appreciation. Across many of the studies included, parents expressed their gratitude for the work invested into the interventions offered. Having therapists with specialist insight was described by one parent as "a gift"(Rodgers et al., 2019), while another offered effusive praise for staff members offering guidance. Nearly half of the studies included offered parents' explicit endorsement of the interventions they participated in.

Feeling unsupported by the wider system. Conversely, various parents described experiencing a lack of support from at least one component of the care systems designed to support their autistic child. Parents described experiencing a desperation from support throughout their autistic child's upbringing – as one mother explained, "I just feel like I've been banging my head against a wall actually I'm going around in circles I keep being sent back to where we started, and they say, no we can't help, so on to the next bit who then send us back. No one listens"(Jackson et al., 2020). Some noted a lack of support from their child's school, with one parent outlining that "schools need to be much more aware, flexible and understanding of needs" (Ashworth et al., 2025). For others, local authorities denied them important funding. Some found support systems rigid; as one parent described, "If you wanted to do anything that was outside of this little box it was like 'Oh no, we can't let you do that'"(Grindle et al., 2009). Others felt desolate in their isolation – one parent recalled thinking "I thought I can't manage this on my own anymore", while another lamented that professionals seemed to not understand the extent of their autistic child's difficulties: : "you

have had a child who has been hysterically sobbing and banging their head against the wall or harming themselves or wanting to throw themselves out of the window. Do you know what that's like…I don't think they do"(Jackson et al., 2020; Pettitt, 2024). The sense of needing to prove that support was required proved frustrating for parents across many of the studies; as one father summarised, "You always have to justify yourself. (Trudgeon & Carr, 2007)"

Contending with CAMHS

Several studies depicted parents' struggles to access adequate mental health treatment for their autistic child from CAMHS. In these studies, parents described long waits for their child's treatment. Parents' sense of impending crisis was prevalent in such studies; one reflected that "you just sit on lists until things get so bad they have to help, or they're too late and another young person loses their life" while another recalled thinking "I need the help now …what do I do now? How do I get through these next few months?"(Ashworth et al., 2025; Jackson et al., 2020). Alongside such waits, parents reported grappling with high diagnostic thresholds that sometimes excluded autistic children entirely. One parent reported a service wouldn't see their child "because she's autistic so we had 6 months of them arguing between themselves", while another was told that a CAMHS service "don't deal with autistic children"(Ashworth et al., 2025; Jackson et al., 2020). Several reported that treatment was offered only at crisis point; parents reported being "told she doesn't meet the criteria as she isn't in crisis or harming herself", another reflected that "it's not until you become critical that you actually get some help" and a third said they were "only listened to when the self-harm and risk of suicide escalated."(Ashworth et al., 2025; Pettitt, 2024). Parents' perceptions of their child's mental health treatment varied. Some described positive experiences; one mother reflected that her child "made a real brilliant recovery, which is maybe testament to family based therapy", while another described CAMHS staff as "the first professionals who

actually identified the real problem and solution"(Ashworth et al., 2025; Pettitt, 2024). Others, however, described less helpful encounters; for instance, one parent described a clinician as "very text book, very wooden… it almost felt like she was going home and reading up on CBT strategies"(Jackson et al., 2020). Lack of accommodation for autistic children was described in several studies; one parent stated that their "daughter was forced into a meltdown when the nurse asked around 50 direct questions on the first appointment despite [them] explaining she wouldn't cope.", while treatment environments were not always hospitable to sensory differences, as summarised by another parent: "being in a different room each time and very noisy building. She'd be… distracted with people walking past." (Ashworth et al., 2025; Pettitt, 2024). These studies included recommendations for service improvement. These included screening for autism in CAMHS: "anybody who goes to CAMHS, the minute they hit their system they should be looking at that", offering support immediately following diagnosis: "there is nothing post-diagnosis which is awful… there should be a separate mental health/autism team who support families once diagnosed!!", alternative therapeutic approaches: "CAMHS causing more harm by offering therapies which are inappropriate e.g. CBT, DBT, PBS – There needs to be … therapies to let them express freely, not made to conform" and simply validating difficult experiences: "Please, just acknowledge there's an issue"(Ashworth et al., 2025; Jackson et al., 2020; Pettitt, 2024).

Theme 3 – Parents' Need To Process

Five of fifteen studies contributed to this theme's development. Three were deemed high quality (Jackson et al., 2020; Leadbitter et al., 2020; Palmer et al., 2020) and two medium quality (Grindle et al., 2009; Trudgeon & Carr, 2007).

Feeling discouraged. Various parents reported difficult feelings that arose throughout interventions. For some, life got in the way of their participation, such as the mother who

reported “I was trying to work as well and I don’t have much time for it.”(Palmer et al., 2020). Some reported waning motivation as the intervention progressed; one explained “My feelings of motivation fluctuate all the time. Sometimes I get very depressed about the whole thing” (Grindle et al., 2009). For those who did not find the success they were hoping for their child, disappointment was difficult to process; as one shared, “we were hoping his speech would have improved with the intervention, but it didn’t.. . . it just hasn’t really happened”. (Leadbitter et al., 2020). In one study, guilt was rife as parents reflected on their children’s distress, worrying that they had allowed it to escalate. These parents shared sentiments such as “I didn’t know if I’d done something to make it worse”, “I feel I really missed the boat” and, in reflecting on how they approached support from services, “I think I was naïve and just trusted I would be told about all these services that were on offer… I should have pushed not just accepted”(Jackson et al., 2020).

Coming to terms with their journeys. Various parents described the impact raising autistic children had had on their personal lives, and their personal processes of accepting the difficulties accompanying their differences. Some missed opportunities to further themselves professionally: “It’s had more of an impact on my career... I really wanted to do a Master’s and stuff, but the reality of trying to do that and cope with (name)...”(Trudgeon & Carr, 2007). Some parents withdrew socially: “We used to stop going places because we couldn’t take (child’s name)” (Trudgeon & Carr, 2007). Some witnessed the deterioration of their child’s mental health, and experienced their own distress as a result; one mother described being on the “verge of a nervous breakdown” as a result of her child’s anxiety (Jackson et al., 2020). For some parents, participating in their intervention invoked acceptance, as their child did not make the progress they had hoped. One described this realisation as “grieving for the loss of the child we thought we were going to have”(Leadbitter et al., 2020).

Theme 4 – Solidarity

Of five studies contributing to this theme, two were deemed high quality (Ashworth et al., 2025; Cutress & Muncer, 2014), one medium quality (Hodgson et al., 2018), and two low quality (McConachie et al., 2014; Rodgers et al., 2019).

Most papers explored the unique bonds forged in shared journeys by participating parents. As one explained, "As a parent of a newly diagnosed child with autism it is ideal to meet others in the same situation"(Cutress & Muncer, 2014)– parents were able to receive both practically useful advice, and emotional validation from others who understood their particular struggles. Remarks such as "it was nice to say what you wanted without judgement" capture the felt sense relief of parents to share space with others who understood the particular lens they viewed the world through given the unique challenges of raising autistic children (Rodgers et al., 2019). This sense of connectivity was not always felt in day-to-day life, as another parent explained: "It was nice to talk to other people as well who understood what you were going through, any other parent that, like in the school playground, that you talk to who isn't in same position as yourself don't understand. . . when you're trying to talk about your children with these people the things are so different between the children"(Hodgson et al., 2018). Parents across studies explained that these shared spaces facilitated their coming to terms with diagnoses, helped them work out practical solutions, and help them develop good role models for their own unique parenting journeys. Parents identified that their children could benefit from similar shared spaces: "we wouldn't have a child with this level of anxiety if they had met peers who were similar to them... They'd feel less lonely and their anxiety would be reduced. They'd be more independent and have improved self-esteem."(Ashworth et al., 2025). Parents whose child participated in interventions reported witnessing similar solidarity in these peer groups – as one parent

explained, their child “felt he could be himself and he actually said that it was nice to meet other kids just like him. He didn’t have to act differently” (McConachie et al., 2014).

Discussion

This review sought to synthesise the experiences of parents receiving interventions aimed at supporting their autistic children in the United Kingdom from 2004-2024. The qualitative results and quality of fifteen studies were explored in this review. Quality appraisal established that eight of these studies were of high quality, five medium quality, and two low quality. Results capture components of parents’ experiences that may offer useful insights for those designing future interventions for such parents.

Interpretation and Implications

The current review captured parents’ descriptions of the positive changes they experienced due to the interventions they participated in. Facilitators of positive change included learning, structure, rigour and a sense of empowerment, while identified barriers included delivery issues and unhelpful information. Such results can be interpreted with greater confidence given that the majority of studies informing the theme of parents’ relationship with change were of high quality. Parents’ reporting of positive change corroborates various quantitative reviews & meta-analyses reporting varying degrees of effectiveness of parent groups for autistic children, particularly improvements for parents, children and parent-child relationships (Deb et al., 2020; Gerow et al., 2018; Li et al., 2024; O’Donovan et al., 2019; Oono et al., 2013). It is perhaps notable that the evidence base substantiating such reported effectiveness has been found lacking, particularly outside the United States; heterogeneity of intervention content, outcome measurement and design, plus low reported study quality, complicate conclusions regarding the effectiveness and

generalisability of quantitative papers in this area (Dawson-Squibb et al., 2020; Deb et al., 2020; O'Donovan et al., 2019). Accounting for one excluded study, this review offers the novel finding that half of qualitative studies exploring this topic in UK contexts are of high quality.

Findings regarding the sense of solidarity across the interventions reviewed echo literature extolling the benefits of mutual parental support in this population, including a sense of belonging, benefiting from practical insight, and emotional support (Gillberg et al., 2024; Lee et al., 2024). However, despite these identified benefits, and substantive literature consistently describing parents' experiences (Batchelor et al., 2021; Meadan et al., 2010; Moody et al., 2019; Shilling et al., 2013), exploration of how interventions for parents of autistic children can best facilitate such solidarity is scant in literature. While the quality of studies describing parents' experiences of solidarity varied, its' identification in several high-quality studies suggest that the concept warrants further investigation as an intervention component.

Parents' exploration of the complex emotional process involved in supporting their autistic child's mental health was outlined in a third of papers, all of which were high or medium quality. The emotional processes described by parents in the reflective spaces that interventions offered are similar to the construct of "resolution" as described by Naicker et al. (2023): understanding an autistic child's diagnosis and its' implications on parents' schemas of their child. This phenomenon involves adjusting expectations to fit with the reality of raising an autistic child and accept the consequent emotional journey (Da Paz et al., 2018; Milshtein et al., 2010). Descriptions of frustration and sacrifice across the studies included in this review are echoed in systematic review of factors related to parental resolution of ASD

diagnoses (Naicker et al., 2023). To date, however, no intervention in literature has explicitly aimed to support parental resolution; one study has explored its' association with intervention fidelity (Grogan et al., 2023).

Relationships between parents of autistic children and relevant service providers are well documented in research (Hodgetts et al., 2013; Samsell et al., 2022; Sperry et al., 1999). The opposing paradigms of unsupportive wider systems and appreciation discussed across the fifteen studies reviewed are reflected in wider literature; systematic reviews chronicle both the importance of support from diverse services (Wallace-Watkin et al., 2023) and the positive effects of good interactions with professionals on future provider relationships (Boshoff et al., 2018). Of the studies included in this review, most informing this theme were deemed high quality and thus offer appropriate findings with which to inform future innovations by clinicians. Given the notable expertise parents wield through seeking appropriate interventions for their autistic children (Edwards et al., 2018), co-production could facilitate design of interventions across diverse services by allowing parents direct input into the support such services provide. Early collaborative successes with mental health (Cullingham et al., 2024) and research bodies (Aabe et al., 2019) for parents of autistic children may offer insight into doing so – one study included in our review may be the first of its kind in the UK (Leadbitter et al., 2024).

Quality of Review Evidence

Methodological quality across included studies varied, with eight deemed high-quality, five medium-quality, and two low-quality. Most of the studies synthesised described objectives sufficiently, clearly explained their designs and contexts, detailed clear and systematic data collection and analytical processes, and used verification procedures. Given

the inherent subjectivity of qualitative research, applications of such methods strengthens the reliability of qualitative findings (Ahmed, 2024). Such rigour across included studies therefore benefits this review with relative transferability and dependability.

Notably, only three of fifteen studies were deemed to offer fully reflexive accounts. Reflexivity in qualitative research typically describes a researcher's process of situating their selves – including their contexts, their opinions and their biases – within the topic they are exploring (Braun & Clarke, 2021b). It is particularly important given current challenges in autism research, such as the ideological questions underpinning autism conceptually, the difficulties defining quality of life for autistic people, concerns regarding whether current understandings of autism are fit for purpose, ableism, and perceptions of social value pertaining to autism (Botha & Cage, 2022). Such reflective dialogue is important in ensuring practitioners engage with the support of autistic young people meaningfully (Horton et al., 2024). Given the relative lack of reflexivity described across the evidence base reviewed, readers should be mindful that many of the beliefs, values and methodological preferences informing data synthesised in this study are unclear. Future research would benefit from researchers' described introspection regarding parents, autism and therapeutic interventions.

While all studies at least partially contextualised their research within wider academic literature, only two of fifteen studies reviewed were deemed as connecting sufficiently to a theoretical framework. As Creswell and Clark (2017) explain, grounding research in theory is pivotal; outlining relevant theory ensures that constructs are defined and measured appropriately and consistently, and facilitates academic exploration of interventions' mechanisms of change. Given the variety of interventions across nearly two decades in our study, this synthesis lacks established theoretical coherence in exploring parents' shared

experiences of therapeutic interventions for autistic children. It is therefore encouraged that future research in this area underpin their research theoretically; doing so may support exploration of effective intervention components.

It is also notable that only half of selected studies were purely qualitative in design – the rest used mixed-methods approaches. In itself, this is not an issue – intervention mixed methods frameworks are often used in such research, with qualitative data sought to contextualise an interventions' factors and results relevant to its' outcome (Fetters et al., 2013). However, such approaches are advised to implement embedding processes into their study design, whereby qualitative data is used to inform interventions throughout data collection and analysis- for example, establishing appropriate measures, identifying contextual biases and explaining results (Fetters et al., 2013). None of the mixed-method studies in this review outlined embedding processes used in their research, suggesting missed opportunities to develop more enriched and rigorous interventions.

Limitations of the Review Process

The use of the Kmet et al. (2004) quality appraisal tool in this review is susceptible to critiques regarding the use of quality appraisal tools in qualitative research. Firstly, qualitative research spans a wide range of epistemological positions, ranging from relativism to critical realism – critiquing papers from such differing philosophical approaches indiscriminately arguably lacks nuance (Walsh & Downe, 2006). Furthermore, no criteria within the Kmet et al. (2004) tool explores rigor of data analysis, ethical considerations or saturation – elements all considered by other qualitative quality appraisal tools (Munthe-Kaas et al., 2019). Finally, quality appraisal tools in general raise questions regarding whether appraisal is based upon quality of research or quality of reporting methods; as Braun et al.

(2022) note, many studies describe themselves as using Thematic Analysis while not applying sufficient methodological rigour.

Furthermore, this review did not evaluate the effectiveness of interventions undertaken by participants of studies included. As O"Cathain et al. (2019) explain, intervention outcomes directly impact how phenomena such as experiences, mechanisms and relationships are described qualitatively; therefore, while this review captures parents' experiences of interventions, it did not account for how intervention effectiveness may have influenced themes. Future research could benefit from innovative approaches such as the juxtaposing of qualitative themes with quantitative outcomes, or Qualitative Comparative Analysis to link effect sizes to qualitative themes (Chandler et al., 2019).

Conclusion

Across fifteen studies in the period 2004-2025, hundreds of parents participated in qualitative research across the UK that aimed to capture their experiences of interventions supporting their autistic child. Our review found that these studies, when synthesised, portrayed themes of change, relationship to help, solidarity and reflective space. Study quality varied widely – future research would benefit from stronger theoretical links, more rigorous embedding processes and greater reflexivity displayed by researchers.

Practitioner Points

1. *Facilitating Positive Change*
    - 1.1. Offer substantive and novel learning opportunities.
    - 1.2. Design appropriately structured interventions with rigorous elements.
    - 1.3. Include opportunities for empowerment throughout interventions.
    - 1.4. Provide clarity regarding intervention processes.

1.5. Develop evidence-based inclusion & exclusion criteria and communicate these to parents in advance.

2. *Supporting Parent-Staff Relationships*

2.1. Parents consistently voiced appreciation for such interventions – continue to offer them.

2.2. Parents voiced appreciation for empathy and acknowledgement of the difficulties they experience navigating complex support systems by staff.

2.3. Consider means of supporting parents following their child's ASD diagnosis and parents waiting for interventions.

2.4. Should autistic children not meet inclusion criteria, cross-service signposting should be clearly communicated both to parents and between services.

2.5. Adapt intervention environments so that they are neurodiverse-friendly.

2.6. Co-produce interventions for parents of autistic children.

3. *Promoting Resolution and Solidarity*

3.1. Include reflective components in interventions that facilitate parental resolution of their child's autism.

3.2. Facilitate opportunities for connection, mutual validation, and practical support between parents.

References

Aabe, N. O., Fox, F., Rai, D., & Redwood, S. (2019). Inside, outside and in-between: the process and impact of co-producing knowledge about autism in a UK Somali community. *Health Expectations*, *22*(4), 752-760.

Anandaciva, S. (2023). How does the NHS compare to the health care systems of other countries? *King's Fund*.

Ashworth, E., Bray, L., Hanlon, C., Stanway, H., Pavlopoulou, G., Moore, D., Donaghy, B., Coen, E., & Firth, E. (2025). 'Accumulating harm and waiting for crisis': Parents' perspectives of accessing Child and Adolescent Mental Health Services for their autistic child experiencing mental health difficulties. *Autism*, *0*(0), 13623613251335715. https://doi.org/10.1177/13623613251335715

Aylaz, R., Yılmaz, U., & Polat, S. (2012). Effect of difficulties experienced by parents of autistic children on their sexual life: A qualitative study. *Sexuality and Disability*, *30*, 395-406.

Babalola, T., Sanguedolce, G., Dipper, L., & Botting, N. (2024). Barriers and Facilitators of Healthcare Access for Autistic Children in the UK: a Systematic Review. *Review Journal of Autism and Developmental Disorders*. https://doi.org/10.1007/s40489-023-00420-3

Batchelor, M., Maguire, S., & Shearn, J. (2021). "They just get it" an exploration of father's experiences and perceptions of a support group for men caring for children with disabilities and/or developmental delay. *J Appl Res Intellect Disabil*, *34*(1), 263-273. https://doi.org/10.1111/jar.12804

Bonis, S. (2016). Stress and parents of children with autism: A review of literature. *Issues in mental health nursing*, *37*(3), 153-163.

Boshoff, K., Bowen-Salter, H., Gibbs, D., Phillips, R. L., Porter, L., & Wiles, L. (2021). A meta-synthesis of how parents of children with autism describe their experience of accessing and using routine healthcare services for their children. *Health & Social Care in the Community*, *29*(6), 1668-1682. https://doi.org/https://doi.org/10.1111/hsc.13369

Boshoff, K., Gibbs, D., Phillips, R. L., Wiles, L., & Porter, L. (2018). Parents' voices: "Our process of advocating for our child with autism." A meta-synthesis of parents' perspectives. *Child Care Health Dev*, *44*(1), 147-160. https://doi.org/10.1111/cch.12504

Botha, M., & Cage, E. (2022). "Autism research is in crisis": A mixed method study of researcher's constructions of autistic people and autism research [Original Research]. *Frontiers in Psychology, Volume 13 - 2022*. https://doi.org/10.3389/fpsyg.2022.1050897

Braun, V., & Clarke, V. (2021). Thematic analysis: A practical guide.

Braun, V., Victoria, C., & and Hayfield, N. (2022). 'A starting point for your journey, not a map': Nikki Hayfield in conversation with Virginia Braun and Victoria Clarke about thematic analysis. *Qualitative Research in Psychology*, *19*(2), 424-445. https://doi.org/10.1080/14780887.2019.1670765

Brice, S., Rodgers, J., Ingham, B., Mason, D., Wilson, C., Freeston, M., Couteur, A. L., & Parr, J. R. (2021). The importance and availability of adjustments to improve access for autistic adults who need mental and physical healthcare: findings from UK surveys. *BMJ Open*, *11*(3), e043336. https://doi.org/10.1136/bmjopen-2020-043336

Cachia, R. L., Anderson, A., & Moore, D. W. (2016). Mindfulness, stress and well-being in parents of children with autism spectrum disorder: A systematic review. *Journal of Child and Family Studies*, *25*, 1-14.

Conrad, C. E., Rimestad, M. L., Rohde, J. F., Petersen, B. H., Korfitsen, C. B., Tarp, S., Cantio, C., Lauritsen, M. B., & Händel, M. N. (2021). Parent-mediated interventions for children and adolescents with autism spectrum disorders: a systematic review and meta-analysis. *Frontiers in Psychiatry*, *12*, 773604.

Cooper, K., Loades, M., & Russell, A. (2018). Adapting psychological therapies for autism. *Research in Autism Spectrum Disorders*, *45*, 43-50.

Corcoran, J., Berry, A., & Hill, S. (2015). The lived experience of US parents of children with autism spectrum disorders: A systematic review and meta-synthesis. *Journal of Intellectual Disabilities*, *19*(4), 356-366.

Crane, L., Batty, R., Adeyinka, H., Goddard, L., Henry, L. A., & Hill, E. L. (2018). Autism diagnosis in the United Kingdom: Perspectives of autistic adults, parents and professionals. *Journal of autism and developmental disorders*, *48*, 3761-3772.

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

Cullingham, T., Rennard, U., Creswell, C., Milton, D., Buckle, K. L., Godber, L., Gordon, K., Larkin, M., & Green, J. (2024). The process of co-design for a new anxiety intervention for autistic children. *Jcpp Advances*, e12255.

Cutress, A. L., & Muncer, S. J. (2014). Parents' views of the national autistic society's earlybird plus programme. *Autism*. https://www.scopus.com/inward/record.uri?eid=2-s2.0-84904615703&doi=10.1177%2f1362361313495718&partnerID=40&md5=9cb96add604a3d529272a6c6b25bc42e

Da Paz, N. S., Siegel, B., Coccia, M. A., & Epel, E. S. (2018). Acceptance or despair? Maternal adjustment to having a child diagnosed with autism. *Journal of Autism and Developmental Disorders*, *48*, 1971-1981.

Dawson-Squibb, J.-J., Davids, E. L., Harrison, A. J., Molony, M. A., & de Vries, P. J. (2020). Parent education and training for autism spectrum disorders: Scoping the evidence. *Autism*, *24*(1), 7-25.

Deb, S. S., Retzer, A., Roy, M., Acharya, R., Limbu, B., & Roy, A. (2020). The effectiveness of parent training for children with autism spectrum disorder: a systematic review and meta-analyses. *Bmc Psychiatry*, *20*(1), 583. https://doi.org/10.1186/s12888-020-02973-7

Denne, L. D., Hastings, R. P., & Hughes, J. C. (2017). UK parents' beliefs about applied behaviour analysis as an approach to autism education. *European Journal of Special Needs Education*, *32*(4), 543-555. https://doi.org/https://doi.org/10.1080/08856257.2017.1297568

DePape, A.-M., & Lindsay, S. (2014). Parents' Experiences of Caring for a Child With Autism Spectrum Disorder. *Qualitative Health Research*, *25*(4), 569-583. https://doi.org/10.1177/1049732314552455

Edwards, A. G., Brebner, C. M., McCormack, P. F., & MacDougall, C. J. (2018). From 'parent'to 'expert': How parents of children with autism spectrum disorder make decisions about which intervention approaches to access. *Journal of Autism and Developmental Disorders*, *48*, 2122-2138.

Falk, N. H., Norris, K., & Quinn, M. G. (2014). The factors predicting stress, anxiety and depression in the parents of children with autism. *Journal of autism and developmental disorders*, *44*, 3185-3203.

Fetters, M. D., Curry, L. A., & Creswell, J. W. (2013). Achieving integration in mixed methods designs-principles and practices. *Health Serv Res*, *48*(6 Pt 2), 2134-2156. https://doi.org/10.1111/1475-6773.12117

Gerow, S., Hagan-Burke, S., Rispoli, M., Gregori, E., Mason, R., & Ninci, J. (2018). A systematic review of parent-implemented functional communication training for children with ASD. *Behavior modification*, *42*(3), 335-363.

Gillberg, N., Carmela, M., & and Westman Andersson, G. (2024). Knowledge and belongingness: experiences of a programme for parents of children with autism. *Educational Research*, *66*(1), 1-17. https://doi.org/10.1080/00131881.2023.2276956

Green, J., Aldred, C., Charman, T., Le Couteur, A., Emsley, R. A., Grahame, V., Howlin, P., Humphrey, N., Leadbitter, K., McConachie, H., Parr, J. R., Pickles, A., Slonims, V., & Taylor, C. (2018). Paediatric Autism Communication Therapy-Generalised (PACT-G) against treatment as usual for reducing symptom severity in young children with autism spectrum disorder: study protocol for a randomised controlled trial. *Trials*, *19*(1), 514. https://doi.org/10.1186/s13063-018-2881-3

Grindle, C. F., Kovshoff, H., Hastings, R. P., & Remington, B. (2009). Parents' experiences of home-based applied behavior analysis programs for young children with autism. *J Autism Dev Disord*, *39*(1), 42-56. https://doi.org/10.1007/s10803-008-0597-z

Grogan, P., Yaari, M., Jellett, R., Unwin, K., & Dissanayake, C. (2023). Parent resolution of diagnosis and intervention fidelity in a parent-delivered intervention for pre-school children with autism: A mixed methods study. *Research in Autism Spectrum Disorders*, *101*, 102102. https://doi.org/https://doi.org/10.1016/j.rasd.2023.102102

Hodgetts, S., Nicholas, D., Zwaigenbaum, L., & McConnell, D. (2013). Parents' and professionals' perceptions of family-centered care for children with autism spectrum disorder across service sectors. *Social Science & Medicine*, *96*, 138-146.

Hodgson, A. R., Grahame, V., Garland, D., Gaultier, F., Lecouturier, J., & Le Couteur, A. (2018). Parents' Opinions about an Intervention to Manage Repetitive Behaviours in

Young Children with Autism Spectrum Disorder: A Qualitative Study. *J Appl Res Intellect Disabil, 31 Suppl 2,* 165-178. https://doi.org/10.1111/jar.12317

Hoon, C. (2013). Meta-Synthesis of Qualitative Case Studies:An Approach to Theory Building. *Organizational Research Methods*, *16*(4), 522-556. https://doi.org/10.1177/1094428113484969

Horton, E., Goldschmied, A. Z., Knops, M. J., Brownhill, L. A., Bycroft, A., Lloyd, A., Tones, D., Wiltshire, B., Toro, C. T., & Jutley-Neilson, J. (2024). Empowering voices: fostering reflective dialogue and redefining research dynamics in participatory approaches with the autistic community. *Journal of Participatory Research Methods*, *5*(3).

Howes, A. E., Burns, M. E., & Surtees, A. D. R. (2021). Barriers, facilitators, and experiences of the autism assessment process: A systematic review of qualitative research with health professionals. *Professional Psychology: Research and Practice*, *52*(5), 449-460. https://doi.org/10.1037/pro0000413

Jackson, L., Keville, S., & Ludlow, A. K. (2020). Mothers' Experiences of Accessing Mental Health Care for their Child with an Autism Spectrum Disorder. *Journal of Child and Family Studies*, *29*(2), 534-545. https://doi.org/https://doi.org/10.1007/s10826-019-01662-8

Jimenez, M. E., Barg, F. K., Guevara, J. P., Gerdes, M., & Fiks, A. G. (2012). Barriers to evaluation for early intervention services: parent and early intervention employee perspectives. *Academic pediatrics*, *12*(6), 551-557.

Kerr, J., Sharry, J., & Wilson, C. (2023). Parents' experiences of raising adolescents with intellectual or developmental disabilities. *Journal of Intellectual & Developmental Disability*, *48*(2), 206-214. https://doi.org/10.3109/13668250.2022.2057843

Khanlou, N., Haque, N., Mustafa, N., Vazquez, L. M., Mantini, A., & Weiss, J. (2017). Access barriers to services by immigrant mothers of children with autism in Canada. *International Journal of Mental Health and Addiction*, *15*, 239-259.

Kmet, L. M., Cook, L. S., & Lee, R. C. (2004). Standard quality assessment criteria for evaluating primary research papers from a variety of fields.

Kreslins, A., Robertson, A. E., & Melville, C. (2015). The effectiveness of psychosocial interventions for anxiety in children and adolescents with autism spectrum disorder: A systematic review and meta-analysis. *Child and Adolescent Psychiatry and Mental Health*, *9*, 1-12.

Lachal, J., Revah-Levy, A., Orri, M., & Moro, M. R. (2017). Metasynthesis: An Original Method to Synthesize Qualitative Literature in Psychiatry. *Front Psychiatry*, *8*, 269. https://doi.org/10.3389/fpsyt.2017.00269

Leadbitter, K., Harrison, L., Langhorne, S., Ellis, C., Smallman, R., Pearson, A., Hackett, L., Kroll, L., Dunkerley, A., Beach, H., Gilbert, J., van Gils, A., Hutton, T., Green, J., & Bee, P. (2024). The development, feasibility and acceptability of Empower-Autism: A new psychoeducational and psychotherapeutic programme for caregivers of children recently diagnosed with autism. *Autism*. https://www.scopus.com/inward/record.uri?eid=2-s2.0-85204609848&doi=10.1177%2f13623613241274566&partnerID=40&md5=58616276b01078cf580b8d42c23716ad

Leadbitter, K., Macdonald, W., Taylor, C., & Buckle, K. L. (2020). Parent perceptions of participation in a parent-mediated communication-focussed intervention with their young child with autism spectrum disorder. *Autism*, *24*(8), 2129-2141. https://doi.org/https://doi.org/10.1177/1362361320936394

Lee, J. D., Terol, A. K., Yoon, C. D., & Meadan, H. (2024). Parent-to-parent support among parents of children with autism: A review of the literature. *Autism*, *28*(2), 263-275. https://doi.org/10.1177/13623613221146444

Lee, V., Albaum, C., Tablon Modica, P., Ahmad, F., Gorter, J. W., Khanlou, N., McMorris, C., Lai, J., Harrison, C., & Hedley, T. (2021). The impact of COVID-19 on the mental health and wellbeing of caregivers of autistic children and youth: A scoping review. *Autism Research*, *14*(12), 2477-2494.

Legg, H., & Tickle, A. (2019). UK parents' experiences of their child receiving a diagnosis of autism spectrum disorder: A systematic review of the qualitative evidence. *Autism*, *23*(8), 1897-1910. https://doi.org/10.1177/1362361319841488

Li, S. N., Chien, W. T., Lam, S. K. K., Chen, Z. Y., & Ma, X. (2024). Effectiveness of parent-focused interventions for improving the mental health of parents and their children with autism spectrum disorder: A systematic review and meta-analysis. *Research in Autism Spectrum Disorders*, *114*, 102389. https://doi.org/https://doi.org/10.1016/j.rasd.2024.102389

Machado Junior, S. B., Celestino, M. I. O., Serra, J. P. C., Caron, J., & Ponde, M. P. (2016). Risk and protective factors for symptoms of anxiety and depression in parents of children with autism spectrum disorder. *Developmental neurorehabilitation*, *19*(3), 146-153.

McAleese, A., Christine, L., & and Dyer, K. F. W. (2014). Evaluating a Psychoeducational, Therapeutic Group for Parents of Children with Autism Spectrum Disorder. *Child Care in Practice*, *20*(2), 162-181. https://doi.org/10.1080/13575279.2013.820171

Meadan, H., Halle, J. W., & Ebata, A. T. (2010). Families with children who have autism spectrum disorders: Stress and support. *Exceptional children*, *77*(1), 7-36.

Milshtein, S., Yirmiya, N., Oppenheim, D., Koren-Karie, N., & Levi, S. (2010). Resolution of the diagnosis among parents of children with autism spectrum disorder: Associations with child and parent characteristics. *Journal of Autism and Developmental Disorders*, *40*, 89-99.

Mitter, N., Ali, A., & Scior, K. (2019). Stigma experienced by families of individuals with intellectual disabilities and autism: A systematic review. *Research in Developmental Disabilities*, *89*, 10-21. https://doi.org/https://doi.org/10.1016/j.ridd.2019.03.001

Moody, E. J., Kaiser, K., Sharp, D., Kubicek, L. F., Rigles, B., Davis, J., McSwegin, S., D'Abreu, L. C., & Rosenberg, C. R. (2019). Improving family functioning following diagnosis of ASD: A randomized trial of a parent mentorship program. *Journal of Child and Family Studies*, *28*, 424-435.

Munthe-Kaas, H. M., Glenton, C., Booth, A., Noyes, J., & Lewin, S. (2019). Systematic mapping of existing tools to appraise methodological strengths and limitations of qualitative research: first stage in the development of the CAMELOT tool. *BMC Medical Research Methodology*, *19*(1), 113. https://doi.org/10.1186/s12874-019-0728-6

Naicker, V. V., Bury, S. M., & Hedley, D. (2023). Factors associated with parental resolution of a child's autism diagnosis: A systematic review. *Frontiers in psychiatry*, *13*, 1079371.

Nevill, R. E., Lecavalier, L., & Stratis, E. A. (2018). Meta-analysis of parent-mediated interventions for young children with autism spectrum disorder. *Autism*, *22*(2), 84-98.

NHS England. (2023). A national framework to deliver improved outcomes in all-age autism assessment pathways: guidance for integrated care boards. https://www.england.nhs.uk/long-read/a-national-framework-to-deliver-improved-

outcomes-in-all-age-autism-assessment-pathways-guidance-for-integrated-care-boards/#foreword

NICE. (2013). *Autism spectrum disorder in under 19s: support and management* (Clinical guideline CG170, Issue. https://www.nice.org.uk/guidance/cg170/chapter/recommendations#specific-interventions-for-the-core-features-of-autism

O'Donovan, K. L., Armitage, S., Featherstone, J., McQuillin, L., Longley, S., & Pollard, N. (2019). Group-based parent training interventions for parents of children with autism spectrum disorders: A literature review. *Review Journal of Autism and Developmental Disorders, 6*(1), 85-95.

Oono, I. P., Honey, E. J., & McConachie, H. (2013). Parent-mediated early intervention for young children with autism spectrum disorders (ASD). *Cochrane Database of Systematic Reviews*(4), Article Cd009774. https://doi.org/10.1002/14651858.CD009774.pub2

Palmer, M., Cáceres, A. S. J., Tarver, J., Howlin, P., Slonims, V., Pellicano, E., & Charman, T. (2020). Feasibility study of the National Autistic Society EarlyBird parent support programme. *Autism, 24*(1), 147-159. https://doi.org/10.1177/1362361319851422

Peckett, H., MacCallum, F., & Knibbs, J. (2016). Maternal experience of Lego Therapy in families with children with autism spectrum conditions: What is the impact on family relationships? *Autism, 20*(7), 879-887. https://doi.org/10.1177/1362361315621054

Peterson, J. L., Earl, R. K., Fox, E. A., Ma, R., Haidar, G., Pepper, M., Berliner, L., Wallace, A. S., & Bernier, R. A. (2019). Trauma and Autism Spectrum Disorder: Review, Proposed Treatment Adaptations and Future Directions. *Journal of Child & Adolescent Trauma, 12*(4), 529-547. https://doi.org/10.1007/s40653-019-00253-5

Pettitt, L. (2024). *A thesis of clinical research and practice: Part B: A thematic exploration of anorexia nervosa treatment for caregivers of autistic young people* University of Surrey]. https://openresearch.surrey.ac.uk/esploro/outputs/doctoral/A-thesis-of-clinical-research-and/99914466502346

Pickles, A., Le Couteur, A., Leadbitter, K., Salomone, E., Cole-Fletcher, R., Tobin, H., Gammer, I., Lowry, J., Vamvakas, G., & Byford, S. (2016). Parent-mediated social communication therapy for young children with autism (PACT): long-term follow-up of a randomised controlled trial. *The Lancet*, *388*(10059), 2501-2509.

Randell, E., McNamara, R., Delport, S., Busse, M., Hastings, R. P., Gillespie, D., Williams-Thomas, R., Brookes-Howell, L., Romeo, R., & Boadu, J. (2019). Sensory integration therapy versus usual care for sensory processing difficulties in autism spectrum disorder in children: study protocol for a pragmatic randomised controlled trial. *Trials*, *20*, 1-11.

Read, N., & Schofield, A. (2010). Autism: are mental health services failing children and parents? *J Fam Health Care*, *20*(4), 120-124.

Roberts, D., & Pickering, N. (2010). Parent training programme for autism spectrum disorders: an evaluation. *Community practitioner : the journal of the Community Practitioners' & Health Visitors' Association*. https://www.scopus.com/inward/record.uri?eid=2-s2.0-79952111716&partnerID=40&md5=2a1b46535e4dbc9bc9b7dc61c833963c

Rodgers, J., Goodwin, J., Parr, J. R., Grahame, V., Wright, C., Padget, J., Garland, D., Osborne, M., Labus, M., Kernohan, A., & Freeston, M. (2019). Coping with Uncertainty in Everyday Situations (CUES©) to address intolerance of uncertainty in autistic children: study protocol for an intervention feasibility trial. *Trials*, *20*(1), 385. https://doi.org/10.1186/s13063-019-3479-0

Roughan, L. A., Parker, J. R., & Mercer, L. (2019). Improving interventions for parents of children and young people with autism spectrum disorder (ASD) in CAMHS. *BMJ Open Qual*, *8*(2), e000261. https://doi.org/10.1136/bmjoq-2017-000261

Samsell, B., Lothman, K., Samsell, E. E., & Ideishi, R. I. (2022). Parents' experiences of caring for a child with autism spectrum disorder in the United States: A systematic review and metasynthesis of qualitative evidence. *Families, Systems, & Health*, *40*(1), 93.

Shilling, V., Morris, C., Thompson-Coon, J., Ukoumunne, O., Rogers, M., & Logan, S. (2013). Peer support for parents of children with chronic disabling conditions: a systematic review of quantitative and qualitative studies. *Developmental medicine & child neurology*, *55*(7), 602-609.

Smith, K. A., Gehricke, J.-G., Iadarola, S., Wolfe, A., & Kuhlthau, K. A. (2020). Disparities in service use among children with autism: A systematic review. *Pediatrics*, *145*(Supplement_1), S35-S46.

Smith-Young, J., Chafe, R., Audas, R., & Gustafson, D. L. (2022). "I Know How to Advocate": Parents' Experiences in Advocating for Children and Youth Diagnosed With Autism Spectrum Disorder. *Health services insights*, *15*, 11786329221078803.

Smith-Young, J., Pike, A., Swab, M., & Chafe, R. (2025). Parents' and guardians' experiences of barriers and facilitators in accessing autism spectrum disorder diagnostic services for their children: a qualitative systematic review. *JBI Evid Synth*, *23*(1), 6-68. https://doi.org/10.11124/jbies-23-00332

Smółka, J. (2022). Institutional Analysis of Healthcare Systems in Selected Developed Countries. In *Economics and Mathematical Modeling in Health-Related Research* (pp. 75-103). Brill.

Sperry, L. A., Whaley, K. T., Shaw, E., & Brame, K. (1999). Services for young children with autism spectrum disorder: Voices of parents and providers. *Infants & Young Children*, *11*(4), 17-33.

Stoner, J. B., & Stoner, C. R. (2016). Career disruption: The impact of transitioning from a full-time career professional to the primary caregiver of a child with autism spectrum disorder. *Focus on Autism and Other Developmental Disabilities*, *31*(2), 104-114.

Tissot, C. (2011). Working together? Parent and local authority views on the process of obtaining appropriate educational provision for children with autism spectrum disorders. *Educational Research*, *53*(1), 1-15. https://doi.org/10.1080/00131881.2011.552228

Trembath, D., Gurm, M., Scheerer, N. E., Trevisan, D. A., Paynter, J., Bohadana, G., Roberts, J., & Iarocci, G. (2019). Systematic review of factors that may influence the outcomes and generalizability of parent-mediated interventions for young children with autism spectrum disorder. *Autism Research*, *12*(9), 1304-1321. https://doi.org/https://doi.org/10.1002/aur.2168

Trudgeon, C., & Carr, D. (2007). The Impacts of Home-Based Early Behavioural Intervention Programmes on Families of Children with Autism. *Journal of Applied Research in Intellectual Disabilities*, *20*(4), 285-296. https://doi.org/https://doi.org/10.1111/j.1468-3148.2006.00331.x

Wallace-Watkin, C., Sigafoos, J., & Waddington, H. (2023). Barriers and facilitators for obtaining support services among underserved families with an autistic child: A systematic qualitative review. *Autism*, *27*(3), 588-601. https://doi.org/10.1177/13623613221123712

Walsh, D., & Downe, S. (2006). Appraising the quality of qualitative research. *Midwifery*, *22*(2), 108-119. https://doi.org/https://doi.org/10.1016/j.midw.2005.05.004

Wichers, R. H., van der Wouw, L. C., Brouwer, M. E., Lok, A., & Bockting, C. L. (2023). Psychotherapy for co-occurring symptoms of depression, anxiety and obsessive-compulsive disorder in children and adults with autism spectrum disorder: a systematic review and meta-analysis. *Psychological Medicine*, *53*(1), 17-33.

4. Service Improvement Project

Title: ***"You never know who you're gonna speak to": Exploring Psychological Wellbeing Practitioners' Experiences of Assessing Traumatic Events.***

John Kerr

Green Templeton College

University of Oxford

John.kerr@gtc.ox.ac.uk

Thesis submitted in partial fulfilment of the degree of Doctor of Clinical Psychology (DClinPsych)

Internal Supervisors: Professor Craig Steel and Dr Victoria Roberts

External Supervisors: Dr Hjördis Lorenz | Dr Graham Thew

Consultant: Dr Samantha Sadler

Journal: The Cognitive Behavioural Therapist. This was chosen as it is a leading journal reporting on clinical psychology that has previously featured research on NHS Talking Therapy services. The current study may offer findings generalisable to clinical psychologists nationally.

Word Count: 4,989

Date: 16th June 2024

Abstract

Background: Clinicians in NHS Talking Therapies for Anxiety and Depression (NHS-TT) services often assess people who have experience of traumatic events. Psychological Wellbeing Practitioners (PWPs) experience unique challenges in recognising and treating trauma. PWPs are recognised in literature as particularly vulnerable to burnout and emotional distress; such circumstances are pertinent when working with people reporting traumatic events. This study explored PWP experiences of assessments featuring traumatic events.

Method: Eleven PWPs from an NHS-TT service participated in semi-structured interviews and themes were identified through reflective thematic analysis.

Results: Participants discussed themes of ambiguity in distinguishing trauma problems, high levels of pressure, management of personal distress, appropriate training, and personal support in-service.

Conclusions: Findings corroborate previous research regarding challenges experienced by PWPs and offer novel insight into the challenges faced when assessing service-users' experiences of traumatic events. Recommendations regarding future training, service design and emotional outlets for PWPs were offered.

Practitioner Points:

- PWPs can find assigning appropriate problem descriptors more difficult in service-user assessments featuring discussion of traumatic events
- Assessments featuring traumatic events can have long-standing emotional repercussions for PWPs
- Assessments featuring traumatic events often involve supplementary tasks that add substantial pressure to PWP workloads
- Peers, supervisors, duty supervisors and the clinical leadership team shape PWPs' emotional experience

Introduction

NHS Talking Therapies, for anxiety and depression (NHS-TT, formerly Improving Access to Psychological Therapies (IAPT)) was established in the United Kingdom (UK) in 2008 to deliver treatment for common mental health issues such as anxiety and depression (Clark, 2018) within the National Health Service (NHS). NHS-TT operates a stepped care framework, in which treatment resources are allocated based on condition severity and National Institute for Health and Care Excellence (NICE) guidelines regarding the treatment of particular conditions (NHS Talking Therapies, 2024). Most service users initially receive a 'low-intensity' treatment (ranging from use of self-help books or computer platforms to receiving short-term manualised Cognitive Behavioural Therapy (CBT) sessions), then if clinically indicated, go on to receive a 'high-intensity' treatment, which typically involves 12-20 therapy sessions based on an individualised formulation (Chan & Adams, 2014; Richards et al., 2012). For some clinical conditions such as Post-Traumatic Stress Disorder (PTSD), low-intensity interventions are not recommended by NICE, so some service users start with a high-intensity intervention (NHS Talking Therapies, 2024).

Upon presenting to NHS-TT services, service users are typically assessed by Psychological Wellbeing Practitioners (PWPs), a junior workforce within NHS-TT that conduct assessments and deliver cognitive-behaviourally informed low-intensity interventions. During assessments, the PWP and service user discuss current difficulties and consider the main problem the service user would like to work on. Based on this, the PWP selects a 'problem descriptor' (descriptions of psychological difficulty derived from ICD-10 codes) in the electronic patient care record, and allocates the service-user to an appropriate low-intensity (sometimes called 'Step 2') or high-intensity ('Step 3') treatment (NHS Talking Therapies, 2024). NHS-TT uses problem descriptors to match service-users to appropriate, disorder-specific Cognitive Behavioural Therapy (CBT) protocols (Saunders et al., 2020).

NHS-TT services using problem descriptors frequently and accurately achieve higher rates of recovery and reliable improvement (Clark, 2018; Skelton et al., 2023).

The NHS-TT assessment process poses challenges for PWPs given that large amounts of clinical, safety, and practical information must be collected in short time periods, while simultaneously conveying empathy, understanding and openness to patients (Scott, 2018). PWPs must also be able to assess service users who are experiencing conditions they are not trained to treat; one such condition is PTSD. PWPs need to be able to discuss traumatic events with service users, identify if PTSD is present and the main presenting difficulty, and consider the most appropriate intervention, which may include NHS-TT interventions or referral to other services if service-user needs cannot be met within NHS-TT (NHS Talking Therapies, 2024).

NHS service users frequently report experience of traumatic events (Finch et al., 2020; Sandford, 2023). Prevalence research in this area indicates that between 50-75% of primary mental healthcare service-users in the UK have experienced clinically significant traumatic events in the year preceding assessments; furthermore, 67% report at least one experience of childhood trauma (Hepgul et al., 2016; Thomlinson et al., 2017). Experiencing a traumatic event is Criterion A of a PTSD diagnosis, according to the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; (American Psychatric Association, 2013), which defines a traumatic event as actual or threatened, death, serious injury or sexual violence, directly experienced, witnessed or learned about happening to a close relative or close friend. While traumatic events are often distressing and subsequently distressing to discuss openly in therapy (Boterhoven de Haan et al., 2021), experiencing a traumatic event is not synonymous with a PTSD diagnosis; PTSD is just one of many potential psychological reactions to trauma

(Ehrenreich, 2003).The prevalence of Post-Traumatic Stress Disorder (PTSD) in the UK is estimated at 4.4% (Baker & Kirk-Wade, 2021).

Clinician capacity to distinguish between PTSD and other psychological experiences involving traumatic events can be limited, particularly in primary care settings (Cowlishaw et al., 2021; Ehlers et al., 2009). Several factors complicate such recognition (Frissa et al., 2016). Firstly, information regarding trauma exposure is not always disclosed during initial assessments (Spoont et al., 2015). Secondly, service-users with experience of trauma may perceive somatic symptoms as indicators of physical illness rather than mental distress (American Psychatric Association, 2013); conversely, colloquial use of terms such as 'traumatic' can contribute to both professionals and patients conflating difficult life experiences with PTSD (Tully et al., 2021). Finally, diagnostic measures of trauma disorders may be susceptible to pathologizing contextually normal reactions as trauma symptoms (Rosen & Lilienfeld, 2008). Such ambiguities highlight the importance of clinician knowledge and competency in identifying and appropriately responding to disclosure of traumatic event experience (Hall & Hall, 2007).

How cases involving experience of traumatic events are assessed in mental health services can influence service-user outcomes (Sweeney et al., 2019). Furthermore, the effectiveness of various PTSD treatments is influenced by assessment quality (Ehlers & Wild, 2022; Laliotis & Shapiro, 2022; Schnyder & Cloitre, 2022). Robust assessment procedures in psychological services can guard against longitudinal harm to service-users and encourage treatment engagement (Hardy et al., 2019). Quality of such assessments is somewhat dependent on factors including clinician training provision, service culture, bureaucratic pressures, idiosyncratic skill application and therapeutic alliance strength (Nakash & Alegría, 2013).

Despite the importance of the accurate assessment of traumatic events, particularly in distinguishing experience of traumatic events from meeting diagnostic thresholds for PTSD, how clinicians in UK mental health services conduct such assessments in practice remains unclear in literature. (Turner et al., 2018).

Additionally, it is well documented that working with service-users who have experienced trauma can prove stressful for clinicians (Voss Horrell et al., 2011). In-depth exploration of traumatic events can contribute to vicarious trauma in therapists, whereby repeated exposure to descriptions of trauma by service-users can alter therapist worldview and induce distressing cognitive and physiological symptoms (McNeillie & Rose, 2021). While research on PWP experience of secondary traumatic stress is scant, Vivolo et al. (2024) highlight high levels of burnout and stress amongst PWPs. PWPs are provided weekly supervision, designed to offer case management, clinical oversight and wellbeing restoration. They can also access 'duty supervision' for support managing issues of clinical risk and safeguarding concerns. However, research surrounding CBT supervision indicates that experiences of supervisory practice can vary widely (Roscoe et al., 2022).

The present study therefore aimed to explore PWPs experiences of assessments featuring the discussion of traumatic events within an NHS-TT service.

Methods

This study's scope was established through collaboration between the trainee clinical psychologist and the NHS-TT service's clinical leadership team, following staff feedback regarding challenges associated with assessing PTSD. The service anticipated that thorough exploration of PWPs' experiences of assessments featuring discussion of traumatic events would culminate in deeper understanding of challenges within the role, and eventual

development of future training for PWPs. It was envisioned that the study could eventually support improvement of PWPs' resilience, enhancement of PWPs' PTSD identification and greater understanding of what future supports might benefit PWPs most.

Design

The study used individual semi-structured hour-long qualitative interviews. A semi-structured interview guide (see Appendix 2.2) was developed by the research team. Questions examined the emotional impact of assessing patients' experience of traumatic events, the practical feasibility of conducting assessment calls featuring patient experience of traumatic events, and satisfaction with training regarding assessments featuring discussion of traumatic events.

Participants

Eligible participants had to be aged 18 or over, capable of providing informed consent, and currently employed as a PWP in the same NHS-TT service. Twelve participants were recruited in-service. Each participant was anonymised by the primary investigator.

Procedure

All participants received study information and provided informed consent before participating. Given that this study was conducted under the remit of service improvement, ethical approval was not required. The project was approved by the Oxford Health Clinical Audit department (see Appendix 2.3), and ethical oversight throughout the project was managed through Oxford Health's AMaT (Audit Management and Tracking) system.

Interviews were conducted by the primary investigator between August-September 2023. Of the 11 interviews, 10 were conducted via Microsoft Teams and 1 was conducted face-to-face

due to participant preference. Technological issues led to the omission of data from the twelfth interview. Interviews lasted an average of 50 minutes. They were audio and video-recorded using Microsoft Teams and transcribed verbatim.

Analysis

Data from 11 participants were included in analysis. In line with recommendations from Braun and Clarke (2021a) the data gathered was agreed upon as sufficiently rich and multi-faceted by the research team. Data were analysed inductively according to the principles of reflective thematic analysis, outlined through a six-stage approach recommended by Braun and Clarke (2021a). Following multiple readings of each transcript to facilitate familiarisation (Stage 1: Familiarisation), transcripts were broken down into individual items of meaning based on content and labelled with codes (Stage 2: Generating initial codes). An inductive orientation to coding was taken, with semantic coding used throughout the dataset. The primary investigator (a trainee clinical psychologist) coded with an ontological positioning of critical realism, assuming a tangible reality separate from one's perception of it while believing that one's understandings of such reality are mediated by personal biases. Initial themes were then generated from these codes (Stage 3) using thematic mapping, and through reflexive conversation with supervisors were reviewed and developed (Stage 4). Themes were subsequently refined, defined and named (Stage 5). A thematic map detailing relationships between themes and subthemes was designed (see Figure 1). Finally, analysis was written (Stage 6).

Reflexivity

The first author completed this project as partial requirement of their Doctorate of Clinical Psychology. They spent one year on placement at this service in a separate workstream from

PWPs. They approached this research mindful of the systemic challenges experienced by NHS-TT professionals.

Patient and Public Involvement (PPI)

Following initial analysis, two PWPs working for an NHS-TT service in a neighbouring Trust were interviewed regarding results. Their perspectives regarding themes, subthemes and quotes outlined in the Results section were explored and alterations were made accordingly.

Results

Nine women and two men were interviewed. Table 1 outlines their demographic information. Six themes, comprising 13 subthemes, were established (see Figure 1). These themes and respective subthemes are explored in sequence below. Further quotes from participants are available in Appendix 2.4.

Table 1

Participant Demographics

Characteristics	Mean (SD)	Percentage (n)
Age (years)	28.5 (5.31), range 23-42	
Gender (female)		81.8 (9)
Ethnicity		
White British:		54.5 (6)
White Other:		18.2 (2)
Black Caribbean British		9 (1)
Arabian:		9 (1)

1 British Indian/Asian:	9 (1)
PWP Role	
Lead PWP:	9 (1)
Qualified PWP:	63.6 (7)
Trainee:	27.3 (3)
Average Time As PWP (months)	23.5 (9.8), range 5-36
Average Number of Assessments	81 (62.7)
Featuring Traumatic Events In Service:	

Note: PWP=Psychological Wellbeing Practitioner

Just over four-fifths of participants were female, while over half identified as White British. On average, participants had almost two years' experience in-role.

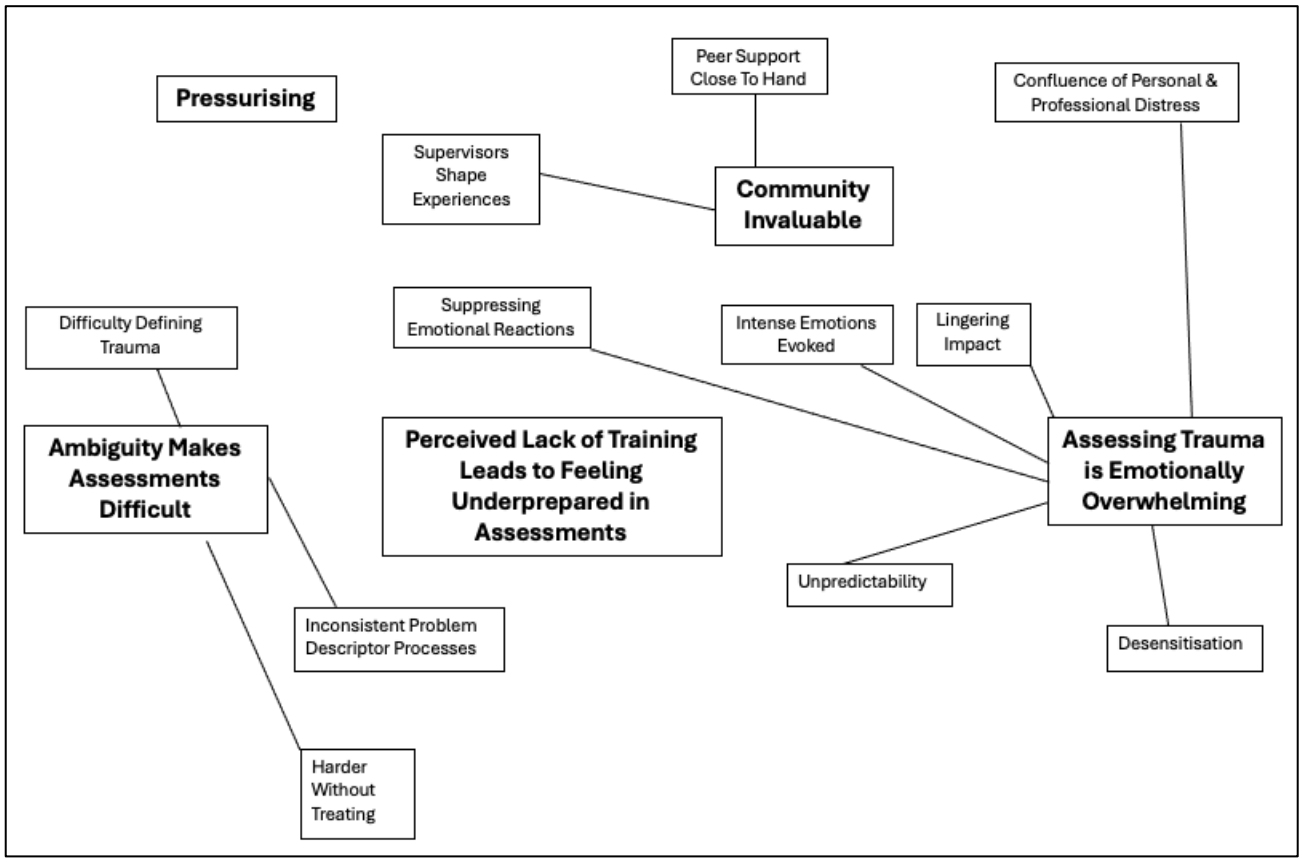


Figure 1: Thematic Map

Navigating Ambiguity Makes Assessments More Difficult

Difficulties in fitting the life experiences reported by service users into NHS-TT problem descriptor criteria were described throughout the dataset. Among such challenges were navigating ambiguity regarding diagnostic criteria, inconsistent processes in assignment of problem descriptors, and uncertain discernment of appropriate referrals in a role untrained for PTSD treatment.

Difficulties Defining Trauma Problems

Participants reported difficulties in distilling service users' experiences of traumatic events into concrete problem descriptors and accordant treatment pathways. Numerous respondents explained challenges in identifying appropriate thresholds upon which trauma could be assigned to a problem descriptor:

"In terms of descriptors… unless it's PTSD... it feels hard to know what the right problem descriptor is." [P1]

Feeling lost upon encountering some patients reporting traumatic experiences was described:

"When people don't have those classic symptoms of PTSD... I'm not sure whether I'm asking the right questions. I'm not sure if I'm gathering enough information to assess whether it is actual trauma". [P2]

Patients' understanding of their experiences as traumatic sometimes contravened service trauma definitions:

"You have patients who say trauma just because they've gone through something stressful" [P4]

Recognising symptoms as those of trauma, rather than simply difficult life experiences, was also depicted as challenging by various participants:

"Probably got quite a lot of people that sort of would say they've experienced trauma or experienced like childhood trauma or … different trauma from the workplace. And it feels like it's a word that's used quite a lot." [P5]

Service users themselves can struggle to recognise trauma-related symptoms, complicating assessments further:

"Do they know they are experiencing some kind of trauma symptom?" [P6]

Inconsistent Process for Assigning Problem Descriptors

Reported decision-making processes for trauma-related problem descriptors varied widely between participants. Some PWPs believed that choice of problem descriptor should be led by patients:

"I think I would still be led by the patient and choose the problem descriptor that I think matches their sort of presentation, their goals, what they want to focus on." [P8]

Others felt dependent on measures that identified symptoms concretely:

"Maybe I've done the PCL-5 with them and that, sort of, is scoring in caseness ... then I would put PTSD as the problem descriptor there." [P7]

Some believed supervisors should decide whether trauma-related problem descriptors were appropriate:

"I personally… would not put trauma as a descriptor unless my supervisor said to do that." (P2)

Beliefs that handling traumatic events was unfeasible for PWPs were managed differently by different participants. Some attempt to conceptualise issues workable at Step 2:

"If they have traumatic events from the past and it doesn't actually seem like PTSD, I suppose my go to is… what step 2 problem does it associate with? I would probably just fall

back on that … cause I don't think trauma is just one that we can put on the problem descriptor." [P7]

Others defer to Step 3:

"I don't think I'm qualified enough to say, is this trauma appropriate for IAPT [NHS-TT] *or not? ... I think it's so good that it's … not just left to us to decide."* [P9]

Not Treating PTSD Makes Assessing For It Harder

Assessing for PSTD in a role not designed to treat it presents significant challenges:

"I didn't know necessarily what questions to ask... We're trained to an extent how to assess PTSD and trauma, but obviously we're not trained in how to treat it… I also don't necessarily know how that treatment's going to look for them either." [P5]

Some felt they lacked sufficient understanding of PTSD to assign its' problem descriptor:

"I don't feel very confident putting a PTSD descriptor on because I can't diagnose that or assess that really because I don't treat it." [P4]

A Perceived Lack Of Training Leaves PWPs Feeling Underprepared To Assess Trauma

Describing formal and in-service training interchangeably, various participants shared beliefs that they were not sufficiently prepared to conduct assessments of traumatic events. PWPs felt that training did not address distinctions between PTSD and other trauma problems:

"In the training, they didn't really mention anything between like the differences between trauma and PTSD ... you do feel a bit left in the dark" [P5].

PWPs also sought guidance in balancing patient boundaries with the accumulation of necessary information:

"How much do I explore that area? That trauma for that patient when they're saying… it's not relevant… we haven't had specific training in that." [P2]

Overall, some relayed that their training on assessing traumatic events had been scant:

"I think in those 2 years there's only been one instance of PTSD training that I remember." [P9]

Knowledge regarding assessment of traumatic events stemmed from learning gained while working, rather than from formal training:

"In assessing traumatic events… I don't think we necessarily went over anything with that in training, even recognizing… I think that's something we've made picked up from service." [P7]

Such experiential learning contributed to feeling underprepared, especially given PWP roles are typically entry-level:

"It does feel like there's almost a bit of a gap there… Where we're sort of thrown in to the deep end." [P5].

Assessing Traumatic Events Is Emotionally Overwhelming

Assessment of traumatic events were consistently described by participants as an emotionally overwhelming experience.

Assessment Calls Involving Trauma Invoke Intense Emotions

PWPs described a multitude of powerful emotions following assessment calls:

"I do feel quite drained… can feel a little bit down as well because it's not the nicest thing to hear" [P10].

The emotional weight of being the first to hear disclosure of traumatic experiences is particular to such assessments:

"Some patients have come to me and disclosed that I would be the first person that they've ever disclosed this information to… It's upsetting to feel that, you know, they've gone through this and I'm the only person that they've ever spoken to" [P10]

Some ruminated upon service-users' circumstances:

"I think you can't help but think about this person's sort of life picture". [P8]

Memories of such assessments caused physical distress:

"Two years ago… I can still feel it now. I could just feel something in my stomach" [P3]

Not being able to help some service-users invoked frustration and disillusionment:

"I'm aware of the limitations of low intensity CBT, so I think it it's almost a bit disheartening in a way because I know that myself as an individual, I can't make a difference to that person." [P2]

Emotional Difficulties Are Compounded By Their Unpredictability

According to participants, this sense of overwhelm is exacerbated by unpredictability; PWPs do not know what presentation will arise before beginning an assessment:

"I guess you never know who you're gonna speak to, what problem are they going to present with?" [P3]

Such unpredictability does not feel like an opportune starting point for those assessing:

"Starting that with uncertainty… is not a good place to begin." [P2]

Supressing Emotional Reactions

Various participants detailed their suppression of emotional distress caused by assessments of traumatic events. For some, such suppression was practically necessary:

"You have to put your feelings aside for a minute to focus on your next patient. Because sometimes you just don't have that time to deal with your own emotions." [P10]

Often, time constraints perpetuate avoidance of processing such distress:

"I guess the reality is… you normally just say oh yeah fine, because you don't have enough time in case management supervision to discuss about half your patients anyway" [P5]

Lingering Emotional Impacts

Such assessments can lead to adverse emotional effects for some PWPs. These include carrying traumatic events in memory for months due to their emotional intensity:

"Even now a year on, I can recall a good amount of cases that have had traumatic events… that's how traumatic they were" [P10]

Difficult memories can lead to PWPs feeling nervous when trauma is mentioned in future assessments:

"If they pull it out quite early, then I guess I'm a little bit more tense as to what are they gonna talk about next." [P2]

Or struggling to empathise with other patients who are experiencing less intense issues:

"It's more Step 2 straightforward cases, I might struggle with the empathy more because I've given it for the other more difficult ones and those just become a bit more routine." [P1]

Desensitisation

Participants described becoming desensitised to discussion of traumatic events following multiple assessments of such:

"I think as the role [progresses] *you do get desensitized; you get used to hearing quite unpleasant things. Quite quickly."* [P1]

Some view such detachment as positive, conceptualising it as evidence of resilience:

"To an extent it's good, it's almost like if you're… if you were to take a lot of that with you to the next call, it might impact how you go through with the next call. So in that sense it can be quite helpful." [P11]

Others found themselves numbed in their personal lives:

"I guess it comes back to the desensitisation thing… when I'm like watching a film or something or hear on a telly program that people have been through these traumatic events, I almost feel like I'm not as shocked by it". [P5]

Confluence of Personal and Professional Distress

Some participants' personal and professional difficulties impacted one another. Such impacts could directly complicate assessment of traumatic experiences.

Assessments added to personal strife:

"If you have difficult times in your personal life, it… just adds to any personal stress." [P8]

and personal issues made assessments more difficult:

"There are other times where maybe you come to work and you haven't had a particularly good day or there's other things going on in your life… and then you get hit with this… hearing these traumatic things." [P5]

Various participants reported imagining themselves in similar situations and becoming distressed at such a prospect:

"The thought oh God, what if this happened to me or someone I cared about, that will cross your mind, that thought" [P6].

Many felt that they took assessments of traumatic events home with them more than they would other assessments:

"It's probably on those days that I'd… think more about work maybe when I went home." [P11]

Ultimately, assessing service-users that reported traumatic events changed the way that some PWPs engaged with the world:

"I barely read the news because I always say that I hear enough depressing stuff during my workday… kind of taking on some of that." [P1]

Assessing Traumatic Events is Pressurising

Multifaceted, relentless pressure was described by participants throughout the dataset. Time-limits complicated assessments for PWPs:

"When it comes to assessing trauma, given everything else we also have to explore, that can become quite tight timing wise. And often the appointments will need to overrun if you're going to gather sufficient information." [P1]

Such constraints sometimes prevented PWPs from self-care following difficult assessments:

"I take a step away, get a cup of tea or give myself a breather before having to jump on the next call. But you know, it's trauma that sometimes can be coupled with complexity or risk. Sometimes that wasn't an option and you had to immediately be responding to it" [P1]

Calls involving risk to service-users further can add further pressure to PWPs during assessments featuring traumatic events:

"I would say we're probably trained not to panic, but... I need to, sort of, follow as many steps as I can remember in that sort of chaotic moment...You feel that pressure to… remain calm." [P8]

These constraints were suggested to affect PWPs performances of their roles:

"It can sometimes feel… a bit muddled as well because you... weigh up, in the short amount of time that you've got, you know, what do I concentrate on?" [P8]

Participants contextualised relentless pressure within NHS-TT's focus on meeting service-wide targets:

"You don't have that space to destress… It's just, having these targets you have to meet per day" [P9]

In-Service Support Is Invaluable

The camaraderie, guidance and comfort of colleagues was regularly depicted as central to PWP's experience of assessing traumatic events.

Peer Support Is Close to Hand

Informal peer support during and after assessments of traumatic events were consistently described. Fellow PWPs provide mutual understanding to one another:

"Sometimes just getting that off your chest that really helps and having that sort of supportive person who knows what it's like because they probably experienced the same." [P11]

Training in cohorts created a sense of solidarity:

"I think just the natural fact that you train in cohorts… you've got people you can turn to, other people are going through the same experience of "I don't know what I'm doing" at the same time." [P1]

The invaluable nature peer support in crisis situations was also described:

"When my colleague had a sort of active, you know, someone… tried to end their life... I could go and find a Duty worker in the building to come over and support with that." [P8]

Such experiences contrast with some PWPs' experiences of isolation, whether working from home or on-site. Participants described distance from colleagues as a barrier to accessing impromptu emotional support:

"I've always got the option to like work from home… but I've always thought that it's better for me to be here and be around people" [P3]

In an expanding service, some described being physically isolated while on-site, and the additional stressors this can present:

"If you're working where there aren't many people in the office or you're at home, that can sometimes be more difficult because you've gotta rely on… finding teams yourself". [P8]

Supervisors Shape PWPs' Emotional Experiences

The quality of support provided by supervisors was also recognised as a pivotal variable by participants:

"I think supervisors are an incredibly important part of your experience. And if you have one that isn't quite working so well, then that has a huge impact on the day-to-day work… But I think if it's all working then that support is there." [P1]

Equally, substandard supervisory experiences compounded the emotional challenges of assessing traumatic events. These included focusing on case management without fully acknowledging PWPs' emotional needs:

"[My] *supervisor was like... must have been difficult for you... And then on to the next one. Yeah, it was quite quick. I might not have spoke about as much as I would have liked"* [P3]

Or having their own stress compounded by supervisors' stress:

"Like you can tell when someone's really stressed ... particularly if that person is a supervisor… they're there to support the people that are lower down and if they're not there and present, how am I being supported?" [P2]

Similarly, the wider Talking Therapies system was regarded as a pivotal emotional support in the context of assessing traumatic event. Informal support from Duty was appreciated:

"If a case has been difficult, if you wanted to talk through with someone from Duty, there is that option… they're often able to recognize that this was not an easy call for you to go through" [P1]

Instances in which senior staff members were perceived as emotionally invalidating compounded PWPs' emotional duress:

"They've approached all of the people in senior management… they feel like they've been fobbed off and told to suck it up and get on with it" [P2]

However, a sense of support throughout the system was also reported:

"I feel like you can speak to anyone you know however senior they are." [P8]

Discussion

This study aimed to investigate the experience of assessing traumatic events as a PWP within NHS-TT and establish results that may contribute to service and PWP training improvements. The study was collaboratively designed with the participating NHS-TT service's research team.

Factors important to improving service

Participants highlighted difficulties in identifying appropriate problem descriptors for many patients that reported experiencing traumatic events, inconsistencies in how such descriptors were identified, and the challenging nature of recognising a problem they did not treat. These represent novel findings within NHS-TT research. Awareness of the specific processes complicating assignment of appropriate problem descriptors is particularly pertinent given findings that identification of problem descriptors in NHS-TT achieves better clinical outcomes (Clark, 2018; Saunders et al., 2020).

Participants identified knowledge gaps regarding trauma, PTSD and distinction thereof, and noted that experiential learning created a sense of unpreparedness in treating trauma problems. Such findings substantiate Murray (2017)'s recognition of NHS-TT therapists' minimal training in working with trauma problems and NHS-TT's resultant need to

collaborate with universities to disseminate training programmes specifically designed to develop staff understanding of trauma problems.

Participants described how assessing trauma problems produced long-standing emotional impacts, exacerbated confluences between personal and professional distress and occasionally resulted in emotional detachment. These descriptions are consistent with a growing body of research depicting NHS-TT staff's experience of burnout, compassion fatigue and secondary traumatic stress (Owen et al., 2021) and, in turn, the experience of psychological professionals overall (McCormack et al., 2018). Several of the quotes included in this study illustrate experiences analogous with secondary traumatic stress, including desensitisation, physiological anxiety, and schematic change based on exposure to descriptions of trauma. Future research of secondary traumatic stress or vicarious trauma among PWPs could benefit future NHS-TT workforces.

While research consistently illustrates the PWP role as pressurised, this study provided novel findings regarding the pressures experienced whilst assessing trauma. Supplementary processes such as safeguarding, implementing diagnosis-specific questionnaires and balancing appraisal with appropriate sensitivity were described as burdensome for PWPs.

Participants relayed the importance of peer relationships, supervisors and Duty as support structures when assessing traumatic events. Such findings corroborate those of Harper et al. (2020). However, insight into the specific benefits of peer support following PWP assessment of traumatic events are novel, as are those identifying duty supervision as valuable support.

Dissemination of Results

Findings were shared with the NHS-TT service's clinical leadership team. A joint meeting was held with the service to discuss key findings and recommendations and an executive summary of the study's findings was produced and shared with staff. It was planned that this study's findings would be disseminated with the wider staff team before provision of training based on this study's recommendations.

Recommendations

1. Staff training to support PWPs with:
    i. Trauma, PTSD and distinguishing these phenomena clinically
    ii. How trauma problems, particularly PTSD, are treated
    iii. Decision-making in emotionally intense situations
    iv. Grounding patients following discussion of traumatic events
    v. Eliciting diagnostically relevant information sensitively
2. Service policy guidance regarding:
    i. A clear & uniform process about how trauma-related problem descriptors are decided
3. Supplement assessment of traumatic events by:
    i. Screening referrals for experience of traumatic events prior to assessment calls.
    ii. Providing PWPs with a pro forma document outlining necessary questions and considerations (e.g. risk, signposting)
4. Support PWP's emotional processes through:
    i. Stipulating that line managers should consistently encourage PWPs to use available in-service reflective practice spaces
    ii. Visually advertising in-service reflective practice spaces on-site

iii. Highlighting PWPs' appropriate processes of escalation following unsatisfactory interactions with management figures
iv. Formally providing debriefs for PWPs following assessments featuring discussion of traumatic events

Limitations

The generalisability of these findings to other NHS-TT services is limited, particularly given that the focus of some interview questions regarded experiences within the service conducting this study. This was partially offset by the participation of PWPs from a neighbouring Trust in the PPI process – nevertheless, replication of this project across various services would lend greater validity to these findings. Given that this study relied on PWPs using their limited spare time to participate, findings may be self-selective and include more polarised feedback. Furthermore, only staff views were represented in discussing assessments featuring traumatic events; service-user perspectives on such assessments was beyond the scope of this study but would doubtlessly contribute valuable insight to inform service recommendations.

Future Implications

This project offered thorough exploration of PWPs' experiences of assessing traumatic events and generated recommendations towards the improvement of clinical knowledge, emotional wellbeing, and NHS-TT service design. The service is considering the design of a pro forma document to support PWPs with assessments featuring discussions of traumatic events, outlining necessary information, processes and supports. Further annual in-service training regarding PWP assessment of PTSD, including content recommended by this study, is planned.

References

American Psychatric Association. (2013). Diagnostic and statistical manual of mental disorders : DSM-5. In (5th ed. ed.). Arlington, VA :.

Baker, C., & Kirk-Wade, E. (2021). Mental health statistics: prevalence, services and funding in England. *The House of Commons Library*.

Boterhoven de Haan, K. L., Lee, C. W., Correia, H., Menninga, S., Fassbinder, E., Köehne, S., & Arntz, A. (2021). Patient and therapist perspectives on treatment for adults with PTSD from childhood trauma. *Journal of Clinical Medicine*, *10*(5), 954.

Braun, V., & Clarke, V. (2021). *Thematic analysis : a practical guide*. SAGE.

Chan, S. W., & Adams, M. (2014). Service use, drop-out rate and clinical outcomes: a comparison between high and low intensity treatments in an IAPT service. *Behavioural and Cognitive Psychotherapy*, *42*(6), 747-759.

Clark, D. M. (2018). Realizing the Mass Public Benefit of Evidence-Based Psychological Therapies: The IAPT Program. *Annu Rev Clin Psychol*, *14*, 159-183. https://doi.org/10.1146/annurev-clinpsy-050817-084833

Clemons, B. (2020). *Systematic Literature Review: Burnout, Compassion Fatigue, Vicarious Trauma, and Secondary Trauma Amongst MSW Student Interns and Entry Level Professionals*. California State University, Northridge. https://books.google.co.uk/books?id=b8STzgEACAAJ

Cowlishaw, S., Metcalf, O., Stone, C., O'Donnell, M., Lotzin, A., Forbes, D., Hegarty, K., & Kessler, D. (2021). Posttraumatic Stress Disorder in Primary Care: A Study of General Practices in England. *J Clin Psychol Med Settings*, *28*(3), 427-435. https://doi.org/10.1007/s10880-020-09732-6

Ehlers, A., Gene-Cos, N., & Perrin, S. (2009). Low Recognition of Posttraumatic Stress Disorder in Primary Care. *London J Prim Care (Abingdon)*, *2*(1), 36-42.

Ehlers, A., & Wild, J. (2022). Cognitive Therapy for PTSD: Updating Memories and Meanings of Trauma. In U. Schnyder & M. Cloitre (Eds.), *Evidence Based Treatments for Trauma-Related Psychological Disorders: A Practical Guide for Clinicians* (pp. 181-210). Springer International Publishing. https://doi.org/10.1007/978-3-030-97802-0_9

Ehrenreich, J. H. (2003). Understanding PTSD: forgetting "trauma". *Analyses of Social Issues and Public Policy*, *3*(1), 15-28.

Finch, J., Ford, C., Lombardo, C., & Meiser-Stedman, R. (2020). A survey of evidence-based practice, training, supervision and clinician confidence relating to post-traumatic stress disorder (PTSD) therapies in UK child and adolescent mental health professionals. *European Journal of Psychotraumatology*, *11*(1), 1815281.

Frissa, S., Hatch, S. L., Fear, N. T., Dorrington, S., Goodwin, L., & Hotopf, M. (2016). Challenges in the retrospective assessment of trauma: comparing a checklist approach to a single item trauma experience screening question. *BMC psychiatry*, *16*(1), 1-9.

Hall, R. C. W., & Hall, R. C. W. (2007). Detection of Malingered PTSD: An Overview of Clinical, Psychometric, and Physiological Assessment: Where Do We Stand? *Journal of Forensic Sciences*, *52*(3), 717-725. https://doi.org/https://doi.org/10.1111/j.1556-4029.2007.00434.x

Hardy, G. E., Bishop-Edwards, L., Chambers, E., Connell, J., Dent-Brown, K., Kothari, G., O'hara, R., & Parry, G. D. (2019). Risk factors for negative experiences during psychotherapy. *Psychotherapy Research*, *29*(3), 403-414. https://doi.org/10.1080/10503307.2017.1393575

Harper, K., Bhutani, G., Rao, A. S., & Clarke, J. (2020). Wellbeing matters in IAPT practitioners: Identity vs system. *International Journal of Stress Prevention and Wellbeing*, *4*(4), 1-12.

Hepgul, N., King, S., Amarasinghe, M., Breen, G., Grant, N., Grey, N., Hotopf, M., Moran, P., Pariante, C. M., Tylee, A., Wingrove, J., Young, A. H., & Cleare, A. J. (2016). Clinical characteristics of patients assessed within an Improving Access to Psychological Therapies (IAPT) service: results from a naturalistic cohort study (Predicting Outcome Following Psychological Therapy; PROMPT). *BMC psychiatry*, *16*(1), 52. https://doi.org/10.1186/s12888-016-0736-6

Laliotis, D., & Shapiro, F. (2022). EMDR Therapy for Trauma-Related Disorders. In U. Schnyder & M. Cloitre (Eds.), *Evidence Based Treatments for Trauma-Related Psychological Disorders: A Practical Guide for Clinicians* (pp. 227-254). Springer International Publishing. https://doi.org/10.1007/978-3-030-97802-0_11

McCormack, H. M., MacIntyre, T. E., O'Shea, D., Herring, M. P., & Campbell, M. J. (2018). The prevalence and cause (s) of burnout among applied psychologists: A systematic review. *Frontiers in Psychology*, *9*, 376988.

Murray, H. (2017). Evaluation of a trauma-focused CBT training programme for IAPT services. *Behavioural and Cognitive Psychotherapy*, *45*(5), 467-482.

Nakash, O., & Alegría, M. (2013). Examination of the role of implicit clinical judgments during the mental health intake. *Qual Health Res*, *23*(5), 645-654. https://doi.org/10.1177/1049732312471732

NHS Talking Therapies. (2024). *NHS Talking Therapies for anxiety and depression Manual* (T. N. C. C. f. M. Health, Ed.) https://www.england.nhs.uk/wp-content/uploads/2018/06/NHS-talking-therapies-manual-v7-1.pdf

Owen, J., Crouch-Read, L., Smith, M., & Fisher, P. (2021). Stress and burnout in Improving Access to Psychological Therapies (IAPT) trainees: a systematic review. *The Cognitive Behaviour Therapist*, *14*, e20.

Richards, D. A., Bower, P., Pagel, C., Weaver, A., Utley, M., Cape, J., Pilling, S., Lovell, K., Gilbody, S., & Leibowitz, J. (2012). Delivering stepped care: an analysis of implementation in routine practice. *Implementation Science*, *7*, 1-11.

Roscoe, J., Taylor, J., Harrington, R., & Wilbraham, S. (2022). CBT supervision behind closed doors: Supervisor and supervisee reflections on their expectations and use of clinical supervision. *Counselling and Psychotherapy Research*, *22*(4), 1056-1067.

Rosen, G. M., & Lilienfeld, S. O. (2008). Posttraumatic stress disorder: An empirical evaluation of core assumptions. *Clinical psychology review*, *28*(5), 837-868. https://doi.org/https://doi.org/10.1016/j.cpr.2007.12.002

Sandford, D. M. (2023). *Understanding the factors associated with mental health practitioners' engagement in effective suicide prevention activities within an Improving Access to Psychological Therapies (IAPT) service* University of Glasgow].

Saunders, R., Cape, J., Leibowitz, J., Aguirre, E., Jena, R., Cirkovic, M., Wheatley, J., Main, N., Pilling, S., & Buckman, J. E. (2020). Improvement in IAPT outcomes over time: are they driven by changes in clinical practice? *The Cognitive Behaviour Therapist*, *13*, e16.

Schnyder, U., & Cloitre, M. (2022). Introduction. In U. Schnyder & M. Cloitre (Eds.), *Evidence Based Treatments for Trauma-Related Psychological Disorders: A Practical Guide for Clinicians* (pp. 1-9). Springer International Publishing. https://doi.org/10.1007/978-3-030-97802-0_1

Scott, M. J. (2018). Improving Access to Psychological Therapies (IAPT)-The need for radical reform. *Journal of Health Psychology*, *23*(9), 1136-1147.

Skelton, M., Carr, E., Buckman, J. E., Davies, M. R., Goldsmith, K. A., Hirsch, C. R., Peel, A. J., Rayner, C., Rimes, K. A., & Saunders, R. (2023). Trajectories of depression and anxiety symptom severity during psychological therapy for common mental health problems. *Psychological medicine*, *53*(13), 6183-6193.

Spoont, M. R., Williams, J. W., Kehle-Forbes, S., Nieuwsma, J. A., Mann-Wrobel, M. C., & Gross, R. (2015). Does this patient have posttraumatic stress disorder?: rational clinical examination systematic review. *Jama*, *314*(5), 501-510.

Sweeney, A., Clement, S., Gribble, K., Jackson, E., Carr, S., Catty, J., & Gillard, S. (2019). A systematic review of qualitative studies of adults' experiences of being assessed for psychological therapies. *Health Expectations*, *22*(2), 133-148. https://doi.org/https://doi.org/10.1111/hex.12844

Thomlinson, R., Muncer, S., & Dent, H. (2017). Comorbidity between PTSD and anxiety and depression: implications for IAPT services. *Archives of Depression and Anxiety*, *3*(1), 14-17.

Tully, J., Bhugra, D., Lewis, S. J., Drennan, G., & Markham, S. (2021). Is PTSD overdiagnosed? *bmj*, *373*.

Turner, J., Brown, J. C., & Carpenter, D. T. (2018). Telephone-based CBT and the therapeutic relationship: The views and experiences of IAPT practitioners in a low-intensity service. *Journal of Psychiatric and Mental Health Nursing*, *25*(5-6), 285-296. https://doi.org/https://doi.org/10.1111/jpm.12440

Voss Horrell, S. C., Holohan, D. R., Didion, L. M., & Vance, G. T. (2011). Treating traumatized OEF/OIF veterans: How does trauma treatment affect the clinician? *Professional Psychology: Research and Practice*, *42*(1), 79.

5. Theory-Driven Research Project

Title: *Examining the effectiveness of a single-session school-based outreach intervention to increase anxiety literacy and help-seeking intentions in adolescence*

John Kerr

Green Templeton College

University of Oxford

John.kerr@gtc.ox.ac.uk

Thesis submitted in partial fulfilment of the degree of Doctor of Clinical Psychology (DClinPsych)

Internal Supervisors: Dr Louise Johns

External Supervisor: Dr Alex Lau-Zhu

Journal: Child and Adolescent Mental Health. This was chosen as it is a leading international journal reporting on clinical psychology that has previously featured research on school-based help-seeking interventions.

Word Count: 4,500

Date: 28th February 2025

Abstract

Background: Mental health needs are at all-time highs in UK adolescents, and anxiety is one of the most commonly experienced difficulties. Many adolescents do not seek professional help for these difficulties or understand when their difficulties warrant support. Adaptations of Azjen's Theory of Planned Behaviour argue that increasing mental health literacy and addressing stigma, illness appraisal and attitudes towards help-seeking may lead to increased help-seeking intentions. The present study sought to i) develop a single-session, school-based intervention on anxiety and related help-seeking (ALHS), ii) test its' efficacy in improving anxiety literacy and help-seeking for anxiety and iii) explore the moderating influence of stigma, attitudes, and appraisal towards anxiety.

Methods: The ALHS' effectiveness was tested using a randomised, controlled experimental design at three timepoints (pre, post and one-month follow-up). Students (n=273) aged 12-13 were randomised at class level to either the ALHS or a control intervention about general mental wellbeing. Participants completed measures of anxiety literacy, help-seeking intentions, stigma, appraisal, help-seeking attitudes, and acceptability at each timepoint.

Results: 210 students completed primary outcome measures at pre- and post-intervention, with 104 completing both at three timepoints. The ALHS led to significantly higher anxiety literacy than the control post-intervention, with effects not sustained at follow-up. The ALHS did not lead to significantly greater help-seeking intentions for anxiety - help-seeking intentions in both groups increased significantly post-intervention, an effect sustained at follow-up.

Conclusions: While a single-session, school-based intervention can produce short-term improvements in anxiety literacy, more comprehensive intervention may be needed to produce lasting effects and encourage help-seeking.

Introduction

UK children and adolescents are presently experiencing the cohort's highest mental health need on record, with one in six young people experiencing mental health problems (Newlove-Delgado et al., 2021). This aligns with trends throughout previous decades, with longitudinal prevalence research illustrating an increase in mental health problems in UK youth (Patalay & Gage, 2019).. These trends are notable across gender and age group, but particularly prominent for young women and older children (Collishaw et al., 2010; NHS Digital, 2022). The COVID-19 pandemic has both contributed to, and exacerbated, such trends (Panchal et al., 2023).

Anxiety problems are among the most common mental health problems experienced during adolescence (James et al., 2020). The National Survey of Mental Health of Children and Young People established anxiety as the most prevalent mental health issue in UK adolescents (Vizard et al., 2018). Longitudinal cohort research set in the UK indicates that anxiety during adolescence is significantly associated with persistent mental health difficulties, and setbacks in employment and education, during adulthood (Morales-Muñoz et al., 2023). Such anxiety problems prove societally costly (Pollard et al., 2023), therefore presenting an important target for prevention and early intervention strategies

Factors exacerbating such trends include logistical barriers to accessing support for clinically relevant mental health difficulties, such as inadequate service provision, lengthy waitlists, and limited specialist support (Lawrence et al., 2016). Equally concerning barriers are young people's illiteracy regarding mental health and their reluctance to seek help (O'Brien et al., 2016; Reardon et al., 2017). Help-seeking, defined by (Cornally & McCarthy, 2011) as "a problem focused, planned behaviour, involving interpersonal interaction with a selected professional", is recognised as a major barrier to supporting youth mental health. Less than

two-thirds of UK youth with mental health difficulties seek professional help, and a quarter seek neither professional nor informal support (Sadler et al., 2018). A recent systematic review suggests that young people are unsure about where they can receive support, whether their mental health difficulties require external support, and whether such professional help would be effective (Radez et al., 2021). Such issues have been identified within anxious adolescents particularly. Calear et al. (2021) found limited anxiety literacy, prevalent stigma, and reluctance to seek help for anxiety in a large-scale adolescent cohort.

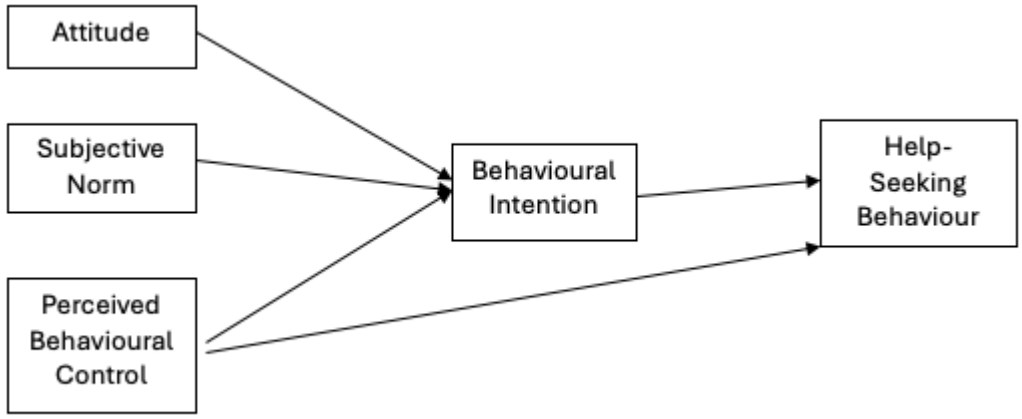
Help-seeking trends for mental health issues are not proportionately similar across adolescent populations (Cauce et al., 2002; Galdas et al., 2005) Seeking and receiving support from mental health services are particularly challenging for young men (Burke et al., 2022), British minoritized ethnic British adolescents (Meechan et al., 2021) and LGBT-identifying adolescents (Hatchel et al., 2019). Within such demographics, help-seeking can be perceived as indicative of weakness (Clark et al., 2018), and providers of help as incompatible with their cultural backgrounds (Jacobs & Pentaris, 2021) or fundamentally unable to understand them due to differing characteristics (Hassett & Isbister, 2017; Lindsey et al., 2006).

There are several theoretical models of help-seeking (Gulliver, Griffiths, Christensen, & Brewer, 2012), and the Theory of Planned Behaviour is the most widely applied model used to understand help-seeking in clinical psychology research (Adams et al., 2022). This model, proposed by Ajzen (1991), suggests that subjective norms (perceived societal rules on how people should behave), perceived behavioural control (beliefs about the self's capacity, opportunity and resources to enact a behaviour), and attitudes towards the behaviour in question interact to influence people's intentions to act. Within the context of mental health help-seeking interventions, these components can be related to stigma, perceived barriers to

help-seeking (both internal and external), and attitudes regarding help-seeking respectively (Damghanian & Alijanzadeh, 2018) (see Figure 1).

Figure 1

The Theory of Planned Behavioural structural model. Adapted from (Damghanian & Alijanzadeh, 2018).



Through application of Ajzen's model, help-seeking intentions have been found to predict mental health help-seeking behaviour in adult men (Smith et al., 2008), young people with depression (Zorrilla et al., 2019) and individuals at risk of affective disorders (Damghanian & Alijanzadeh, 2018). A recent scoping review has identified a robust evidence base for this theory's ability to predict mental health-related help-seeking intentions using attitudes, perceived behavioural control and social norms (Adams et al., 2022). However, the theory's application within help-seeking contexts has received criticism for failing to elucidate how beliefs related to help-seeking become salient and inform people's choices on seeking help across each model component (Chan, 2013).

Help-seeking interventions often aim to normalise adverse mental health experiences (both above and below clinical thresholds), increase recognition of mental health difficulties, and create positive attitudes towards service use through the improvement of mental health literacy (MHL) (Lubman et al., 2020). Jorm (2015) has defined MHL as knowledge surrounding mental illness and its' prevention, recognition of developing mental health issues, and knowledge regarding available help-seeking options and self-help strategies. While early reviews of MHL interventions showed limited effectiveness in increasing help seeking intentions (Gulliver, Griffiths, Christensen, & Brewer, 2012), a more recent systematic review and meta-analysis of such interventions demonstrated positive short-term and long-term improvements (Xu et al., 2018).

School-based approaches represent a promising approach for addressing youth mental health, given their capacity to efficiently provide psychoeducation and encourage de-stigmatisation of mental health (Ma, Anderson, et al., 2023). However, most school-based MHL interventions address mental health difficulties generally rather than specifically (e.g., focusing on 'mental health' rather than anxiety problems), and focus primarily on awareness (i.e. introducing concepts regarding mental health problems) rather than recognition (i.e., explaining symptomology of mental health difficulties and distinguishing clinically relevant symptoms from everyday difficulties) (Ma, Anderson, et al., 2023). Kutcher et al. (2016) have further contended that successful MHL interventions must be developmentally appropriate – for example, using age-appropriate languages and cultural references.

Concerns have also been raised that interventions promoting mental health help-seeking, without providing adequate and available options for support, simply perpetuate mental health difficulties; furthermore, without distinguishing between clinical and non-clinical

difficulties, young people's normal experiences can be pathologized (Foulkes & Andrews, 2023). Legitimate societal hardships such as poverty also risk being attributed to internalised mental health issues (Watts, 2024). Finally, few studies have involved mental health service outreach informing adolescents of the formal and informal supports available for their mental health (Aguirre Velasco et al., 2020), despite several high-quality, large-sample studies demonstrating increases in adolescent help-seeking intentions following education regarding such resources (Deane et al., 2007; Rughani, 2011; Wilson et al., 2008).

Of school-based studies that have incorporated disorder-specific approaches in adolescence, most focus on depression (e.g. (Swartz et al., 2010) or substance use (e.g. (Lubman et al., 2020) with little research exploring improvement of literacy surrounding anxiety problems (Calear et al., 2021). The present study therefore aims to investigate whether a single-session, anxiety-specific, school-based intervention can improve both anxiety literacy and help-seeking intentions. The study also examines whether anxiety-related stigma (societal norms), anxiety appraisal (perceived behavioural control) and attitudes towards help-seeking for anxiety problems (attitudes) potentially mediate a predicted significant positive relationship between anxiety literacy and help-seeking intentions, as hypothesised by the Theory of Planned Behaviour.

Hypotheses

In this study, we developed and delivered a single-session, school-based intervention ('Anxiety Literacy & Help Seeking', or 'ALHS') to promote knowledge of anxiety symptoms, recognition of the distinction between adaptive and problematic anxiety, and awareness of available psychological supports for adolescents aged 12-13 struggling with anxiety problems. As a check on the independent variable, we first ascertained whether the

ALHS significantly improved anxiety literacy compared to a control intervention. Several hypotheses were then generated:

1) Our primary hypothesis was that the ALHS would significantly improve adolescents' help-seeking intentions for anxiety.
2) Our secondary hypotheses were that the ALHS would significantly improve adolescents' appraisal, attitudes, and reduce stigma, regarding anxiety.
3) We further hypothesised that appraisal, attitudes and stigma would act as mediators in a significant positive relationship between anxiety literacy and help-seeking.
4) Finally, we hypothesised that the ALHS would be significantly more acceptable to recipients than the control intervention.

We hypothesised that, compared with a control intervention, this Anxiety Literacy Help-Seeking (ALHS) intervention would improve adolescents' anxiety-literacy and help-seeking intentions for anxiety, alongside the hypothesised mediators.

Methods

Ethical Information

This study was granted full ethical approval by the Oxford University Research Ethics Committee (CUREC; reference R91444/RE001; see Appendix 3.2). All participants were required to provide informed consent prior to participating.

Participants

A local secondary school was recruited to take part in this research following discussions with the year group's pastoral lead and headteacher. In April 2024, the school distributed child and parent information sheets and electronic opt-out forms to all parents of Year 8 (age

12-13) students (N=302). Children were provided the option of opting themselves out of the study on assent forms (see Appendix 3.3). 273 students participated (see Table 1).

Design

This study used a randomised, controlled experimental design with a one-month follow-up.

Table 1

Participant Demographics.

Factor	Total Sample (%)	ALHS	Control
Age			
12	70(25.6)	40 (29.4)	30 (23.6)
13	192(70.3)	95(69.9)	97(76.4)
Missing	11(4.1)	1(.7)	10(7.8)
Sex			
n	273	136	127
Male	140	67(49.3)	66(52)
Female	132	68(50)	61(48)
Missing	1	1(.7)	0(0)
Gender			
n	273	136	127
Male	127 (46.5)	64(47.1)	60(47.2)
Female	118(43.2)	58(42.6)	63(49.6)
Other	12(4.4)	11(8.1)	4(2.9)
Missing	16(5.9)	3(2.2)	9(7.1)
Ethnicity			
n	273	136	127
White	148(54.2)	69(50.7)	79(62.2)
Other	111 (40.7)	64(47.1)	47(37)
Black	21(8.2)	11(8.7)	10(7.9)
Hispanic	6(2.2)	3(2.2)	3(2.4)
Asian	41(15)	23(16.9)	18(14.2)
Middle Eastern	9(3.3)	3(2.2)	6(4.7)
Mixed	34(12.45)	23(17.1)	11(8.6)
Missing	14(5.1)	3(2.2)	1(.8)

Sample Size Calculation

A priori power analysis was conducted using G* Power 3 (Faul et al., 2007). Given that previous meta-analysis regarding help-seeking interventions found an average effect size of Cohen D =0.26 (Xu et al., 2018), and a previous RCT regarding adolescent mental health literacy used a Cohen's d of 0.20 (Perry et al., 2014), an estimated small effect size of 0.20 was used to calculate power. With an alpha level of 0.05, power = 0.80 and effect size of Cohen *d* = 0.20, it was established that a sample size of at least N = 200 was needed for the main analyses.

Measures

Measures used to assess anxiety literacy, help-seeking intentions, and stigma, illness appraisal and attitudes related to anxiety have all been designed and tested with young people of similar age to this study's sample. However, few validated anxiety-specific questionnaires on these constructs are available. Therefore, existing questionnaires were adapted. These were piloted with two young people between 11-13 years old, who reported that the questionnaires were suitable and understandable. Reliability coefficients were calculated for each measure (see Figure 2).

Figure 2

Measure Reliability Coefficients

Measure	α (pre)	α (post)	α (FU)
ALQ	.90	.88	.91
GHSQ	.73	.75	.81
SAMA	.64	.67	.75
MHSA	.85	.9	.93
GASS	.87	.9	.9

Independent Variable Check:

Adapted Anxiety Literacy Questionnaire (ALQ): The A-Lit, developed by Gulliver, Griffiths, Christensen, Mackinnon, et al. (2012), originally consisted of 22 items assessing

anxiety-specific mental health literacy. Each item is scored one point for a correct answer between true, false, and don't know. It has an internal consistency of .76 and test-retest reliability of .83 in a sample of young adults. This measure was adapted to reflect the definition of mental health literacy by Jorm (2015), through adding items relating to recognising anxiety and removing those related to antidepressant consumption (see Appendix 3.4).

Primary Outcome Measure:

General Help-Seeking Questionnaire (GHSQ), Part 1: The first part of the GHSQ (Wilson et al., 2005) consists of ten items, measuring respondents' intentions to seek help from both informal and professional sources (see Appendix 3.5). It is the help-seeking measure most widely used across relevant literature (Divin et al., 2018). The measure demonstrates good external validity and convergent validity with other instruments assessing help-seeking intentions. The measure was adapted by modifying items to relate to anxiety problems specifically.

Measures of Hypothesised Mediators:

Illness Appraisal - Stress Appraisal Measure for Adolescents (SAMA): The SAMA (Rowley et al., 2005) features 14 items relating to three domains: threat, challenge, and resources (see Appendix 3.6). It was adapted from the Stress Appraisal Measure designed by Peacock and Wong (1990) and established suitable, gender-equivalent invariance across each domain of the measure. Discriminant and convergent validity with measures of depression were established in consistency with similar research. This measure was adapted by modifying items to relate to anxiety problems specifically.

Attitudes - Adapted Mental Help Seeking Attitudes Scale (MHSAS): The 9-item MHSAS (Hammer et al., 2018) assesses respondents' appraisal of their help-seeking from professionals (see Appendix 3.7). It has demonstrated good internal consistency, test-retest reliability, and construct reliability. The measure also demonstrated convergent validity with older measures of help-seeking attitudes (Fischer & Turner, 1970; Mackenzie et al., 2004). This measure was adapted by modifying items to relate to anxiety problems specifically.

Stigma - Generalised Anxiety Stigma Scale (GASS): The GASS (Griffiths et al., 2011), consisting of 20 items, measures respondents' stigma towards anxiety problems (see Appendix 3.8). It has two subscales; Personal Stigma (which measures one's own views regarding anxiety) and Perceived Stigma (which measures one's perceptions of how others in the community view anxiety). This measure has shown good test-retest reliability, convergent validity, and construct validity. This measure was adapted by modifying items to relate to anxiety problems specifically.

Acceptability Measure

This measure (Voutilainen et al., 2016) was used to assess the ALHS' acceptability by participants (see Appendix 3.9). It is generally found to be responsive, valid, and reliable (Hasson & Arnetz, 2005).

Interventions

Anxiety Literacy & Help-Seeking (ALHS)

The ALHS is a single, 25-minute psychoeducational session delivered in classrooms by a mental health practitioner aimed at increasing young adolescent students' anxiety literacy and help-seeking intentions. The session included a) details of anxiety symptoms, b)

distinction between adaptive and problematic anxiety, c) information about relevant local resources of support for anxiety and d) addressing common myths associated with help-seeking for mental health problems.

This psychoeducational session, informed by the Theory of Planned Behaviour by Ajzen (1991), was designed by JK, ALZ and LJ. It was subsequently modified following consultations with a team of 35 clinicians and researchers experienced in working with young people, based at the University of Oxford. Additionally, two parents, two teachers and two adolescents provided feedback to ensure relevance, engagement, and comprehensibility for the target population.

Control (5 Ways To Wellbeing)

A single 25-minute educational session on general wellbeing and mental health was used as an active control condition. The session was entitled 'Be Physically Active – 5 Ways to Wellbeing' and had previously been used as a control condition in similar help-seeking research (Radez et al., 2024), and was developed by the local NHS trust. No information was provided on recognition of anxiety problems, formal/informal help-seeking, stigma, misconceptions about anxiety problems, or attitudes towards anxiety problems.

Procedure

This study was conducted in a single, large (>1500 students), mixed comprehensive school in Southern England. Each class was randomly assigned to either the control or ALHS condition using the Sealed Envelope randomisation website. In May 2024, the lead researcher (JK), a trainee clinical psychologist, delivered both ALHS and control sessions during 60-minute school lessons over a period of two weeks. In both conditions, participants were asked

to fill in six brief measures taking approximately 20 minutes. Upon completion, the ALHS/control were delivered. Immediately afterwards, participants were asked to again complete each measure. Approximately one month later, participants were asked to fill in the questionnaires again. They were administered without input by teachers during class time. All questionnaires were provided in paper form. Questionnaires were collected by the lead researcher (JK) upon completion. Following data collection, all young people in the control condition were given access to a pre-recorded ALHS session. Unique ID codes were used to ensure that pre, post and follow-up questionnaires could be matched while preserving anonymity. No personally identifiable data were collected.

Statistical Analyses

Data were manually inputted into SPSS by the primary researcher (JK) and checked twice for accuracy. Cases where written ID codes were initially unmatched were extricated and matched based on recognised typographical errors (e.g. participant writing the letter 'l' instead of the number '1'). To check the independent variable (by evaluating changes in anxiety literacy) and evaluate the primary hypothesis (that help-seeking intentions would significantly improve in the ALHS condition compared to the control condition), 2 (condition: ALHS vs control) x 2 (timepoints: T1 vs T2) and 2 (condition: ALHS vs control) x 3 (timepoints: T1 vs T3) analyses of variance (ANOVA) were used. For mediation hypotheses, potential mediators were analysed using similar 2x2 ANOVAs to assess suitability for mediation analysis. Exploratory 2x2x2 ANOVAs (condition x sex/ethnic group x timepoints) were ran to analyse the effectiveness of the ALHS in relevant societal subgroups.

Chi squares were used to examine associations between sex (male, female), ethnic group (White, non-White) and condition (ALHS, control), and between the primary outcome measure (GHSQ) and the aforementioned categorical variables. Thresholds for minimum completion rates were set in accordance with measure instructions and standard clinical research practice. Whereupon measures were not fully completed but met these thresholds, pro-ration methods were employed; either those prescribed by the measures used or, if none existed, an 80% minimum threshold was agreed. Binary logistic regression was used to explore predictors of missing data. All analyses were conducted using IBM SPSS 27 at an alpha level of .05.

Results

A summary of our findings, highlighting variable means, standard deviations and attrition rates across each timepoint, can be found in Table 2. Baseline characteristics for each measure were established (see Appendix 3.11).

Table 2

Summary of findings

Measure	Baseline			Post-Intervention			Follow-up		
	Intervention	Control		Intervention	Control		Intervention	Control	
	M (SD)	M (SD)	N (%)	M (SD)	M (SD)	N (%)	M (SD)	M (SD)	N (%)
ALQ	14.43 (5.78)	13.12 (5.58)	273 (100)	17.76 (5.1)	14.36 (5.15)	212 (75.66)	15.89 (6.16)	15.36 (5)	109 (40)
GHSQ	34.78 (9.84)	34.5 (10.2)	273 (100)	36.27 (11.17)	34.18 (10.22)	210 (76.9)	33.11 (11.51)	32.62 (9.94)	104 (38.1)
MHSA	4.78 (1.12)	4.66 (.84)	273 (100)	5.02 (1.31)	4.73 (1.02)	177 (64.84)	5 (1.4)	4.7 (1.11)	85 (31.14)

SAMA	2.11 (.5)	2.01 (.57)	273 (100)	2.21 (.54)	2.1 (.53)	194 (71.06)	2.16 (.45)	2.16 (.49)	93 (34.07)
GASS	49.52 (12.63)	50.61 (10.77)	273 (100)	47.51 (13.12)	48.75 (12.08)	170 (62.27)	50.25 (13.44)	49.61 (11.64)	72 (26.37)

Preliminary Analyses

Missing Data Analysis

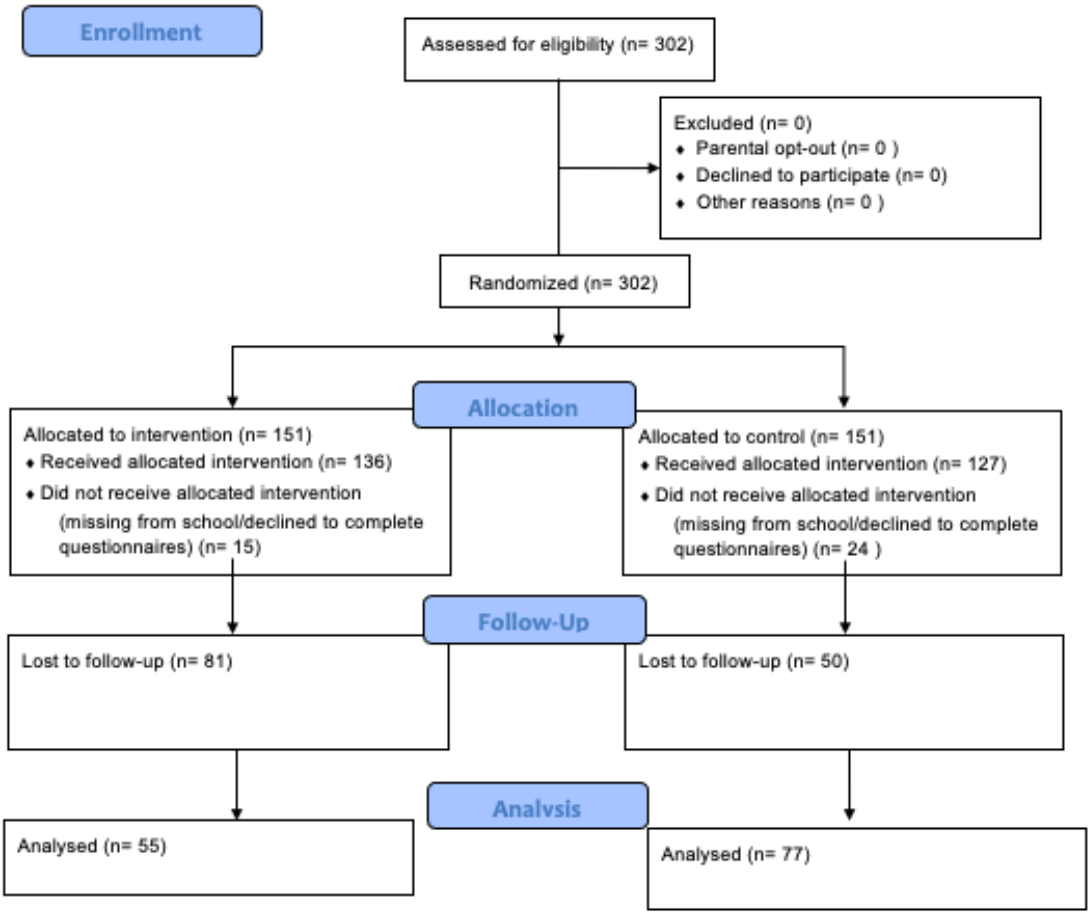
Of the 273 participating adolescents at T1, 131(47.98%) were lost to attrition at follow-up (see Figure 3). The proportion of missing responses across the whole sample was varied, ranging from 0-62.8% (see Appendix 3.10). Binary logistic regression was used to explore patterns of missing data regarding sex, ethnic group and condition. Between T1-T2, girls were less likely to complete measures than boys, while at follow-up, those in the control group were less likely to complete measures (except for MHSA) (see Appendix 3.13).

Figure 3

Participant Flow Diagram

CONSORT
TRANSPARENT REPORTING of TRIALS

CONSORT 2010 Flow Diagram



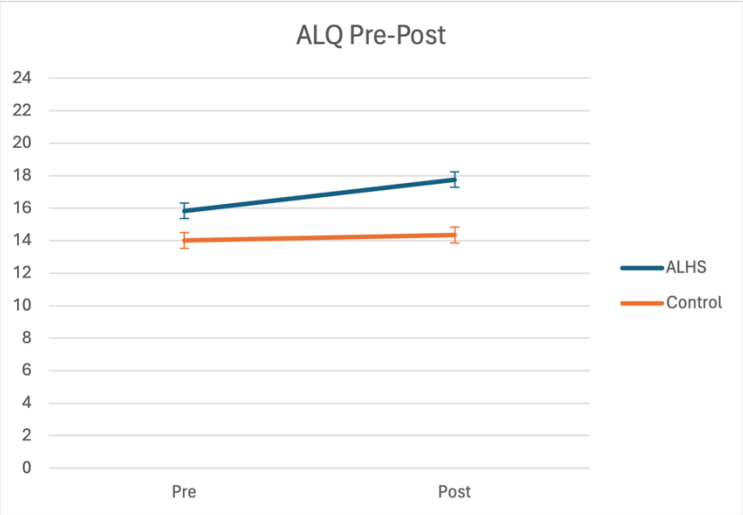
Chi squares indicated no significant association between sex and condition (χ^2 (1,262) =.143, *p*=.71, V=0.02) or ethnic group and condition (χ^2 (1,259) =3.09, *p*=.08, V=0.11). There was a significant association between GHSQ completion post-intervention and sex – girls were more likely to complete the measure post-intervention than boys (χ^2 (1,270) =.12.1, *p*= <.001, V=.212). There was no significant association between GHSQ completion post-intervention and condition (χ^2 (1,263) =.12, *p*=..269, V=0.7) or ethnic group (χ^2 (1,259) =.67, *p*=.41, V=0.05).

Independent Variable Check*: Effect of ALHS on Anxiety Literacy*

Time 1-2: Analysis yielded significant effects for time, F (1, 210) = 16.63, p<.001, η^2=.08, condition, F (1, 210) =18.59, p=<.001, η^2=.08, and interaction between time and condition, F (1,210) = 8.18, p=.005, η^2=.04. Anxiety literacy improved significantly over time in the ALHS condition compared to the control condition between T1-T2 (see Figure 4). Exploratory analysis revealed no significant three-way interaction between time, condition and sex or ethnicity (see Appendix 3.14).

Figure 4

Participant changes in Anxiety Literacy between Time 1-2.



Time 1-3: Analysis identified no significant effect for time, F (2, 214) = 1.316, p = .27, η^2=.01, or interaction of time and condition, F(2, 214) = .57, p = .57, η^2=.01. Exploratory analysis revealed no significant three-way interaction between time, condition and participant sex or participant ethnicity (see Appendix 3.14).

These results indicate that the ALHS produced immediate improvements in anxiety literacy that were not sustained at follow-up and thus, it was viable to evaluate the primary outcome.

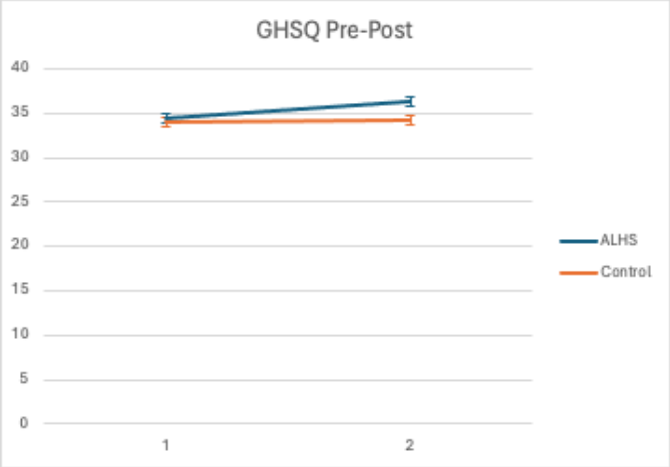
Main Analyses

Primary Outcome: *Effect of ALHS on Help-Seeking Intentions*

Time 1-2: A significant effect for time, F (1,208) =5.08, p<.05, η^2=.02, was found, but not for condition, F (1,208) =.84, p=.36, η^2=0, or interaction of time and condition, F (1,208) =3.54, p<.06, η^2=.02 (see Figure 5). Exploratory analysis revealed no significant three-way interaction between time, condition, and sex/ethnicity (see Appendix 3.14). These findings suggest an immediate increase in help-seeking intentions across both groups.

Figure 5

Participant Changes in Help-Seeking Intentions between Time 1-2.



Time 1-3: There was a significant effect for time, F(2, 204) = 3.58, p = .03, η^2=.03. However, there was no significant effect for condition, F(1, 102) = .42, p = .52, η^2=0, or interaction between time and condition, F(2, 204) = .34, p = .39, η^2=.01. Exploratory analysis revealed no significant three-way interaction between time, condition, and sex. Significant three-way interaction between time, condition and participant ethnicity was

found, and a main effect for time – however, no other significant main or interaction effects were found (see Appendix 3.14).

Secondary Outcomes: Evaluation of Potential Mediators

SAMA (Anxiety Appraisal)

The main effect of time was significant between T1-T2, F (1,192) =3.93, p>.05, η^2=.02, but not at T3, F(2, 182) = 1.38, p = .25, η^2=.02. There was no main effect for condition at T1-T2, F (1, 192) =2.04, p=.16, η^2=.01, or at T3, F (1, 91) =.96, p=.33, η^2=0.1. There was no significant interaction between time and condition T1-T2, F (2,182) =1.17, p=.19, η^2=0, or at T3, F (2, 182) =1.65, p=.19, η^2=.02 (see Appendix 3.16). Exploratory analysis revealed no significant three-way interaction between time, condition, and sex/ethnicity (see Appendix 3.14).

MHSA (Anxiety Help-Seeking Attitudes)

The main effect of time was significant between T1-T2, F (1,175) =5.57, p=.02, η^2=.03, but not at T3, F (2, 166) =.25, p=.78, η^2=0. There was no significant main effect for condition between T1-T2, F (1, 175) = 2.36, p=.13, η^2=.01, or at T3, F (1,83) =2.19, p=.14, η^2=.03. There was no significant interaction between time and condition either T1-T2, F (1,175) =.85, p=.36, η^2=.01, or at T3, F (2,166) =.1, p=.9, η^2=0 (see Appendix 3.16). Exploratory analysis revealed no significant three-way interaction between time, condition, and sex/ethnicity (see Appendix 3.14).

GASS (Anxiety-Related Stigma)

There was no significant main effect for time either between T1-T2, F (1,168) = 1.97, p=.16, η^2=.01, or at T3, F(2, 140) = 2.61, p=.08, η^2=.04. No significant main effects were found for

condition T1-T2, F (1, 168) =.68, p=.41, η^2=0, or at T3, F (1, 70) =.12, p=.729, η^2=0. Similarly, no significant interactions between time and condition were observed T1-T2, F (1,168) = .06, p=.81, η^2=0, or at T3, F (2, 140) =.57, p=.57, η^2=.01 (see Appendix 3.15). Exploratory analysis revealed no significant three-way interaction between time, condition, and sex/ethnicity (see Appendix 3.14).

Exploratory Outcome: Mediation Analysis

As there was no significant interaction effects found between time and condition for any of the secondary outcomes, mediation analysis was not conducted.

Exploratory Outcome: Acceptability

One hundred and fifty-five participants completed the acceptability measure post-intervention (see Table 3). ALHS participants viewed their intervention as more helpful (t (147) = 6.25, p<.001), understandable (t (148) = 4.69, p<.001), relevant (t (144) = 4.33, p<.001) and recommendable to peers (t (142) = 4.12, p<.001) compared with participants in the control condition.

Table 3

Mean Acceptability Scores

	ALHS M(SD)	Control M(SD)
Helpful	7.11 (2.1)	4.8 (2.41)
Understandable	8.12 (1.82)	6.52(2.35)
Relevant	7.41(2.13)	5.7(2.62)
Would recommend to peers	7.42(2.35)	5.72(2.57)

Discussion

This study aimed to develop and duly evaluate the effectiveness of a single-session, school-based psychoeducational intervention for help-seeking intentions related to anxiety (ALHS) in adolescents aged 12-13 in an English secondary school, relative to a control psychoeducation session on general wellbeing. It also evaluated improvements in anxiety literacy as an independent variable check. This study further aimed to explore the ALHS' impact on stigma, anxiety appraisal, and attitudes, as potential mediators between the novel intervention and increased in help-seeking intentions, as potentially predicted by the Theory of Planned Behaviour. Further subgroup analyses aimed to explore the ALHS's effectiveness within subgroups based on sex and ethnicity.

We found that the ALHS was effective in increasing anxiety literacy immediately following its' delivery, relative to the control condition; however, these effects were not sustained at follow-up. Significant increase of anxiety literacy in the intervention arm demonstrated that the ALHS' functioned as hoped and the study could thereby evaluate whether this improvement led to an increase in help seeking. However, help-seeking intentions for anxiety problems were significantly improved in both ALHS and control conditions immediately following intervention delivery. These improvements were also not sustained at follow-up. There were also no significant changes in attitude, stigma or anxiety appraisal following the ALHS relative to the control group. The ALHS was found to be more acceptable to participants than the control intervention. The implications of each of these findings will be discussed in turn.

Consistent with previous research evaluating anxiety literacy interventions, our study noted significant improvement post-intervention. This improvement demonstrated that the ALHS's

design was fit for purpose and provided sufficient grounds for exploration of the primary outcome variable in the context of the Theory of Planned Behaviour.

However, a myriad of recent studies indicate that a lack of significant improvement in help-seeking on the ALHS' part should not be viewed in isolation. Systematic review by Hayes et al. (2024) of universal, school based interventions aimed at improving help-seeking intentions in adolescents revealed that all such studies produced either small effect sizes, or negative effects - reducing help-seeking intentions for their mental health. Similar results were found by Ma, Burn, et al. (2023), who concluded that there were no strong evidence that universal help-seeking interventions improved intentions to do so.

Furthermore, concerns currently exist that beyond questionable effectiveness, such MHL/help-seeking programmes might pose risk of harm to young people. For instance, a large-scale research programme exploring the effectiveness of school-based mental health interventions (Approaches for Wellbeing and Mental Health Literacy: Research in Education, or 'AWARE) found in addition to not improving long-term help-seeking intentions, the programme coincided with increased emotional difficulties and decreased life satisfaction in participating students (Deighton et al., 2025). Similar school-based psychoeducational programmes have also reported mildly adverse mental health effects (Montero-Marin et al., 2022; Stallard et al., 2012). As Foulkes and Andrews (2023) note, it is presently unclear whether such effects stem from over-identification with mental health problems or improved recognition; until this is clarified, proponents of universal school-based MHL and help-seeking interventions should proceed with caution.

The ALHS being rated by students as more helpful, understandable, relevant, and likely to recommend than its' control counterpart suggests that the content of the intervention

designed by the research team was received better than typical mental-health related workshops available to the school. This indicates that while the brevity of the intervention may have contributed to its' shortcomings, its' core content was viewed positively by students.

Limitations

This study was limited by several factors. Firstly, the high volume of measures included in this study may have hampered engagement; as Scott et al. (2023) note, ease of completion and appropriate measure length can be barriers in implementing child-centred outcome measures. This can be observed in high attrition rates – over 50% of participants did not complete follow-up measures, with some questionnaire items missing over 60% of responses. Such attrition is mirrored in many similar MHL school-based interventions (Townsend et al., 2019) (Hart et al., 2018) (McLuckie et al., 2014). Relatedly, contamination risks using randomised control designs are high in school settings (Patafio et al., 2021) – it cannot be ruled out that ALHS participants discussed the content of their intervention with control participants, and vice versa. Furthermore, despite the potential benefit of improved mental health literacy on mental health outcomes as explored by Kutcher et al (2016), our study did not evaluate anxious symptomology. Finally, recent meta-analysis indicates that many literacy interventions may not change help-seeking behaviour (Amado-Rodríguez et al., 2022). The ALHS was didactic in design; Powell et al. (2014) posit that interventions related to mental health typically do little to invoke behavioural change if they are passive in nature, in contrast to effective help-seeking interventions featuring participatory activities such as MAKINGtheLINK (Lubman et al., 2020). Future interventions may also benefit from greater input from adolescents. Peer-led interventions have shown effectiveness in increasing both mental health literacy (Booth et al., 2023; Patalay et al., 2017) and help-seeking intentions (Sun et al., 2022) (Ahorsu et al., 2021)

Conclusions

Our study was effective in producing immediate increase in anxiety literacy in the ALHS condition compared to an active control group. However, these increases were not sustained. While immediate increases in help-seeking intentions were observed (as well as in anxiety appraisals and attitudes), these were not specific to the ALHS condition. Theorised mediators were not viable for mediation analysis given non-specific results. (given the non-specific results). These results imply that school-based single-session approaches to increase help-seeking intentions for adolescent anxiety, via improvement in anxiety literacy, are unlikely to be effective or to produce meaningful impact above and beyond traditional wellbeing programs such as those already commonplace in schools.

References

Aabe, N. O., Fox, F., Rai, D., & Redwood, S. (2019). Inside, outside and in-between: the process and impact of co-producing knowledge about autism in a UK Somali community. *Health Expectations*, *22*(4), 752-760.

Adams, C., Gringart, E., & Strobel, N. (2022). Explaining adults' mental health help-seeking through the lens of the theory of planned behavior: a scoping review. *Systematic Reviews*, *11*(1), 160. https://doi.org/10.1186/s13643-022-02034-y

Aguirre Velasco, A., Cruz, I. S. S., Billings, J., Jimenez, M., & Rowe, S. (2020). What are the barriers, facilitators and interventions targeting help-seeking behaviours for common mental health problems in adolescents? A systematic review. *BMC Psychiatry*, *20*(1), 293. https://doi.org/10.1186/s12888-020-02659-0

Ahmed, S. K. (2024). The pillars of trustworthiness in qualitative research. *Journal of Medicine, Surgery, and Public Health*, *2*, 100051. https://doi.org/https://doi.org/10.1016/j.glmedi.2024.100051

Ahorsu, D. K., Sánchez Vidaña, D. I., Lipardo, D., Shah, P. B., Cruz González, P., Shende, S., Gurung, S., Venkatesan, H., Duongthipthewa, A., & Ansari, T. Q. (2021). Effect of a peer-led intervention combining mental health promotion with coping-strategy-based workshops on mental health awareness, help-seeking behavior, and wellbeing among university students in Hong Kong. *International journal of mental health systems*, *15*, 1-10.

Ajzen, I. (1991). The theory of planned behavior. *Organizational behavior and human decision processes*, *50*(2), 179-211.

Amado-Rodríguez, I. D., Casañas, R., Mas-Expósito, L., Castellví, P., Roldan-Merino, J. F., Casas, I., Lalucat-Jo, L., & Fernández-San Martín, M. I. (2022). Effectiveness of Mental Health Literacy Programs in Primary and Secondary Schools: A Systematic Review with Meta-Analysis. *Children*, *9*(4), 480. https://www.mdpi.com/2227-9067/9/4/480

American Psychatric Association. (2013). Diagnostic and statistical manual of mental disorders : DSM-5. In (5th ed. ed.). Arlington, VA :.

Anandaciva, S. (2023). How does the NHS compare to the health care systems of other countries? *King's Fund*.

Ashworth, E., Bray, L., Hanlon, C., Stanway, H., Pavlopoulou, G., Moore, D., Donaghy, B., Coen, E., & Firth, E. (2025). 'Accumulating harm and waiting for crisis': Parents' perspectives of accessing Child and Adolescent Mental Health Services for their autistic child experiencing mental health difficulties. *Autism*, *0*(0), 13623613251335715. https://doi.org/10.1177/13623613251335715

Aylaz, R., Yılmaz, U., & Polat, S. (2012). Effect of difficulties experienced by parents of autistic children on their sexual life: A qualitative study. *Sexuality and Disability*, *30*, 395-406.

Babalola, T., Sanguedolce, G., Dipper, L., & Botting, N. (2024). Barriers and Facilitators of Healthcare Access for Autistic Children in the UK: a Systematic Review. *Review Journal of Autism and Developmental Disorders*. https://doi.org/10.1007/s40489-023-00420-3

Baker, C., & Kirk-Wade, E. (2021). Mental health statistics: prevalence, services and funding in England. *The House of Commons Library*.

Batchelor, M., Maguire, S., & Shearn, J. (2021). "They just get it" an exploration of father's experiences and perceptions of a support group for men caring for children with disabilities and/or developmental delay. *J Appl Res Intellect Disabil*, *34*(1), 263-273. https://doi.org/10.1111/jar.12804

Bonis, S. (2016). Stress and parents of children with autism: A review of literature. *Issues in mental health nursing*, *37*(3), 153-163.

Booth, A., Doyle, E., & O'Reilly, A. (2023). School-based health promotion to improve mental health literacy: a comparative study of peer-versus adult-led delivery. *Journal of Mental Health*, *32*(1), 226-233.

Boshoff, K., Bowen-Salter, H., Gibbs, D., Phillips, R. L., Porter, L., & Wiles, L. (2021). A meta-synthesis of how parents of children with autism describe their experience of accessing and using routine healthcare services for their children. *Health & Social Care in the Community*, *29*(6), 1668-1682. https://doi.org/https://doi.org/10.1111/hsc.13369

Boshoff, K., Gibbs, D., Phillips, R. L., Wiles, L., & Porter, L. (2018). Parents' voices: "Our process of advocating for our child with autism." A meta-synthesis of parents' perspectives. *Child Care Health Dev*, *44*(1), 147-160. https://doi.org/10.1111/cch.12504

Boterhoven de Haan, K. L., Lee, C. W., Correia, H., Menninga, S., Fassbinder, E., Köehne, S., & Arntz, A. (2021). Patient and therapist perspectives on treatment for adults with PTSD from childhood trauma. *Journal of Clinical Medicine*, *10*(5), 954.

Botha, M., & Cage, E. (2022). "Autism research is in crisis": A mixed method study of researcher's constructions of autistic people and autism research [Original Research]. *Frontiers in Psychology, Volume 13 - 2022*. https://doi.org/10.3389/fpsyg.2022.1050897

Braun, V., & Clarke, V. (2021a). *Thematic analysis : a practical guide*. SAGE.

Braun, V., & Clarke, V. (2021b). Thematic analysis: A practical guide.

Braun, V., Victoria, C., & and Hayfield, N. (2022). 'A starting point for your journey, not a map': Nikki Hayfield in conversation with Virginia Braun and Victoria Clarke about thematic analysis. *Qualitative Research in Psychology*, *19*(2), 424-445. https://doi.org/10.1080/14780887.2019.1670765

Brice, S., Rodgers, J., Ingham, B., Mason, D., Wilson, C., Freeston, M., Couteur, A. L., & Parr, J. R. (2021). The importance and availability of adjustments to improve access for autistic adults who need mental and physical healthcare: findings from UK surveys. *BMJ Open*, *11*(3), e043336. https://doi.org/10.1136/bmjopen-2020-043336

Burke, L., John, M., & Hanna, P. (2022). A qualitative exploration of how young men in the UK perceive and experience informal help-seeking for mental health difficulties. *Children and Youth Services Review*, *137*, 106440. https://doi.org/https://doi.org/10.1016/j.childyouth.2022.106440

Cachia, R. L., Anderson, A., & Moore, D. W. (2016). Mindfulness, stress and well-being in parents of children with autism spectrum disorder: A systematic review. *Journal of Child and Family Studies*, *25*, 1-14.

Calear, A. L., Batterham, P. J., Torok, M., & McCallum, S. (2021). Help-seeking attitudes and intentions for generalised anxiety disorder in adolescents: the role of anxiety literacy and stigma. *European Child & Adolescent Psychiatry*, *30*(2), 243-251. https://doi.org/10.1007/s00787-020-01512-9

Cauce, A. M., Domenech-Rodríguez, M., Paradise, M., Cochran, B. N., Shea, J. M., Srebnik, D., & Baydar, N. (2002). Cultural and contextual influences in mental health help seeking: A focus on ethnic minority youth. *Journal of Consulting and Clinical Psychology*, *70*(1), 44-55. https://doi.org/10.1037/0022-006X.70.1.44

Chan, M. E. (2013). Antecedents of Instrumental Interpersonal Help-Seeking: An Integrative Review. *Applied Psychology*, *62*(4), 571-596. https://doi.org/https://doi.org/10.1111/j.1464-0597.2012.00496.x

Chan, S. W., & Adams, M. (2014). Service use, drop-out rate and clinical outcomes: a comparison between high and low intensity treatments in an IAPT service. *Behavioural and Cognitive Psychotherapy*, *42*(6), 747-759.

Chandler, J., Cumpston, M., Li, T., Page, M. J., & Welch, V. (2019). Cochrane handbook for systematic reviews of interventions. *Hoboken: Wiley*, *4*(1002), 14651858.

Clark, D. M. (2018). Realizing the Mass Public Benefit of Evidence-Based Psychological Therapies: The IAPT Program. *Annu Rev Clin Psychol*, *14*, 159-183. https://doi.org/10.1146/annurev-clinpsy-050817-084833

Clark, L. H., Hudson, J. L., Dunstan, D. A., & Clark, G. I. (2018). Barriers and facilitating factors to help-seeking for symptoms of clinical anxiety in adolescent males. *Australian Journal of Psychology*, *70*(3), 225-234.

Collishaw, S., Maughan, B., Natarajan, L., & Pickles, A. (2010). Trends in adolescent emotional problems in England: a comparison of two national cohorts twenty years apart. *Journal of child psychology and psychiatry*, *51*(8), 885-894.

Conrad, C. E., Rimestad, M. L., Rohde, J. F., Petersen, B. H., Korfitsen, C. B., Tarp, S., Cantio, C., Lauritsen, M. B., & Händel, M. N. (2021). Parent-mediated interventions for children and adolescents with autism spectrum disorders: a systematic review and meta-analysis. *Frontiers in Psychiatry*, *12*, 773604.

Cooper, K., Loades, M., & Russell, A. (2018). Adapting psychological therapies for autism. *Research in Autism Spectrum Disorders*, *45*, 43-50.

Corcoran, J., Berry, A., & Hill, S. (2015). The lived experience of US parents of children with autism spectrum disorders: A systematic review and meta-synthesis. *Journal of Intellectual Disabilities*, *19*(4), 356-366.

Cornally, N., & McCarthy, G. (2011). Help-seeking behaviour: A concept analysis. *International journal of nursing practice*, *17*(3), 280-288.

Cowlishaw, S., Metcalf, O., Stone, C., O'Donnell, M., Lotzin, A., Forbes, D., Hegarty, K., & Kessler, D. (2021). Posttraumatic Stress Disorder in Primary Care: A Study of General Practices in England. *J Clin Psychol Med Settings*, *28*(3), 427-435. https://doi.org/10.1007/s10880-020-09732-6

Crane, L., Batty, R., Adeyinka, H., Goddard, L., Henry, L. A., & Hill, E. L. (2018). Autism diagnosis in the United Kingdom: Perspectives of autistic adults, parents and professionals. *Journal of autism and developmental disorders*, *48*, 3761-3772.

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

Cullingham, T., Rennard, U., Creswell, C., Milton, D., Buckle, K. L., Godber, L., Gordon, K., Larkin, M., & Green, J. (2024). The process of co-design for a new anxiety intervention for autistic children. *Jcpp Advances*, e12255.

Cutress, & Muncer. (2014). Parents' views of the national autistic society's earlybird plus programme. *Autism*. https://www.scopus.com/inward/record.uri?eid=2-s2.0-84904615703&doi=10.1177%2f1362361313495718&partnerID=40&md5=9cb96add604a3d529272a6c6b25bc42e

Da Paz, N. S., Siegel, B., Coccia, M. A., & Epel, E. S. (2018). Acceptance or despair? Maternal adjustment to having a child diagnosed with autism. *Journal of Autism and Developmental Disorders*, *48*, 1971-1981.

Damghanian, M., & Alijanzadeh, M. (2018). Theory of planned behavior, self-stigma, and perceived barriers explains the behavior of seeking mental health services for people at risk of affective disorders. *Social Health and Behavior*, *1*(2), 54.

Dawson-Squibb, J.-J., Davids, E. L., Harrison, A. J., Molony, M. A., & de Vries, P. J. (2020). Parent education and training for autism spectrum disorders: Scoping the evidence. *Autism*, *24*(1), 7-25.

Deane, F. P., Wilson, C. J., & Russell, N. (2007). Brief report: Impact of classroom presentations about health and help-seeking on rural Australian adolescents' intentions to consult health care professionals. *Journal of adolescence*, *30*, 695-699. https://doi.org/10.1016/j.adolescence.2007.03.001

Deb, S. S., Retzer, A., Roy, M., Acharya, R., Limbu, B., & Roy, A. (2020). The effectiveness of parent training for children with autism spectrum disorder: a systematic review and meta-analyses. *Bmc Psychiatry*, *20*(1), 583. https://doi.org/10.1186/s12888-020-02973-7

Deighton, J., Thompson, A., Humphrey, N., Thornton, E., Knowles, C., Patalay, P., Zhang, K., Evans-Lacko, S., Hayes, D., & March, A. (2025). Effectiveness of School Mental Health Awareness Interventions. *UK Department for Education*.

Denne, L. D., Hastings, R. P., & Hughes, J. C. (2017). UK parents' beliefs about applied behaviour analysis as an approach to autism education. *European Journal of Special Needs Education*, *32*(4), 543-555. https://doi.org/https://doi.org/10.1080/08856257.2017.1297568

DePape, A.-M., & Lindsay, S. (2014). Parents' Experiences of Caring for a Child With Autism Spectrum Disorder. *Qualitative Health Research*, *25*(4), 569-583. https://doi.org/10.1177/1049732314552455

Divin, N., Harper, P., Curran, E., Corry, D., & Leavey, G. (2018). Help-Seeking Measures and Their Use in Adolescents: A Systematic Review. *Adolescent Research Review*, *3*(1), 113-122. https://doi.org/10.1007/s40894-017-0078-8

Edwards, A. G., Brebner, C. M., McCormack, P. F., & MacDougall, C. J. (2018). From 'parent'to 'expert': How parents of children with autism spectrum disorder make decisions about which intervention approaches to access. *Journal of Autism and Developmental Disorders*, *48*, 2122-2138.

Ehlers, A., Gene-Cos, N., & Perrin, S. (2009). Low Recognition of Posttraumatic Stress Disorder in Primary Care. *London J Prim Care (Abingdon)*, *2*(1), 36-42.

Ehlers, A., & Wild, J. (2022). Cognitive Therapy for PTSD: Updating Memories and Meanings of Trauma. In U. Schnyder & M. Cloitre (Eds.), *Evidence Based Treatments for Trauma-Related Psychological Disorders: A Practical Guide for Clinicians* (pp. 181-210). Springer International Publishing. https://doi.org/10.1007/978-3-030-97802-0_9

Ehrenreich, J. H. (2003). Understanding PTSD: forgetting "trauma". *Analyses of Social Issues and Public Policy*, *3*(1), 15-28.

Falk, N. H., Norris, K., & Quinn, M. G. (2014). The factors predicting stress, anxiety and depression in the parents of children with autism. *Journal of autism and developmental disorders*, *44*, 3185-3203.

Faul, F., Erdfelder, E., Lang, A.-G., & Buchner, A. (2007). G*Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. *Behavior Research Methods*, *39*(2), 175-191. https://doi.org/10.3758/BF03193146

Fetters, M. D., Curry, L. A., & Creswell, J. W. (2013). Achieving integration in mixed methods designs-principles and practices. *Health Serv Res*, *48*(6 Pt 2), 2134-2156. https://doi.org/10.1111/1475-6773.12117

Finch, J., Ford, C., Lombardo, C., & Meiser-Stedman, R. (2020). A survey of evidence-based practice, training, supervision and clinician confidence relating to post-traumatic stress disorder (PTSD) therapies in UK child and adolescent mental health professionals. *European Journal of Psychotraumatology*, *11*(1), 1815281.

Fischer, E. H., & Turner, J. I. (1970). Orientations to seeking professional help: Development and research utility of an attitude scale. *Journal of Consulting and Clinical Psychology*, *35*, 79-90. https://doi.org/10.1037/h0029636

Foulkes, L., & Andrews, J. L. (2023). Are mental health awareness efforts contributing to the rise in reported mental health problems? A call to test the prevalence inflation hypothesis. *New Ideas in Psychology*, *69*, 101010. https://doi.org/https://doi.org/10.1016/j.newideapsych.2023.101010

Frissa, S., Hatch, S. L., Fear, N. T., Dorrington, S., Goodwin, L., & Hotopf, M. (2016). Challenges in the retrospective assessment of trauma: comparing a checklist approach to a single item trauma experience screening question. *BMC psychiatry*, *16*(1), 1-9.

Galdas, P. M., Cheater, F., & Marshall, P. (2005). Men and health help-seeking behaviour: literature review. *Journal of Advanced Nursing*, *49*(6), 616-623.

Gerow, S., Hagan-Burke, S., Rispoli, M., Gregori, E., Mason, R., & Ninci, J. (2018). A systematic review of parent-implemented functional communication training for children with ASD. *Behavior modification*, *42*(3), 335-363.

Gillberg, N., Carmela, M., & and Westman Andersson, G. (2024). Knowledge and belongingness: experiences of a programme for parents of children with autism. *Educational Research*, *66*(1), 1-17. https://doi.org/10.1080/00131881.2023.2276956

Green, J., Aldred, C., Charman, T., Le Couteur, A., Emsley, R. A., Grahame, V., Howlin, P., Humphrey, N., Leadbitter, K., McConachie, H., Parr, J. R., Pickles, A., Slonims, V., & Taylor, C. (2018). Paediatric Autism Communication Therapy-Generalised (PACT-G) against treatment as usual for reducing symptom severity in young children with autism spectrum disorder: study protocol for a randomised controlled trial. *Trials*, *19*(1), 514. https://doi.org/10.1186/s13063-018-2881-3

Griffiths, K. M., Batterham, P. J., Barney, L., & Parsons, A. (2011). The Generalised Anxiety Stigma Scale (GASS): psychometric properties in a community sample. *BMC Psychiatry*, *11*, 184. https://doi.org/10.1186/1471-244x-11-184

Grindle, C. F., Kovshoff, H., Hastings, R. P., & Remington, B. (2009). Parents' experiences of home-based applied behavior analysis programs for young children with autism. *J Autism Dev Disord*, *39*(1), 42-56. https://doi.org/10.1007/s10803-008-0597-z

Grogan, P., Yaari, M., Jellett, R., Unwin, K., & Dissanayake, C. (2023). Parent resolution of diagnosis and intervention fidelity in a parent-delivered intervention for pre-school children with autism: A mixed methods study. *Research in Autism Spectrum Disorders*, *101*, 102102. https://doi.org/https://doi.org/10.1016/j.rasd.2023.102102

Gulliver, A., Griffiths, K. M., Christensen, H., & Brewer, J. L. (2012). A systematic review of help-seeking interventions for depression, anxiety and general psychological distress. *BMC Psychiatry*, *12*(1), 81. https://doi.org/10.1186/1471-244X-12-81

Gulliver, A., Griffiths, K. M., Christensen, H., Mackinnon, A., Calear, A. L., Parsons, A., Bennett, K., Batterham, P. J., & Stanimirovic, R. (2012). Internet-based interventions to promote mental health help-seeking in elite athletes: an exploratory randomized controlled trial. *J Med Internet Res*, *14*(3), e69. https://doi.org/10.2196/jmir.1864

Guzick, A. G., Schneider, S. C., Kendall, P. C., Wood, J. J., Kerns, C. M., Small, B. J., Park, Y. E., Cepeda, S. L., & Storch, E. A. (2022). Change during cognitive and exposure phases of cognitive–behavioral therapy for autistic youth with anxiety disorders. *Journal of consulting and clinical psychology*, *90*(9), 709.

Hall, R. C. W., & Hall, R. C. W. (2007). Detection of Malingered PTSD: An Overview of Clinical, Psychometric, and Physiological Assessment: Where Do We Stand? *Journal of Forensic Sciences*, *52*(3), 717-725. https://doi.org/https://doi.org/10.1111/j.1556-4029.2007.00434.x

Hammer, J. H., Parent, M. C., & Spiker, D. A. (2018). Mental Help Seeking Attitudes Scale (MHSAS): Development, Reliability, Validity, and Comparison With the ATSPPH-SF and IASMHS-PO. *J Couns Psychol*, *65*(1), 74-85. https://doi.org/10.1037/cou0000248

Hardy, G. E., Bishop-Edwards, L., Chambers, E., Connell, J., Dent-Brown, K., Kothari, G., O'hara, R., & Parry, G. D. (2019). Risk factors for negative experiences during psychotherapy. *Psychotherapy Research, 29*(3), 403-414. https://doi.org/10.1080/10503307.2017.1393575

Harper, K., Bhutani, G., Rao, A. S., & Clarke, J. (2020). Wellbeing matters in IAPT practitioners: Identity vs system. *International Journal of Stress Prevention and Wellbeing*, *4*(4), 1-12.

Hart, L. M., Morgan, A. J., Rossetto, A., Kelly, C. M., Mackinnon, A., & Jorm, A. F. (2018). Helping adolescents to better support their peers with a mental health problem: A cluster-randomised crossover trial of teen Mental Health First Aid. *Aust N Z J Psychiatry, 52*(7), 638-651. https://doi.org/10.1177/0004867417753552

Hassett, A., & Isbister, C. (2017). Young men's experiences of accessing and receiving help from child and adolescent mental health services following self-harm. *Sage open*, *7*(4), 2158244017745112.

Hasson, D., & Arnetz, B. B. (2005). Validation and findings comparing VAS vs. Likert scales for psychosocial measurements. *International Electronic Journal of Health Education*, *8*, 178-192.

Hatchel, T., Ingram, K. M., Mintz, S., Hartley, C., Valido, A., Espelage, D. L., & Wyman, P. (2019). Predictors of suicidal ideation and attempts among LGBTQ adolescents: The roles of help-seeking beliefs, peer victimization, depressive symptoms, and drug use. *Journal of Child and Family Studies*, *28*, 2443-2455.

Hayes, D., Mansfield, R., Mason, C., Santos, J., Moore, A., Boehnke, J., Ashworth, E., Moltrecht, B., Humphrey, N., & Stallard, P. (2024). The impact of universal, school based, interventions on help seeking in children and young people: a systematic literature review. *European Child & Adolescent Psychiatry*, *33*(9), 2911-2928.

Helland, S., Baardstu, S., Kjøbli, J., Aalberg, M., & Neumer, S. (2023). Exploring the mechanisms in cognitive behavioural therapy for anxious children: does change in emotion regulation explain treatment effect? *Prevention Science*, *24*(2), 214-225.

Hepgul, N., King, S., Amarasinghe, M., Breen, G., Grant, N., Grey, N., Hotopf, M., Moran, P., Pariante, C. M., Tylee, A., Wingrove, J., Young, A. H., & Cleare, A. J. (2016). Clinical characteristics of patients assessed within an Improving Access to Psychological Therapies (IAPT) service: results from a naturalistic cohort study (Predicting Outcome Following Psychological Therapy; PROMPT). *BMC psychiatry*, *16*(1), 52. https://doi.org/10.1186/s12888-016-0736-6

Hodgetts, S., Nicholas, D., Zwaigenbaum, L., & McConnell, D. (2013). Parents' and professionals' perceptions of family-centered care for children with autism spectrum disorder across service sectors. *Social Science & Medicine*, *96*, 138-146.

Hodgson, A. R., Grahame, V., Garland, D., Gaultier, F., Lecouturier, J., & Le Couteur, A. (2018). Parents' Opinions about an Intervention to Manage Repetitive Behaviours in Young Children with Autism Spectrum Disorder: A Qualitative Study. *J Appl Res Intellect Disabil*, *31 Suppl 2*, 165-178. https://doi.org/10.1111/jar.12317

Hoon, C. (2013). Meta-Synthesis of Qualitative Case Studies:An Approach to Theory Building. *Organizational Research Methods*, *16*(4), 522-556. https://doi.org/10.1177/1094428113484969

Horton, E., Goldschmied, A. Z., Knops, M. J., Brownhill, L. A., Bycroft, A., Lloyd, A., Tones, D., Wiltshire, B., Toro, C. T., & Jutley-Neilson, J. (2024). Empowering voices: fostering reflective dialogue and redefining research dynamics in participatory approaches with the autistic community. *Journal of Participatory Research Methods*, *5*(3).

Howes, A. E., Burns, M. E., & Surtees, A. D. R. (2021). Barriers, facilitators, and experiences of the autism assessment process: A systematic review of qualitative research with health professionals. *Professional Psychology: Research and Practice*, *52*(5), 449-460. https://doi.org/10.1037/pro0000413

Jackson, L., Keville, S., & Ludlow, A. K. (2020). Mothers' Experiences of Accessing Mental Health Care for their Child with an Autism Spectrum Disorder. *Journal of Child and Family Studies*, *29*(2), 534-545. https://doi.org/https://doi.org/10.1007/s10826-019-01662-8

Jacobs, L., & Pentaris, P. (2021). Factors affecting the help-seeking behaviour of Black Asian Minority Ethnic (BAME) groups for mental health services in the UK: a literature review. *Greenwich Social Work Review*, *2*(1), 156-170.

James, A. C., Reardon, T., Soler, A., James, G., & Creswell, C. (2020). Cognitive behavioural therapy for anxiety disorders in children and adolescents. *Cochrane database of systematic reviews*(11).

Jimenez, M. E., Barg, F. K., Guevara, J. P., Gerdes, M., & Fiks, A. G. (2012). Barriers to evaluation for early intervention services: parent and early intervention employee perspectives. *Academic pediatrics*, *12*(6), 551-557.

Jorm, A. F. (2015). Why We Need the Concept of "Mental Health Literacy". *Health Communication*, *30*(12), 1166-1168. https://doi.org/10.1080/10410236.2015.1037423

Kerr, J., Sharry, J., & Wilson, C. (2023). Parents' experiences of raising adolescents with intellectual or developmental disabilities. *Journal of Intellectual & Developmental Disability*, *48*(2), 206-214. https://doi.org/10.3109/13668250.2022.2057843

Khanlou, N., Haque, N., Mustafa, N., Vazquez, L. M., Mantini, A., & Weiss, J. (2017). Access barriers to services by immigrant mothers of children with autism in Canada. *International Journal of Mental Health and Addiction*, *15*, 239-259.

Kmet, L. M., Cook, L. S., & Lee, R. C. (2004). Standard quality assessment criteria for evaluating primary research papers from a variety of fields.

Kreslins, A., Robertson, A. E., & Melville, C. (2015). The effectiveness of psychosocial interventions for anxiety in children and adolescents with autism spectrum disorder: A systematic review and meta-analysis. *Child and Adolescent Psychiatry and Mental Health*, *9*, 1-12.

Kutcher, S., Wei, Y., & Coniglio, C. (2016). Mental Health Literacy: Past, Present, and Future. *Can J Psychiatry*, *61*(3), 154-158. https://doi.org/10.1177/0706743715616609

Lachal, J., Revah-Levy, A., Orri, M., & Moro, M. R. (2017). Metasynthesis: An Original Method to Synthesize Qualitative Literature in Psychiatry. *Front Psychiatry*, *8*, 269. https://doi.org/10.3389/fpsyt.2017.00269

Laliotis, D., & Shapiro, F. (2022). EMDR Therapy for Trauma-Related Disorders. In U. Schnyder & M. Cloitre (Eds.), *Evidence Based Treatments for Trauma-Related Psychological Disorders: A Practical Guide for Clinicians* (pp. 227-254). Springer International Publishing. https://doi.org/10.1007/978-3-030-97802-0_11

Lawrence, D., Hafekost, J., Johnson, S. E., Saw, S., Buckingham, W. J., Sawyer, M. G., Ainley, J., & Zubrick, S. R. (2016). Key findings from the second Australian Child and Adolescent Survey of Mental Health and Wellbeing. *Aust N Z J Psychiatry*, *50*(9), 876-886. https://doi.org/10.1177/0004867415617836

Leadbitter, Macdonald, W., Taylor, C., & Buckle, K. L. (2020). Parent perceptions of participation in a parent-mediated communication-focussed intervention with their young child with autism spectrum disorder. *Autism*, *24*(8), 2129-2141. https://doi.org/https://doi.org/10.1177/1362361320936394

Leadbitter, K., Harrison, L., Langhorne, S., Ellis, C., Smallman, R., Pearson, A., Hackett, L., Kroll, L., Dunkerley, A., Beach, H., Gilbert, J., van Gils, A., Hutton, T., Green, J., &

Bee, P. (2024). The development, feasibility and acceptability of Empower-Autism: A new psychoeducational and psychotherapeutic programme for caregivers of children recently diagnosed with autism. *Autism*. https://www.scopus.com/inward/record.uri?eid=2-s2.0-85204609848&doi=10.1177%2f13623613241274566&partnerID=40&md5=58616276b01078cf580b8d42c23716ad

Lee, J. D., Terol, A. K., Yoon, C. D., & Meadan, H. (2024). Parent-to-parent support among parents of children with autism: A review of the literature. *Autism*, *28*(2), 263-275. https://doi.org/10.1177/13623613221146444

Lee, V., Albaum, C., Tablon Modica, P., Ahmad, F., Gorter, J. W., Khanlou, N., McMorris, C., Lai, J., Harrison, C., & Hedley, T. (2021). The impact of COVID-19 on the mental health and wellbeing of caregivers of autistic children and youth: A scoping review. *Autism Research*, *14*(12), 2477-2494.

Legg, H., & Tickle, A. (2019). UK parents' experiences of their child receiving a diagnosis of autism spectrum disorder: A systematic review of the qualitative evidence. *Autism*, *23*(8), 1897-1910. https://doi.org/10.1177/1362361319841488

Li, S. N., Chien, W. T., Lam, S. K. K., Chen, Z. Y., & Ma, X. (2024). Effectiveness of parent-focused interventions for improving the mental health of parents and their children with autism spectrum disorder: A systematic review and meta-analysis. *Research in Autism Spectrum Disorders*, *114*, 102389. https://doi.org/https://doi.org/10.1016/j.rasd.2024.102389

Lindsey, M. A., Korr, W. S., Broitman, M., Bone, L., Green, A., & Leaf, P. J. (2006). Help-seeking behaviors and depression among African American adolescent boys. *Social Work*, *51*(1), 49-58.

Lubman, D. I., Cheetham, A., Sandral, E., Wolfe, R., Martin, C., Blee, F., Berridge, B. J., Jorm, A. F., Wilson, C., Allen, N. B., McKay-Brown, L., & Proimos, J. (2020). Twelve-month outcomes of MAKINGtheLINK: A cluster randomized controlled trial of a school-based program to facilitate help-seeking for substance use and mental health problems. *eClinicalMedicine*, *18*. https://doi.org/10.1016/j.eclinm.2019.11.018

Luo, A., & McAloon, J. (2021). Potential mechanisms of change in cognitive behavioral therapy for childhood anxiety: A meta-analysis. *Depression and anxiety*, *38*(2), 220-232.

Ma, K. K. Y., Anderson, J. K., & Burn, A.-M. (2023). Review: School-based interventions to improve mental health literacy and reduce mental health stigma – a systematic review. *Child and Adolescent Mental Health*, *28*(2), 230-240. https://doi.org/https://doi.org/10.1111/camh.12543

Ma, K. K. Y., Burn, A. M., & Anderson, J. K. (2023). School-based mental health literacy interventions to promote help-seeking–a systematic review. *Child and Adolescent Mental Health*, *28*(3), 408-424.

Machado Junior, S. B., Celestino, M. I. O., Serra, J. P. C., Caron, J., & Ponde, M. P. (2016). Risk and protective factors for symptoms of anxiety and depression in parents of children with autism spectrum disorder. *Developmental neurorehabilitation*, *19*(3), 146-153.

Mackenzie, C. S., Knox, V. J., Gekoski, W. L., & Macaulay, H. L. (2004). An adaptation and extension of the attitudes toward seeking professional psychological help scale 1. *Journal of applied social psychology*, *34*(11), 2410-2433.

McAleese, A., Christine, L., & and Dyer, K. F. W. (2014). Evaluating a Psychoeducational, Therapeutic Group for Parents of Children with Autism Spectrum Disorder. *Child Care in Practice*, *20*(2), 162-181. https://doi.org/10.1080/13575279.2013.820171

McConachie, H., McLaughlin, E., Grahame, V., Taylor, H., Honey, E., Tavernor, L., Rodgers, J., Freeston, M., Hemm, C., Steen, N., & Le Couteur, A. (2014). Group therapy for anxiety in children with autism spectrum disorder. *Autism*, *18*(6), 723-732. https://doi.org/10.1177/1362361313488839

McCormack, H. M., MacIntyre, T. E., O'Shea, D., Herring, M. P., & Campbell, M. J. (2018). The prevalence and cause (s) of burnout among applied psychologists: A systematic review. *Frontiers in Psychology*, *9*, 376988.

McLuckie, A., Kutcher, S., Wei, Y., & Weaver, C. (2014). Sustained improvements in students' mental health literacy with use of a mental health curriculum in Canadian schools. *BMC Psychiatry*, *14*, 379. https://doi.org/10.1186/s12888-014-0379-4

McNeillie, N., & Rose, J. (2021). Vicarious trauma in therapists: A meta-ethnographic review. *Behavioural and Cognitive Psychotherapy*, *49*(4), 426-440.

Meadan, H., Halle, J. W., & Ebata, A. T. (2010). Families with children who have autism spectrum disorders: Stress and support. *Exceptional children*, *77*(1), 7-36.

Meechan, H., John, M., & Hanna, P. (2021). Understandings of mental health and support for Black male adolescents living in the UK. *Children and Youth Services Review*, *129*, 106192. https://doi.org/https://doi.org/10.1016/j.childyouth.2021.106192

Milshtein, S., Yirmiya, N., Oppenheim, D., Koren-Karie, N., & Levi, S. (2010). Resolution of the diagnosis among parents of children with autism spectrum disorder: Associations with child and parent characteristics. *Journal of Autism and Developmental Disorders*, *40*, 89-99.

Mitter, N., Ali, A., & Scior, K. (2019). Stigma experienced by families of individuals with intellectual disabilities and autism: A systematic review. *Research in Developmental Disabilities*, *89*, 10-21. https://doi.org/https://doi.org/10.1016/j.ridd.2019.03.001

Montero-Marin, J., Allwood, M., Ball, S., Crane, C., De Wilde, K., Hinze, V., Jones, B., Lord, L., Nuthall, E., Raja, A., Taylor, L., Tudor, K., Blakemore, S. J., Byford, S., Dalgleish, T., Ford, T., Greenberg, M. T., Ukoumunne, O. C., Williams, J. M. G., & Kuyken, W. (2022). School-based mindfulness training in early adolescence: what works, for whom and how in the MYRIAD trial? *Evid Based Ment Health*, *25*(3), 117-124. https://doi.org/10.1136/ebmental-2022-300439

Moody, E. J., Kaiser, K., Sharp, D., Kubicek, L. F., Rigles, B., Davis, J., McSwegin, S., D'Abreu, L. C., & Rosenberg, C. R. (2019). Improving family functioning following diagnosis of ASD: A randomized trial of a parent mentorship program. *Journal of Child and Family Studies*, *28*, 424-435.

Morales-Muñoz, I., Mallikarjun, P. K., Chandan, J. S., Thayakaran, R., Upthegrove, R., & Marwaha, S. (2023). Impact of anxiety and depression across childhood and adolescence on adverse outcomes in young adulthood: a UK birth cohort study. *The British Journal of Psychiatry*, 1-9.

Munthe-Kaas, H. M., Glenton, C., Booth, A., Noyes, J., & Lewin, S. (2019). Systematic mapping of existing tools to appraise methodological strengths and limitations of qualitative research: first stage in the development of the CAMELOT tool. *BMC Medical Research Methodology*, *19*(1), 113. https://doi.org/10.1186/s12874-019-0728-6

Murray, H. (2017). Evaluation of a trauma-focused CBT training programme for IAPT services. *Behavioural and Cognitive Psychotherapy*, *45*(5), 467-482.

Naicker, V. V., Bury, S. M., & Hedley, D. (2023). Factors associated with parental resolution of a child's autism diagnosis: A systematic review. *Frontiers in psychiatry*, *13*, 1079371.

Nakash, O., & Alegría, M. (2013). Examination of the role of implicit clinical judgments during the mental health intake. *Qual Health Res*, *23*(5), 645-654. https://doi.org/10.1177/1049732312471732

Nevill, R. E., Lecavalier, L., & Stratis, E. A. (2018). Meta-analysis of parent-mediated interventions for young children with autism spectrum disorder. *Autism*, *22*(2), 84-98.

Newlove-Delgado, T., McManus, S., Sadler, K., Thandi, S., Vizard, T., Cartwright, C., & Ford, T. (2021). Child mental health in England before and during the COVID-19 lockdown. *The Lancet Psychiatry*, *8*(5), 353-354. https://doi.org/10.1016/S2215-0366(20)30570-8

NHS Digital. (2022). Mental health of children and young people in England 2022–wave 3 follow up to the 2017 survey.

NHS England. (2023). A national framework to deliver improved outcomes in all-age autism assessment pathways: guidance for integrated care boards. https://www.england.nhs.uk/long-read/a-national-framework-to-deliver-improved-outcomes-in-all-age-autism-assessment-pathways-guidance-for-integrated-care-boards/#foreword

NHS Talking Therapies. (2024). *NHS Talking Therapies for anxiety and depression Manual* (T. N. C. C. f. M. Health, Ed.) https://www.england.nhs.uk/wp-content/uploads/2018/06/NHS-talking-therapies-manual-v7-1.pdf

NICE. (2013). *Autism spectrum disorder in under 19s: support and management* (Clinical guideline CG170, Issue. https://www.nice.org.uk/guidance/cg170/chapter/recommendations#specific-interventions-for-the-core-features-of-autism

O'Brien, D., Harvey, K., Howse, J., Reardon, T., & Creswell, C. (2016). Barriers to managing child and adolescent mental health problems: a systematic review of primary care practitioners' perceptions. *British Journal of General Practice*, *66*(651), e693-e707. https://doi.org/10.3399/bjgp16X687061

O'Donovan, K. L., Armitage, S., Featherstone, J., McQuillin, L., Longley, S., & Pollard, N. (2019). Group-based parent training interventions for parents of children with autism spectrum disorders: A literature review. *Review Journal of Autism and Developmental Disorders*, *6*(1), 85-95.

O"Cathain, A., Croot, L., Duncan, E., Rousseau, N., Sworn, K., Turner, K. M., Yardley, L., & Hoddinott, P. (2019). Guidance on how to develop complex interventions to improve health and healthcare. *Bmj Open*, *9*(8), e029954. https://doi.org/10.1136/bmjopen-2019-029954

Oono, I. P., Honey, E. J., & McConachie, H. (2013). Parent-mediated early intervention for young children with autism spectrum disorders (ASD). *Cochrane Database of Systematic Reviews*(4), Article Cd009774. https://doi.org/10.1002/14651858.CD009774.pub2

Owen, J., Crouch-Read, L., Smith, M., & Fisher, P. (2021). Stress and burnout in Improving Access to Psychological Therapies (IAPT) trainees: a systematic review. *The Cognitive Behaviour Therapist*, *14*, e20.

Palmer, M., Cáceres, A. S. J., Tarver, J., Howlin, P., Slonims, V., Pellicano, E., & Charman, T. (2020). Feasibility study of the National Autistic Society EarlyBird parent support programme. *Autism*, *24*(1), 147-159. https://doi.org/10.1177/1362361319851422

Panchal, U., Salazar de Pablo, G., Franco, M., Moreno, C., Parellada, M., Arango, C., & Fusar-Poli, P. (2023). The impact of COVID-19 lockdown on child and adolescent mental health: systematic review. *Eur Child Adolesc Psychiatry*, *32*(7), 1151-1177. https://doi.org/10.1007/s00787-021-01856-w

Patafio, B., Miller, P., Baldwin, R., Taylor, N., & Hyder, S. (2021). A systematic mapping review of interventions to improve adolescent mental health literacy, attitudes and behaviours. *Early Intervention in Psychiatry*, *15*(6), 1470-1501. https://doi.org/https://doi.org/10.1111/eip.13109

Patalay, P., Annis, J., Sharpe, H., Newman, R., Main, D., Ragunathan, T., Parkes, M., & Clarke, K. (2017). A pre-post evaluation of OpenMinds: A sustainable, peer-led mental health literacy programme in universities and secondary schools. *Prevention Science*, *18*, 995-1005.

Patalay, P., & Gage, S. H. (2019). Changes in millennial adolescent mental health and health-related behaviours over 10 years: a population cohort comparison study. *Int J Epidemiol*, *48*(5), 1650-1664. https://doi.org/10.1093/ije/dyz006

Peacock, E. J., & Wong, P. T. P. (1990). The stress appraisal measure (SAM): A multidimensional approach to cognitive appraisal. *Stress Medicine*, *6*(3), 227-236. https://doi.org/https://doi.org/10.1002/smi.2460060308

Peckett, H., MacCallum, F., & Knibbs, J. (2016). Maternal experience of Lego Therapy in families with children with autism spectrum conditions: What is the impact on family relationships? *Autism*, *20*(7), 879-887. https://doi.org/10.1177/1362361315621054

Perry, Y., Petrie, K., Buckley, H., Cavanagh, L., Clarke, D., Winslade, M., Hadzi-Pavlovic, D., Manicavasagar, V., & Christensen, H. (2014). Effects of a classroom-based educational resource on adolescent mental health literacy: A cluster randomised controlled trial. *Journal of adolescence*, *37*(7), 1143-1151.

Pettitt, L. (2024). *A thesis of clinical research and practice: Part B: A thematic exploration of anorexia nervosa treatment for caregivers of autistic young people* University of Surrey]. https://openresearch.surrey.ac.uk/esploro/outputs/doctoral/A-thesis-of-clinical-research-and/99914466502346

Pickles, A., Le Couteur, A., Leadbitter, K., Salomone, E., Cole-Fletcher, R., Tobin, H., Gammer, I., Lowry, J., Vamvakas, G., & Byford, S. (2016). Parent-mediated social communication therapy for young children with autism (PACT): long-term follow-up of a randomised controlled trial. *The Lancet*, *388*(10059), 2501-2509.

Pollard, J., Reardon, T., Williams, C., Creswell, C., Ford, T., Gray, A., Roberts, N., Stallard, P., Ukoumunne, O. C., & Violato, M. (2023). The multifaceted consequences and economic costs of child anxiety problems: A systematic review and meta-analysis. *JCPP Advances*, e12149.

Powell, B. J., Proctor, E. K., & Glass, J. E. (2014). A Systematic Review of Strategies for Implementing Empirically Supported Mental Health Interventions. *Research on Social Work Practice*, *24*(2), 192-212. https://doi.org/10.1177/1049731513505778

Radez, J., Reardon, T., Creswell, C., Lawrence, P. J., Evdoka-Burton, G., & Waite, P. (2021). Why do children and adolescents (not) seek and access professional help for their mental health problems? A systematic review of quantitative and qualitative studies. *European Child & Adolescent Psychiatry*, *30*, 183-211.

Randell, E., McNamara, R., Busse, M., Delport, S., Williams-Thomas, R., Maboshe, W., Gillespie, D., Milosevic, S., Brookes-Howell, L., Wright, M., Hastings, R. P., McKigney, A. M., Glarou, E., & Ahuja, A. (2024). Exploring critical intervention features and trial processes in the evaluation of sensory integration therapy for autistic children. *Trials*, *25*(1), 131. https://doi.org/10.1186/s13063-024-07957-6

Randell, E., McNamara, R., Delport, S., Busse, M., Hastings, R. P., Gillespie, D., Williams-Thomas, R., Brookes-Howell, L., Romeo, R., & Boadu, J. (2019). Sensory integration therapy versus usual care for sensory processing difficulties in autism spectrum disorder in children: study protocol for a pragmatic randomised controlled trial. *Trials*, *20*, 1-11.

Read, N., & Schofield, A. (2010). Autism: are mental health services failing children and parents? *J Fam Health Care*, *20*(4), 120-124.

Reardon, T., Harvey, K., Baranowska, M., O'Brien, D., Smith, L., & Creswell, C. (2017). What do parents perceive are the barriers and facilitators to accessing psychological treatment for mental health problems in children and adolescents? A systematic review of qualitative and quantitative studies. *European Child & Adolescent Psychiatry*, *26*(6), 623-647. https://doi.org/10.1007/s00787-016-0930-6

Richards, D. A., Bower, P., Pagel, C., Weaver, A., Utley, M., Cape, J., Pilling, S., Lovell, K., Gilbody, S., & Leibowitz, J. (2012). Delivering stepped care: an analysis of implementation in routine practice. *Implementation Science*, *7*, 1-11.

Roberts, D., & Pickering, N. (2010). Parent training programme for autism spectrum disorders: an evaluation. *Community practitioner : the journal of the Community Practitioners' & Health Visitors' Association*. https://www.scopus.com/inward/record.uri?eid=2-s2.0-79952111716&partnerID=40&md5=2a1b46535e4dbc9bc9b7dc61c833963c

Rodgers, J., Goodwin, J., Garland, D., Grahame, V., Isard, L., Kernohan, A., Labus, M., Osborne, M. M., Parr, J. R., Rob, P., Wright, C., & Freeston, M. (2023). Coping with uncertainty in everyday situations (CUES©) to address intolerance of uncertainty in autistic children: an intervention feasibility trial. *J Autism Dev Disord*, *53*(9), 3460-3474. https://doi.org/10.1007/s10803-022-05645-5

Rodgers, J., Goodwin, J., Parr, J. R., Grahame, V., Wright, C., Padget, J., Garland, D., Osborne, M., Labus, M., Kernohan, A., & Freeston, M. (2019). Coping with Uncertainty in Everyday Situations (CUES©) to address intolerance of uncertainty in autistic children: study protocol for an intervention feasibility trial. *Trials*, *20*(1), 385. https://doi.org/10.1186/s13063-019-3479-0

Roscoe, J., Taylor, J., Harrington, R., & Wilbraham, S. (2022). CBT supervision behind closed doors: Supervisor and supervisee reflections on their expectations and use of clinical supervision. *Counselling and Psychotherapy Research*, *22*(4), 1056-1067.

Rosen, G. M., & Lilienfeld, S. O. (2008). Posttraumatic stress disorder: An empirical evaluation of core assumptions. *Clinical psychology review*, *28*(5), 837-868. https://doi.org/https://doi.org/10.1016/j.cpr.2007.12.002

Roughan, L. A., Parker, J. R., & Mercer, L. (2019). Improving interventions for parents of children and young people with autism spectrum disorder (ASD) in CAMHS. *BMJ Open Qual*, *8*(2), e000261. https://doi.org/10.1136/bmjoq-2017-000261

Rowley, A. A., Roesch, S. C., Jurica, B. J., & Vaughn, A. A. (2005). Developing and validating a stress appraisal measure for minority adolescents. *Journal of adolescence*, *28*(4), 547-557. https://doi.org/https://doi.org/10.1016/j.adolescence.2004.10.010

Rughani, J. (2011). Adolescents' help-seeking for mental health problems: development and evaluation of a school-based intervention.

Sadler, K., Vizard, T., Ford, T., Marchesell, F., Pearce, N., Mandalia, D., Davis, J., Brodie, E., Forbes, N., & Goodman, A. (2018). Mental health of children and young people in England, 2017.

Samsell, B., Lothman, K., Samsell, E. E., & Ideishi, R. I. (2022). Parents' experiences of caring for a child with autism spectrum disorder in the United States: A systematic review and metasynthesis of qualitative evidence. *Families, Systems, & Health*, *40*(1), 93.

Sandford, D. M. (2023). *Understanding the factors associated with mental health practitioners' engagement in effective suicide prevention activities within an Improving Access to Psychological Therapies (IAPT) service* University of Glasgow].

Saunders, R., Cape, J., Leibowitz, J., Aguirre, E., Jena, R., Cirkovic, M., Wheatley, J., Main, N., Pilling, S., & Buckman, J. E. (2020). Improvement in IAPT outcomes over time: are they driven by changes in clinical practice? *The Cognitive Behaviour Therapist*, *13*, e16.

Schnyder, U., & Cloitre, M. (2022). Introduction. In U. Schnyder & M. Cloitre (Eds.), *Evidence Based Treatments for Trauma-Related Psychological Disorders: A Practical Guide for Clinicians* (pp. 1-9). Springer International Publishing. https://doi.org/10.1007/978-3-030-97802-0_1

Scott, H. M., Braybrook, D., Harðardóttir, D., Ellis-Smith, C., Harding, R., Anderson, A. K., Bayly, J., Bate, L., Bluebond-Langner, M., Box, D., Bristowe, K., Burman, R., Chambers, L., Coombes, L., Craft, A., Craig, F., Delaney, A., Downie, J., Downing, J., . . . On behalf of, C. P. (2023). Implementation of child-centred outcome measures in routine paediatric healthcare practice: a systematic review. *Health and Quality of Life Outcomes*, *21*(1), 63. https://doi.org/10.1186/s12955-023-02143-9

Scott, M. J. (2018). Improving Access to Psychological Therapies (IAPT)-The need for radical reform. *Journal of Health Psychology*, *23*(9), 1136-1147.

Shilling, V., Morris, C., Thompson-Coon, J., Ukoumunne, O., Rogers, M., & Logan, S. (2013). Peer support for parents of children with chronic disabling conditions: a systematic review of quantitative and qualitative studies. *Developmental medicine & child neurology*, *55*(7), 602-609.

Skelton, M., Carr, E., Buckman, J. E., Davies, M. R., Goldsmith, K. A., Hirsch, C. R., Peel, A. J., Rayner, C., Rimes, K. A., & Saunders, R. (2023). Trajectories of depression and anxiety symptom severity during psychological therapy for common mental health problems. *Psychological medicine*, *53*(13), 6183-6193.

Smith, J. P., Tran, G. Q., & Thompson, R. D. (2008). Can the theory of planned behavior help explain men's psychological help-seeking? Evidence for a mediation effect and clinical implications. *Psychology of Men & Masculinity*, *9*(3), 179.

Smith, K. A., Gehricke, J.-G., Iadarola, S., Wolfe, A., & Kuhlthau, K. A. (2020). Disparities in service use among children with autism: A systematic review. *Pediatrics*, *145*(Supplement_1), S35-S46.

Smith-Young, J., Chafe, R., Audas, R., & Gustafson, D. L. (2022). "I Know How to Advocate": Parents' Experiences in Advocating for Children and Youth Diagnosed With Autism Spectrum Disorder. *Health services insights*, *15*, 11786329221078803.

Smith-Young, J., Pike, A., Swab, M., & Chafe, R. (2025). Parents' and guardians' experiences of barriers and facilitators in accessing autism spectrum disorder diagnostic services for their children: a qualitative systematic review. *JBI Evid Synth*, *23*(1), 6-68. https://doi.org/10.11124/jbies-23-00332

Smółka, J. (2022). Institutional Analysis of Healthcare Systems in Selected Developed Countries. In *Economics and Mathematical Modeling in Health-Related Research* (pp. 75-103). Brill.

Sperry, L. A., Whaley, K. T., Shaw, E., & Brame, K. (1999). Services for young children with autism spectrum disorder: Voices of parents and providers. *Infants & Young Children*, *11*(4), 17-33.

Spoont, M. R., Williams, J. W., Kehle-Forbes, S., Nieuwsma, J. A., Mann-Wrobel, M. C., & Gross, R. (2015). Does this patient have posttraumatic stress disorder?: rational clinical examination systematic review. *Jama*, *314*(5), 501-510.

Stallard, P., Sayal, K., Phillips, R., Taylor, J. A., Spears, M., Anderson, R., Araya, R., Lewis, G., Millings, A., & Montgomery, A. A. (2012). Classroom based cognitive behavioural therapy in reducing symptoms of depression in high risk adolescents: pragmatic cluster randomised controlled trial. *BMJ*, *345*.

Stoner, J. B., & Stoner, C. R. (2016). Career disruption: The impact of transitioning from a full-time career professional to the primary caregiver of a child with autism spectrum disorder. *Focus on Autism and Other Developmental Disabilities*, *31*(2), 104-114.

Sun, J., Yin, X., Li, C., Liu, W., & Sun, H. (2022). Stigma and peer-led interventions: a systematic review and meta-analysis. *Frontiers in Psychiatry*, *13*, 915617.

Swartz, K. L., Kastelic, E. A., Hess, S. G., Cox, T. S., Gonzales, L. C., Mink, S. P., & Raymond DePaulo Jr, J. (2010). The effectiveness of a school-based adolescent depression education program. *Health Education & Behavior*, *37*(1), 11-22.

Sweeney, A., Clement, S., Gribble, K., Jackson, E., Carr, S., Catty, J., & Gillard, S. (2019). A systematic review of qualitative studies of adults' experiences of being assessed for psychological therapies. *Health Expectations*, *22*(2), 133-148. https://doi.org/https://doi.org/10.1111/hex.12844

Thomlinson, R., Muncer, S., & Dent, H. (2017). Comorbidity between PTSD and anxiety and depression: implications for IAPT services. *Archives of Depression and Anxiety*, *3*(1), 14-17.

Tissot, C. (2011). Working together? Parent and local authority views on the process of obtaining appropriate educational provision for children with autism spectrum disorders. *Educational Research*, *53*(1), 1-15. https://doi.org/10.1080/00131881.2011.552228

Townsend, L., Musci, R., Stuart, E., Heley, K., Beaudry, M. B., Schweizer, B., Ruble, A., Swartz, K., & Wilcox, H. (2019). Gender Differences in Depression Literacy and Stigma After a Randomized Controlled Evaluation of a Universal Depression Education Program. *Journal of Adolescent Health*, *64*(4), 472-477. https://doi.org/10.1016/j.jadohealth.2018.10.298

Trembath, D., Gurm, M., Scheerer, N. E., Trevisan, D. A., Paynter, J., Bohadana, G., Roberts, J., & Iarocci, G. (2019). Systematic review of factors that may influence the outcomes and generalizability of parent-mediated interventions for young children with autism spectrum disorder. *Autism Research*, *12*(9), 1304-1321. https://doi.org/https://doi.org/10.1002/aur.2168

Trudgeon, C., & Carr, D. (2007). The Impacts of Home-Based Early Behavioural Intervention Programmes on Families of Children with Autism. *Journal of Applied Research in Intellectual Disabilities*, *20*(4), 285-296. https://doi.org/https://doi.org/10.1111/j.1468-3148.2006.00331.x

Tully, J., Bhugra, D., Lewis, S. J., Drennan, G., & Markham, S. (2021). Is PTSD overdiagnosed? *bmj*, *373*.

Turner, J., Brown, J. C., & Carpenter, D. T. (2018). Telephone-based CBT and the therapeutic relationship: The views and experiences of IAPT practitioners in a low-intensity service. *Journal of Psychiatric and Mental Health Nursing*, *25*(5-6), 285-296. https://doi.org/https://doi.org/10.1111/jpm.12440

Vivolo, M., Owen, J., & Fisher, P. (2024). Building resilience in the Improving Access to Psychological Therapy (IAPT) Psychological Wellbeing Practitioner (PWP) role: a qualitative grounded theory study. *Behavioural and Cognitive Psychotherapy*, *52*(2), 135-148.

Vizard, T., Pearce, N., Davis, J., Sadler, K., Ford, T., & Goodman, A. (2018). Mental health of children and young people in England, 2017. *Health and social care information centre*.

Voss Horrell, S. C., Holohan, D. R., Didion, L. M., & Vance, G. T. (2011). Treating traumatized OEF/OIF veterans: How does trauma treatment affect the clinician? *Professional Psychology: Research and Practice*, *42*(1), 79.

Voutilainen, A., Pitkäaho, T., Kvist, T., & Vehviläinen-Julkunen, K. (2016). How to ask about patient satisfaction? The visual analogue scale is less vulnerable to confounding factors and ceiling effect than a symmetric Likert scale. *Journal of Advanced Nursing*, *72*(4), 946-957. https://doi.org/https://doi.org/10.1111/jan.12875

Wallace-Watkin, C., Sigafoos, J., & Waddington, H. (2023). Barriers and facilitators for obtaining support services among underserved families with an autistic child: A systematic qualitative review. *Autism*, *27*(3), 588-601. https://doi.org/10.1177/13623613221123712

Walsh, D., & Downe, S. (2006). Appraising the quality of qualitative research. *Midwifery*, *22*(2), 108-119. https://doi.org/https://doi.org/10.1016/j.midw.2005.05.004

Wang, X., Zhao, J., Huang, S., Chen, S., Zhou, T., Li, Q., Luo, X., & Hao, Y. (2021). Cognitive behavioral therapy for autism spectrum disorders: A systematic review. *Pediatrics*, *147*(5), e2020049880.

Watts, J. (2024). Take it from a psychologist: Rishi Sunak's callous crusade on welfare will have disastrous consequences. *The Guardian*.

Wichers, R. H., van der Wouw, L. C., Brouwer, M. E., Lok, A., & Bockting, C. L. (2023). Psychotherapy for co-occurring symptoms of depression, anxiety and obsessive-compulsive disorder in children and adults with autism spectrum disorder: a systematic review and meta-analysis. *Psychological Medicine*, *53*(1), 17-33.

Wilson, C. J., Deane, F. P., Ciarrochi, J. V., & Rickwood, D. (2005). Measuring help seeking intentions: properties of the general help seeking questionnaire.

Wilson, C. J., Deane, F. P., Marshall, K. L., & Dalley, A. (2008). Reducing adolescents' perceived barriers to treatment and increasing help-seeking intentions: effects of classroom presentations by general practitioners. *Journal of Youth and Adolescence*, *37*, 1257-1269.

Xu, Z., Huang, F., Kösters, M., Staiger, T., Becker, T., Thornicroft, G., & Rüsch, N. (2018). Effectiveness of interventions to promote help-seeking for mental health problems: systematic review and meta-analysis. *Psychological Medicine*, *48*(16), 2658-2667. https://doi.org/10.1017/S0033291718001265

Zorrilla, M. M., Modeste, N., Gleason, P. C., Sealy, D.-A., Banta, J. E., & Trieu, S. L. (2019). Depression and help-seeking intention among young adults: The theory of planned behavior. *American journal of health education*, *50*(4), 236-244.

6. Executive Summary

Examining the effectiveness of a single-session school-based outreach intervention to increase anxiety literacy and help-seeking intentions in adolescence.

Young people in the UK are presenting with historically high, and increasing, mental health need. Anxiety is among the most prevalent of these, and can have longitudinal and societally costly impacts. Such issues were further exacerbated by the COVID-19 pandemic Limited understanding of psychologically maladaptive anxiety, and reluctance to seek support for such problems, is understood to be a major barrier in addressing anxiety; the latter an issue particularly experienced by societal groups such as young men, BAME individuals, and LGBT+ youths.

Several theoretical models explore help-seeking, and of these, Azjen's Theory of Planned Behaviour is the most widely applied in clinical psychology research. Azjen proposes that behaviours are dependent upon perceived societal rules, attitudes, and perceived control regarding the behaviour. In mental health research, these concepts can be conceptualised as stigma, attitudes regarding help-seeking and perceived internal and external barriers to help-seeking respectively.

Applications of this model have produced an evidence base for predicting help-seeking behaviour in various populations, while recent research has identified its' capacity to predict mental health-related help-seeking intentions. However, the model has been criticised for lacking thorough explanation of how beliefs related to seeking help affect behavioural change and inform help-seeking decisions in each of the model's components. Furthermore, while school-based interventions for youth mental health are a promising and popular approach, most

promote literacy for general mental health literacy instead of taking disorder-specific approaches, and promote awareness rather than recognition.

This study thus aims to examine whether a single-session, anxiety-specific, school-based intervention can significantly improve a) anxiety literacy and b) help-seeking for anxiety compared to a control group and c) whether anxiety-related stigma, appraisal and attitudes mediate a significantly positive relationship between anxiety literacy and anxiety-related help-seeking intentions. We hypothesised that anxiety literacy and anxiety-related help-seeking would significantly improve both immediately following intervention and at 1-month follow-up compared to a control intervention and that these improvements would be mediated by anxiety-related stigma, appraisal and attitudes.

This study used a randomised, controlled experimental design with three timepoints (pre-, post-, and follow-up). Existing measures of mental health literacy, help-seeking intentions, stigma, illness appraisal and attitudes were adapted to be anxiety-specific in addition to an acceptability measure. Two-hundred and seventy-three adolescents participated at baseline. Quantitative analysis included 2 (condition) x 2 (timepoints) and 2 (condition) x 3 (timepoints) analyses of variance (ANOVAs) to investigate the primary hypotheses – that anxiety literacy and help-seeking for anxiety would significantly improve in the experimental condition, when compared to the control condition. Potential mediators were analysed using similar 2x2 and 2x3 ANOVAs to assess suitability for mediation analysis.

The intervention significantly increased anxiety literacy relative to the control condition post-intervention, while help-seeking intentions for anxiety were significantly improved across both conditions. There were no significant changes in potential mediators and therefore mediation

analysis was not conducted. The intervention was significantly more acceptable than its' control.

Findings suggest that single-session interventions may not be adequate in producing sustainable improvements in anxiety literacy – while research regarding anxiety literacy in young people is scarce, previous interventions featuring sustained improvement of young people's anxiety literacy have offered more comprehensive psychoeducation over longer periods of time.

Given that help-seeking intentions increased in both conditions, future research using active control conditions in help-seeking research is needed in order to clarify mechanisms of change in interventions for help-seeking intentions – such interventions have shown some effectiveness, but only in comparison to passive controls such as waitlists. High rates of missing data due to attrition limited this study's findings – a limitation consistent with many school-based mental health literacy interventions. Results imply that school-based approaches to increase help-seeking intentions for adolescent anxiety may be unlikely to produce sustained improvement within a single session.

7. Connecting Narrative

Conducting clinical psychology research has been a long-term dream of mine. The idea of collaborating with others to explore meaningful expansions of evidence bases, particularly around accessing substantive psychological support. Becoming a fully-fledged scientist-practitioner has been the most arduous element of this course – learning to dovetail between clinical practice and research involved a lot of self-discipline, careful time management, and organisation. A running theme throughout project development with my research supervisors and course tutor was designing manageable projects and being reasonable with one's own expectations of themselves – a lesson I will definitely take into post-qualification research, where I imagine competing demands will continue . As I consider work as a clinical psychologist, I hope to maintain my growth as a researcher – I have seen first-hand in these three projects how research can be a conduit for service growth, if aligned and guided by the needs of service-users, clinicians and communities.

Service Improvement Project (SIP)

This project was the first research I developed from scratch. When working on my working-age-adult placement in an NHS Talking Therapies service, it became apparent that many service-users who had reported experiencing trauma at their assessments experienced delays in receiving appropriate treatment. It was also commonly recognised by my colleagues that such assessments were incredibly challenging for them emotionally. This frustrated me –both my PWP colleagues and the service users they endeavoured to support were engaging in a process that caused all parties emotional difficulty. Through discussion with the service's deputy clinical lead and my supervisors, we identified knowledge gaps regarding how such assessments were experienced in-service, and thus designed qualitative research aimed at

identifying both practical and emotional elements of assessing trauma in NHS-TT. Taking steps to solve a problem I could see first-hand was immensely satisfying.

My SIP demonstrated to me that effective clinical research did not necessarily entail running massive research trials – small, meaningful insights into how services operate can prove invaluable in improving service-user and staff experiences. I found it incredibly rewarding to have noticed a problem, gathered evidence on it, and shared this with both service leadership teams and the wider evidence base – it made all my work on the project feel meaningful! Taking ownership of the entire research process, from conceptualisation all the way to publication, has given me hope that I can conduct research throughout my career as a clinical psychologist.

Systematic Literature Review

My SRL was probably the most personally meaningful to me. As the brother of an autistic young person, and the son of two parents who have consistently fought for meaningful support for him from psychological services, it felt important to both amplify the voices of similar parents who had been involved in research regarding such support, and to offer guidance to services that, in my experience throughout this doctorate, desperately want to offer such support.

Synthesising parents' experiences across two decades of research was challenging and sometimes felt impossible. As the final of my three projects, completing this thematic synthesis felt really pressuring sometimes – I had to be wary of my instincts to just get the project done, and be mindful of how importance rigour and thorough analysis processes were.

The process of appraising research quality alongside a second rater was enriching – going back and forth on the merits and drawbacks of an evidence base with a peer who I had developed alongside throughout this doctorate felt like a milestone in my development as a researcher. I was also filled with hope while writing this study up – it felt like I was producing something tangible, that could help families like mine. I was grateful for the opportunities to thrive that my supervisor offered me throughout this project, and to complete it with the independence I did felt like a turning point in my confidence as a researcher.

Theory Driven Research Project

Of my three projects, the TDRP felt the 'biggest'. Both in terms of scale – the logistical challenges of delivering a workshop to an entire Year 8 year group felt immense – and complexity, this project was an undertaking that required significant professional growth.

I knew coming into this project that I wanted to contribute to the evidence base regarding young people's access to mental healthcare – narrowing that down to a specific issue, using a specific theoretical model, required both introspection and exploration of research gaps. Discovering a particular systematic review that posed the question that captured me gave me clear direction throughout this project. I remember feeling a thrill when I found this review and my research question began to form – despite the daunting workload ahead, knowing I was filling an important gap in literature motivated me throughout.

The process of completing data-collection, analysis and writing the project up was ironically very anxiety-provoking for me. It felt like so much could go wrong. I remember worrying that the school hosting the research may cancel last-minute, that I would enter data

incorrectly, that I was doing statistical analysis completely wrong – I put a lot of pressure on myself throughout this process to tightly control as many planning variables as I could. Thankfully, it went off without any major hitches – which I hope increases my confidence in my reliability as a researcher following qualification.

Completing my TDRP demonstrated to me the various complexities of completing research – in addition to designing and writing, I met with stakeholders, adapted measures, consulted experts by experience. It gave me valuable experience in the fundamental elements of clinical psychology research that will hopefully prove useful as I embark on my post-qualification research journey. It made me feel like a *real researcher* – being supported to meet with experts from the TOPIC group in the University of Oxford, getting feedback from Year 8 children in other schools and learning about various forms of quantitative analysis helped me to assure myself that conducting relatively large-scale quantitative research was something little old me could do.

8. Acknowledgements

To each of the research supervisors that guided and supported me at every turn of this thesis; your kindness and insight was invaluable. Hjördis, Graham, Sam, Craig, Vicky, Louise, Alex and Ciorsdan – I count my lucky stars for your patience, thoroughness and good humour every step of the way.

To my clinical supervisors, Nicole, Clare, Nicola, Adele, Alice and Clarence – I am beyond grateful for your compassion and encouragement as I balanced the demands of research and practice.

To Matt – your patience, warmth, encouragement and wisdom over these three years has been invaluable. Thank you from the bottom of my heart.

To the 2022 cohort – each of you is spectacular and I cannot wait to see us all flourish. I've learned so much from your passion, your work, your solidarity and your resoluteness. Tasha, Giulia, Rachel and Sean – I cannot thank you enough for your friendship.

To the staff of the Oxford Institute of Clinical Psychology Research and Training – thank you for all the work you've done. It's helped one of my dreams to come true.

To Caoimhe, Jack, Josh and countless others – your friendship has always been the best of me. Thank you for steadfastly being by my side on this long and winding road.

To Liv – your love has sustained me throughout my final year, and the happiness you have brought into my life has carried me over the finish line. I am so lucky to have you.

To Monica – thank you for taking me in.

To Pat – I miss you every day. If you weren't my hero, my life would look a lot different. I hope you know I couldn't have done this without you. Love you forever.

To Mam and Dad – I stand on the shoulders of giants. Thank you.

Finally, to David – I hope you know that you have made me the man I am today. I carry you with me in my heart, and I always will.

9. Appendices

Appendix 1.1: Instructions to Authors

Aims and Scope

Autism is a highly regarded, peer-reviewed, international journal, published 12 times a year, featuring research of direct and practical relevance to help improve the quality of life of autistic individuals and those with closely related diagnoses. This may sometimes include work focused on the families and allies of autistic people, and on practitioners who work with autistic people, since they play a key role in supporting good outcomes.

The journal is proudly international and encourages submissions from across the globe. To help address persistent lack of global representation of autism scholars, and to ensure that work is grounded in the context it describes, it is essential that manuscripts have author representation from the country where the work took place.

Autism provides a high-quality, international forum for peer-reviewed research of direct and practical relevance to the autism community. The journal applies rigorous peer review and expects high-quality reporting standards. The journal's success and popularity reflect the recent worldwide growth in the research and understanding of autism, and the consequent impact on the provision of care and support strategies.

Autism is interdisciplinary in nature, focusing on evaluative research in many areas, including:

- intervention development and evaluation
- diagnosis, including co-occurring diagnoses, and sub-groups
- training and education
- social sciences
- longitudinal, cohort and routine data analyses
- translational and / or applied neuroscience
- psychological processes with real-world relevance
- quality of life issues
- family issues and family services
- medical and genetic issues with clear and short-term practical relevance
- epidemiological research

All issues of Autism are available to browse online.

This journal is a member of the Committee on Publication Ethics (COPE)

Submission Guidelines

The Journal recommends that authors follow the Recommendations for the Conduct, Reporting, Editing, and Publication of Scholarly Work in Medical Journals formulated by the International Committee of Medical Journal Editors (ICMJE).

Sage is committed to upholding the integrity of the academic record. We encourage authors to refer to the Committee on Publication Ethics' International Standards for Authors and view the author responsibilities section on the Sage Journal Author Gateway.

We also encourage you to familiarize yourself with our Editorial Policies and our Publication Ethics Policies.

Sage Publishing disseminated high-quality research and engaged scholarship globally, and we are committed to diversity and inclusion in publishing. We encourage submissions and peer review from a diverse range of authors and reviewers from across all countries and backgrounds. Read our diversity, equity, and inclusion pledge.

There are no fees payable to submit or publish in this journal. Open access options are available – see below.

Key Information

Access: Subscription
Accepts preprints? Yes
Identity transparency: Double anonymized

Publishing fees and open access

There are no fees payable to submit or publish in this journal.

Figures submitted in color will be published in color in the online version of the journal at no cost. If you wish to have color figures in the printed version, the following fees apply standard fees will be applied.

Optional open access publishing is available for a fee via the Sage Choice program, and Open Access agreements, where authors can publish open access either discounted or free of charge depending on the agreement with Sage. Find out if your institution is participating by visiting Open Access Agreements at Sage. Open Access agreement eligibility is determined by the corresponding author's affiliation matching an agreement at acceptance. For more information on Open Access publishing options at Sage please visit Sage Open Access.

For information on funding body compliance, and depositing your article in repositories, please visit Sage's Author Archiving and Re-Use Guidelines and Publishing Policies.

Open access fees do not cover page or color charges and are charged separately.

Preparing your manuscript for submission

Your article must be within the scope of the journal and be of sufficient quality. If not, it will not be reviewed. Please read the journal's Aims and Scope to see if your article is appropriate.

The manuscript must be your original work, you must have the rights to the work, and you must have obtained and be able to supply all necessary permissions for the reproduction of any copyright works not owned by you, including figures, illustrations, tables, lengthy quotations, or other material previously published elsewhere.

Article types

The Journal considers the following kinds of article for publication:

Original Articles. Full papers describing new empirical findings. These papers may present quantitative and/or qualitative data. In each case, the methods should be carefully selected to address the research question being posed, with due justification being given for: needfulness of the research; relevance to autistic people's quality of life; appropriateness of the sample size and diversity; quality of the methods; robustness of the analysis methods; validity of the conclusions.

Fundamental or basic scientific discoveries can be considered for publication but need to make a convincing case for relevance to autistic people's lives, especially if future implementation of the discovery is still far off.

Research Reports are generally restricted to a maximum of 6,000 words, including all elements (title page, abstract [200 words maximum], notes, tables, text), but excluding references. Editors may ask authors to make certain cuts before sending the article out for review.

Before submitting an Original Article, please make sure to review the author guidelines, and especially our reporting expectations.

Reviews. General reviews that provide a synthesis of an area of *autism* research. These will normally be systematic but narrative and/or focused reviews can be considered if the authors make a convincing case for their ability to address a gap in knowledge.

Reviews are generally restricted to a maximum of 6,000 words, including all elements (title page, abstract [200 words maximum], notes, tables, text), but excluding references. Editors may ask authors to make certain cuts before sending the article out for review.

Before submitting a Review, please make sure to review the author guidelines and especially section 2.8 for our reporting expectations.

Short Reports. Brief papers restricted to a maximum of 2,000 words with no more than two tables. The title should begin with 'Short Report'. Short reports also report empirical findings from quantitative and / or qualitative data, but these may be preliminary, low-impact, or otherwise less substantial than a Research Report. Another reason to submit a Short Report is if your rationale, methods and findings are simple and neat. If your paper can be reported within the 2000-word limit, we would encourage you to do so.

Letters to the Editors. Readers' letters should address issues raised by articles published in our journal, or issues in the field of *autism* research more generally. The issues should be contextualised within the literature to permit readers to draw general conclusions. Letters might cover discussions of existing debates in the literature, articulations of new or controversial ideas, comments on work published in our journal, theoretical perspectives, methodological or conceptual critiques, The decision to publish is made by the Editors, in order to ensure a timely appearance in print. Letters should be no more than 1000 words, with no tables and a maximum of 5 references.

Registered Reports, Pre-Data or Post-Data:

There are two types of Registered Reports:

- Registered Reports – Pre-Data, i.e., before any data have been gathered
- Registered Reports – Post-Data, i.e., before already existing data have been examined and analysed.

These submissions are reviewed in two stages. In Stage 1, a study proposal is considered for publication prior to data collection and/or analysis. Stage 1 submissions should include a complete Introduction, Methods, and Proposed Analyses. High-quality proposals will be accepted in principle before data collection and/or data analysis commences. Once the study is completed, the author will finish the article including Results and Discussion sections (Stage 2). Publication of the Stage 2 submission is guaranteed as long as the approved Stage 1 protocol is followed, and the conclusions are appropriate. Full details can be found here. The Journal's manuscript requirements should be adhered to for the stage 2 submission.

Other article types

Please note that Commentaries and Editorials are by invitation only.

In addition, if the journal has an open call for a special issue, the option to submit to this issue will also be available at the point of submission.

Journal-specific content guidance.

All article types above must pay regard to the following guidelines on terminology and content essential for authors seeking publication in Autism.

In particular we strongly encourage authors to share participatory methods and positionality statements in their manuscripts, and in each case offer a 200-word allowance to do so, above standard article limits. See the guidance linked below for details.

1. Language used to discuss autism and autistic people

2. Language used to discuss race and ethnicity

3. Information about inclusion of Participatory Methods and Positionality Statements

Clinical trial registration

The journal conforms to the ICMJE requirement that clinical trials are registered in a WHO-approved public trials registry at or before the time of first participant enrollment as a condition of consideration for publication. The trial registry name and URL, and registration number must be included at the end of the abstract.

Reporting guidelines

The relevant EQUATOR Network reporting guidelines should be followed depending on the type of study. For example, all randomized controlled trials submitted for publication should include a completed CONSORT flow chart as a cited figure and the completed CONSORT checklist should be uploaded with your submission as a supplementary file. Systematic reviews and meta-analyses should include the completed PRISMA flow chart as a cited figure and the completed PRISMA checklist should be uploaded with your submission as a supplementary file. The EQUATOR wizard can help you identify the appropriate guideline.

The What Works Clearinghouse (WWC) guidelines should be followed when submitting in single-case design (SCD) and meet the standards outlined for internal validity of the SCD. Other resources can be found at NLM's Research Reporting Guidelines and Initiatives

Other resources can be found at NLM's Research Reporting Guidelines and Initiatives.

If your research involves animals, you will be asked to confirm that you have carefully read and adhered to the ARRIVE guidelines.

Formatting your manuscript

Accepted file types

The preferred format for your manuscript is Word. You do not need to follow a template, but please ensure your heading levels are clear, and the sections clearly defined.

The LaTeX files are also accepted. A LaTeX template is available on the Sage Journal Author Gateway.

Your article title, keywords, and abstract all contribute to its position in search engine results, directly affecting the number of people who see your work. For details of what you can do to influence this, visit How to help readers find your article online.

Title

Your manuscript's title should be concise, descriptive, unambiguous, accurate, and reflect the precise contents of the manuscript. A descriptive title that includes the topic of the manuscript makes an article more findable in the major indexing services.

Abstract

Please include an unstructured abstract of 150-200 words between the title and main body of your manuscript that concisely states the purpose of the research, major findings, and conclusions.

If your research includes clinical trials, the trial registry name and URL, and registration number must be included at the end of the abstract. Submissions that do not meet this requirement will not be considered.

Lay Abstract

A lay abstract must be provided for all article types that require an abstract. The lay abstract (approx. 300 words) should describe the article using non-technical language, making it accessible to a wider network of readers. They are open access and available to anyone to read when the article is published.

The lay abstract should be embedded in the main anonymised manuscript file below the scientific abstract.

More information and guidance on how to write a lay abstract can be found on our Author Gateway.

If you need professional help writing your Plain Language Summary, please visit our Author Services portal.

Authors may also find the following resources helpful on this topic:

How to write a summary paragraph

Self-Advocacy Resource and Technical Assistance Center (SARTAC): Plain Language

Center for Plain Language: Five steps to Plain Language

Are lay abstracts published in *Autism* readable enough for the general public? A short report - Lan Yi, Xiaohu Yang, 2023 (sagepub.com)

Keywords

Please include a minimum of 4-5 keywords, listed after the abstract. Keywords should be as specific as possible to the research topic.

Artwork, figures, and other graphics

For guidance on the preparation of illustrations, pictures, and graphs in electronic format, please read Sage's artwork guidelines.

Figures supplied in color will appear in color online and in the print version. There is no charge for reproducing figures in color in the printed version.

Please ensure that you have obtained any necessary permission from copyright holders for reproducing any illustrations, tables, figures, or lengthy quotations previously published elsewhere. For further information including guidance on fair dealing for criticism and review, please see the Frequently Asked Questions page on the Sage Journal Author Gateway.

Title page

To ensure fair and anonymous peer review, your manuscript must be fully anonymized. Please ensure any identifying information is removed from the main manuscript document and included on the Title Page instead. Do not include any author names in the manuscript file name and remove names from headers and footers. This version of the manuscript **will** be sent to the peer reviewers. The Title Page **will not** be sent to peer reviewers. See the Sage Journal Author Gateway for detailed guidance on making an anonymous submission.

The Title Page should include:

- Article title
- The full list of authors including names and affiliations of each
    - **The listed affiliation should be the institution where the research was conducted**. If an author has moved to a new institution since completing the research, the new affiliation can be included in a note at the end of the manuscript – please indicate this on the title page.
    - **All persons eligible for authorship must be included at the time of submission (please see the authorship section for more information)**.
- Contact information for the corresponding author: name, institutional address, phone, email
- Acknowledgments section
- Declaration of conflicting interest
- Funding statement
- Ethical approval and informed consent statements
- Data availability statement
- Any other identifying information related to the authors and/or their institutions, funders, approval committees, etc, that might compromise anonymity.

Acknowledgments

If you are including an Acknowledgements section, this will be published at the end of your article. The Acknowledgments section should include all contributors who do

not meet the criteria for authorship. Per ICMJE recommendations, it is best practice to obtain consent from non-author contributors who you are acknowledging in your manuscript.

Writing assistance and third-party submissions: if you have received any writing or editing assistance from a third-party, for example a specialist communications company, this must be clearly stated in the Acknowledgements section and in the covering letter. Please see the Sage Author Gateway for what information to include in your Acknowledgements section. If your submission is being made on your behalf by someone who is not listed as an author, for example the third-party who provided writing/editing assistance, you must state this in the Acknowledgements and also in your covering letter. **Please note that the journal editor reserves the right to not consider submissions made by a third party rather than by the author/s themselves.**

Author contributions

You will be asked to list the contribution of each author as part of the submission process. Please include the Author Contributions heading within your submission after the Acknowledgements section. The information you give on submission will then show under the Author Contributions heading later at the proofing stage.

In order to adhere to SAGE's authorship criteria authors must have been responsible for at **least one** of the following CRediT roles:

· Conceptualization

· Methodology

· Formal Analysis

· Investigation

AND at least one of the following:

· Writing – Original Draft Preparation

· Writing – Review & Editing

Statements and declarations

To ensure proper anonymization, please include a section with the heading 'Statements and Declarations' on your title page, after the Acknowledgements section [and Author Contributions section if applicable] including each of the sub-headings listed below. If a declaration is not applicable to your submission, you must still include the heading and state 'Not applicable' underneath. Please note that you may be asked to justify why a declaration was not applicable to your submission by the Editorial Office. This information will be added to the end of your published paper.

Ethical considerations

Please include your ethics approval statements under this heading, even if you have already included ethics approval information in your methods section. If ethical approval was not required, you need to explicitly state this. You can find information on what to say in your ethical statements as well as example statements on our Publication ethics and research integrity policies page.

All papers reporting studies involving human participants, human data or human tissue must state that the relevant Ethics Committee or Institutional Review Board approved the study, or waived the requirement for approval, providing the full name and institution of the review committee in addition to the approval number. If applicable, please also include this information in the Methods section of your manuscript.

Consent to participate

Please include any participant consent information under this heading and state whether informed consent to participate was written or verbal. If the requirement for informed consent to participate has been waived by the relevant Ethics Committee or Institutional Review Board (i.e. where it has been deemed that consent would be impossible or impracticable to obtain), please state this. If this is not applicable to your manuscript, please state 'Not applicable' in this section. More information and example statements can be found on our Publication ethics and research integrity policies page.

Consent for publication

Submissions containing any data from an individual person (including individual details, images or videos) must include a statement confirming that informed consent for publication was provided by the participant(s) or a legally authorized representative. Non-essential identifying details should be omitted. Please do not submit the participant's actual written informed consent with your article, as this in itself breaches the patient's confidentiality. The Journal requests that you confirm to us, in writing, that you have obtained written informed consent to publish but the written consent itself should be held by the authors/investigators themselves, for example in a patient's hospital record. The confirmatory letter may be uploaded with your submission as a separate file in addition to the statement confirming that consent to publish was obtained within the manuscript text. If this is not applicable to your manuscript, please state 'Not applicable' in this section.

Declaration of conflicting interest

The journal requires a declaration of conflicting interests from all authors so that a statement can be included in your article. For guidance on conflict of interest statements, see our policy on conflicting interest declarations and the ICMJE recommendations.

If no conflict exists, your statement should read: 'The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article'.

Funding statement

All articles need to include a funding statement, under a separate heading, **even if you did not receive funding**. You'll find guidance and examples on our Funding page.

Data availability

The Journal is committed to facilitating openness, transparency and reproducibility of research, and has the following research data sharing policy. For more information, including FAQs please visit the Sage Research Data policy pages.

Subject to appropriate ethical and legal considerations, authors are encouraged to:

- Share your research data in a relevant public data repository
- Include a data availability statement linking to your data. If it is not possible to share your data, use the statement to confirm why it cannot be shared.
- Cite this data in your research

Reference style and citations

The journal follows the APA reference style. View the APA guidelines to ensure your manuscript conforms.

Every in-text citation must have a corresponding citation in the reference list and vice versa. Corresponding citations must have identical spelling and year.

Authors should update any references to preprints when a peer reviewed version is made available, to cite the published research. Citations to preprints are otherwise discouraged.

Supplemental material

This Journal can host additional materials online (e.g. datasets, podcasts, videos, images etc.) alongside the full text of the article. Your supplemental material must be one of our accepted file types. For that list and more information please refer to our guidelines on submitting supplemental files.

English language editing services

Authors seeking assistance with English language editing, translation, or figure and manuscript formatting to fit the journal's specifications should consider using Sage Author Services. Visit Sage Author Services for further information.

Appendix 1.2: Search Terms

Search terms used to retrieve articles involved combinations of the following groups of keywords:

1. Parent*, caregiv*, guardian*, mother*, father*, foster*, carer*, famil*;
2. Child*, adolescen*, teen*, young people, youth, boy*, girl*;
3. Focus group*, interview*, qualitative*, exploration, narrat*, experienc*, participa*, perspective*, perception*, struggle*;
4. Servic*, support*, provide*, system*, access*, interven*, program*;
5. ASD, Asperger*, ASC, autis*, neurodiverse*;
6. United Kingdom, UK, Great Britain, GB.

Boolean operators “AND” & “OR” were used to combine search terms between word sets and connect search terms within word sets respectively. Truncations “*” were also used to pluralise search terms where possible. Search terms were limited to titles and abstracts in English.

Appendix 1.3: Lay Abstract

Parents of autistic children help their children deal with extra challenges, and can sometimes find that hard. The help they and their children need isn’t always available. Sometimes, parents are given help with helping their children. Statistical research isn’t clear about how useful this help is, and there is not a lot of research involving parents talking about their experiences of getting this help. We want to put all the research related to this in the UK together.

We looked through at a number of databases in February 2025. The articles we looked for were published in English after 2004 and used methods that involved parents talking about their experiences of help from services for autistic children. We used a tool to check the quality of each paper we included. We then used a technique called meta-synthesis to summarise what parents had said across the fifteen articles we found.

We found eight high quality articles, five medium-quality article, and two low-quality articles. The help offered in the articles supported parents' understanding of autism psychologically, behaviourally, communicationally and sensorily. We found themes of change, relationship to help, parents' need to process, and solidarity.

We concluded that good change was helped by learning, making parents feel supported, and giving help that was thorough and structured. Parents said that meeting other supportive parents was helpful. Space to understand more about their feelings and autism was useful. The quality of articles was varied, and we encourage more reflection, use of theory, and using a process called "embedding" that involves changing help based on the feedback parents give at the time.

Appendix 2.1: Author Instructions

Aims and Scope

The Cognitive Behaviour Therapist is published for the British Association for Behavioural and Cognitive Psychotherapies and is the sister Journal to *Behavioural and Cognitive Psychotherapy*

The Cognitive Behaviour Therapist is an interdisciplinary peer reviewed journal aimed at CBT practitioners. Published online, the journal will publish a range of types of papers (see below for a full description of each) that support CBT therapists in improving their delivery of CBT, supervision and training and/or develop our knowledge and understanding of CBT across all areas.

A particular feature of the journal is that its electronic nature is designed to ensure timeliness of publication and professional debate whilst also ensuring rigorous standards in the dissemination of high-quality materials with relevance to the practice of the cognitive and behaviour therapies.

Editorial Governance

The Cognitive Behaviour Therapist encompasses most areas of human behaviour and experience, and represents many different research methods, from quantitative to qualitative research, how to flexibly implement specific clinical interventions right through to detailed case studies. Under the guidance of its editorial board *the Cognitive Behaviour Therapist* aims to reflect and influence the continuing changes in the concepts, methodology, and techniques within the cognitive and behaviour therapies.

Editorial Statement – scope of journal content

The Editors welcome authoritative contributions from people involved, in the practice, research, education, training and supervision in the cognitive and behaviour therapies. Articles must be original and focused upon cognitive and/or behaviour therapy. There is no formal word limit, but concision is recommended.

In terms of subject areas, our scope includes.

- the delivery of CBT
- supervision of CBT
- training in CBT
- service model and forms of delivery of CBT.

Papers on these subject areas may fit within any of the types of papers detailed below.

Papers should be submitted online at https://mc.manuscriptcentral.com/cbt

Manuscripts should be submitted with any identifiers removed for blind review. If authors fail to omit identifiers, anonymised review cannot be guaranteed.

The Editor-in-Chief and Editorial Team will make an initial decision on of whether submitted papers fall within the remit of the journal and/or are of sufficient interest and importance to warrant full review.

Types of Paper

Original Research*

Research evidence is at the heart of the practice of cognitive and behavioural psychotherapists. Original research will be published that directly relevant to the practice of CBT, such as the therapeutic relationship, therapeutic process and the evaluation of therapeutic strategies and techniques. It is expected that such reports meet both the necessary standards of scientific rigour and the journal's requirement of clear implications for the practice of CBT. Consequently, the description of the research and the presentation of results should be sufficiently brief to enable sufficient discussion of the practice implications. Consideration will be given to quantitative, qualitative and mixed approaches given appropriate fit between the question, methodology and research methods chosen.

For examples see:

Hutton, J., Ellett, L., & Berry, K. (2017). Adult attachment and paranoia: An experimental investigation. *The Cognitive Behaviour Therapist, 10*, E4. doi:10.1017/S1754470X17000058

Kobori, O., Salkovskis, P., Pagdin, R., Read, J., & Halldorsson, B. (2017). Carer's perception of and reaction to reassurance seeking in obsessive compulsive disorder. *The Cognitive Behaviour Therapist, 10*, E7. doi:10.1017/S1754470X17000095

McManus, F., Leung, C., Muse, K., & Williams, J. (2014). Understanding 'cyberchondria': An interpretive phenomenological analysis of the purpose, methods and impact of seeking health information online for those with health anxiety. *The Cognitive Behaviour Therapist, 7*, E21. doi:10.1017/S1754470X14000270

This category of paper type could also include single-case experimental design research or a case series.

For example, see:

Thomson, C., Wilson, R., Collerton, D., Freeston, M., & Dudley, R. (2017). Cognitive behavioural therapy for visual hallucinations: An investigation using a single-case experimental design. *The Cognitive Behaviour Therapist, 10*, E10. doi:10.1017/S1754470X17000174

Empirically Grounded Clinical Guidance Papers*

Some of the most widely read and discussed papers in tCBT have been those that are the synthesis of clinical experience, using informed reasoning to link limited direct evidence in the field with evidence from wider fields.

tCBT is very keen to consider submission of such papers in relevant fields that are of interest to CBT therapists, supervisors and trainers. These tend to be written by experts in the field and are designed to solve specific practical problems or clarify gaps in our knowledge. Ideally, they lead to practical implications and recommendations whilst generating hypotheses for future research.

For examples see:

Barton, S., Armstrong, P., Wicks, L., Freeman, E., & Meyer, T. (2017). Treating complex depression with cognitive behavioural therapy. *the Cognitive Behaviour Therapist, 10*, E17.

Duffy, M., & Wild, J. (2017). A cognitive approach to persistent complex bereavement disorder (PCBD). *the Cognitive Behaviour Therapist, 10*, E16.

Freeston, M., Tiplady, A., Mawn, L., Bottesi, G., & Thwaites, S. (2020). Towards a model of uncertainty distress in the context of Coronavirus (COVID-19). *The Cognitive Behaviour Therapist, 13*, E31. doi:10.1017/S1754470X2000029X

Freeston, M., Thwaites, R., & Bennett-Levy, J. (2019). 'Courses for Horses': Designing, adapting and implementing self-practice/self-reflection programmes. *The Cognitive Behaviour Therapist, 12*, E28.

Menzies, R., & Menzies, R. (2020). Death anxiety in the time of COVID-19: Theoretical explanations and clinical implications. *The Cognitive Behaviour Therapist, 13*, E19. doi:10.1017/S1754470X20000215

Murray, H., Merritt, C., & Grey, N. (2015). Returning to the scene of the trauma in PTSD treatment - why, how and when? *the Cognitive Behaviour Therapist, 8*, 1–12.

Murray, H., Pethania, Y., & Medin, E. (2021). Survivor guilt: A cognitive approach. *The Cognitive Behaviour Therapist, 14*, E28. doi:10.1017/S1754470X21000246

Warnock-Parkes, E., Wild, J., Thew, G., Kerr, A., Grey, N., Stott, R., . . . Clark, D. (2020). Treating social anxiety disorder remotely with cognitive therapy. *The Cognitive Behaviour Therapist, 13*, E30. doi:10.1017/S1754470X2000032X

Young, K., Chessell, Z., Chisholm, A., Brady, F., Akbar, S., Vann, M., . . . Dixon, L. (2021). A cognitive behavioural therapy (CBT) approach for working with strong feelings of guilt after traumatic events. *The Cognitive Behaviour Therapist, 14*, E26. doi:10.1017/S1754470X21000192

Case Studies*

Dissemination of effective practice will be promoted through the publication of case studies that involve CBT with individuals, couples, groups and families. A suggested template is provided which is designed to ensure sufficient information is provided to allow other therapists to replicate successful therapy. All articles must include 3-5 learning objectives that will be achieved through reading the article. At the end of each paper a summary of the main practice points should be included with suggestions for follow-up reading. This

stipulation is in keeping with the practitioner and professional development aims of the journal.

The case study should contribute to the development of theory or clinical practice, and feed into CBT practice as a whole rather than just relating to the specific case. Case studies should generally follow this structure:

- Abstract
- Key Learning Points
- Introduction: including an outline of theoretical research and clinical literature relevant to the case
- Presenting problem: including information on the presenting problem and associated goals of treatment, diagnosis, relevant history and development of problems, scores on standard and idiographic measures, relevant history
- Formulation: including a relevant theory-based CBT model used as a framework.
- Course of therapy: including methods used linked to theory and assessment of progress; difficulties encountered and any innovations in therapy
- Outcome: including clinical change, progress towards goals, change to measures, plans for follow-up
- Discussion: including relating to theory and evidence-base as well as reflections on own practice; implications for therapy and recommendations for other clinicians
- Key Practice Points
- Further Reading

For examples see:

Bernstein, R., Angell, K., & Dehle, C. (2013). A brief course of cognitive behavioural therapy for the treatment of misophonia: A case example. *The Cognitive Behaviour Therapist, 6*, E10. doi:10.1017/S1754470X13000172

Jenkins, P. (2017). Can temporary cessation of CBT really be therapeutic? A case studies. *The Cognitive Behaviour Therapist, 10*, E8. doi:10.1017/S1754470X17000101

In addition to clinical case studies, there may be case studies related to training or supervision which would require a slightly amended structure to the one outline above.

Invited Papers*

At times tCBT will invite papers on specific issues where there is a gap in the clinical literature. This may involve commissioning papers directly from experts in a particular area or this may be a call to the wider CBT community.

Reviews*

Reviews of historical, contemporary, or innovative approaches to practice are also sought providing that they demonstrate relevance to the practice of the current cognitive and behavioural psychotherapies. Prospective authors for review papers should initially discuss their proposals with the Editor-in-Chief.

Reviews of Assessment Tools and Methods*

Reviews of clinical scales and other assessment methods will also be considered.

These reviews should provide the practitioner with a review of a scales or other tool's purpose and properties, sufficient information to know how and when to use it, and how to interpret the results and make use of them. All articles must include a set of 3-5 learning objectives that will be achieved through reading the paper. At the end of each paper a summary of the main points from the paper must be included with suggestions for follow-up reading. This stipulation is in keeping with the practitioner and professional development aims of the journal.

For examples see:

Hyland, P., Shevlin, M., Adamson, G., & Boduszek, D. (2013). The factor structure and composite reliability of the Profile of Emotional Distress. *The Cognitive Behaviour Therapist, 6*, E15. doi:10.1017/S1754470X13000214

Reiser, R., Cliffe, T., & Milne, D. (2018). An improved competence rating scale for CBT Supervision: Short-SAGE. *The Cognitive Behaviour Therapist, 11*, E7. doi:10.1017/S1754470X18000065

Service Models, Forms of Delivery and Cultural Adaptations of CBT*

The service model is the clinical and operational framework that exists to support the therapist with the delivery of cognitive behavioural therapies. Description and evaluation of innovative clinical service models (both in the UK and internationally) and delivery formats that can be generalised to other services will be considered for publication. Audits will only be considered if they are of wider interest and value in informing the work of other services.

tCBT is keen to publish research that either expands the evidence base for previously under-represented groups or work that describes and evaluates cultural adaptations that are required for different populations.

For examples see:

Jankowska, M. (2019). Cultural modifications of cognitive behavioural treatment of social anxiety among culturally diverse clients: A systematic literature review. The Cognitive Behaviour Therapist, 12, E7. doi:10.1017/S1754470X18000211

King, D., & Said, G. (2019). Working with unaccompanied asylum-seeking young people: Cultural considerations and acceptability of a cognitive behavioural group approach. The Cognitive Behaviour Therapist, 12, E11. doi:10.1017/S1754470X18000260

Thew, G. (2020). IAPT and the internet: The current and future role of therapist-guided internet interventions within routine care settings. The Cognitive Behaviour Therapist, 13, E4. doi:10.1017/S1754470X20000033

Thew, G., MacCallam, J., Salkovskis, P., & Suntharalingam, J. (2017). Developing and evaluating psychological provision in the acute hospital setting for patients with chronic

respiratory disease. The Cognitive Behaviour Therapist, 10, E5. doi:10.1017/S1754470X17000071

Education and Supervision*

The dissemination of effective cognitive and behaviour therapy through evidence-based education and supervision strategies is important to ensure that service users receive proficient therapy and therapists remain up to date. This section will explore educational models, evaluations of innovative education strategies and approaches to the supervision of practice within the cognitive and behavioural psychotherapies. All articles must include a set of 3-5 learning objectives that will be achieved through reading the paper. At the end of each paper a summary of the main points from the paper must be included with suggestions for follow-up reading. This stipulation is in keeping with the practitioner and professional development aims of the journal.

* These article types may be eligible for APC waivers or discounts under one of the agreements Cambridge University Press has made to support open access.

Appendix 2.2: Survey & Interview Schedule

PWP's Experiences of Assessment of Traumatic Events

Survey

Participant Code:

Age:

Ethnicity:

Trainee or qualified?

Time working as a PWP (months)

How often have patients reported having experienced traumatic events to you at assessment, during your time in this role? (to the nearest 5)

Interview Schedule

i)	Understand the experience of PWPs (Psychological Wellbeing Practitioners) conducting assessment sessions that feature discussion of traumatic events.	Can you tell me about what it's like for you, to conduct assessment calls, when service users report having experienced traumatic events?

		• What goes through your mind when traumatic events are reported by service users?
ii)	Develop insight into the emotional difficulties PWPs encounter in assessing traumatic events (Do we also know what helps them assess trauma? Or only the difficulties?)	Does discussing such traumatic events as part of assessment calls impact you emotionally? (If yes, how?) • How do you manage these feelings / this impact? • Do you feel/think/believe… there are any short or longer-term effects of assessing traumatic events for you/in general? Are there aspects of working as a PWP that make this easier or more difficult? • Are their elements of working in your service/team/role that impact this?
iii)	Develop insight into the practical difficulties PWPs encounter in assessing traumatic events	What's your experience of implementing trauma-related theory into practice during assessment calls? What is your experience of assigning problem descriptors during assessment calls when traumatic events are reported? • Do you ever find it challenging to decide the problem descriptor in these situations? What do you consider to make this decision? • Are there service factors in your decision-making process? Are there other difficulties that you have experienced when assessing traumatic events as a PWP? What skills do you find necessary to implement in assessing traumatic events? Is there anything you find helpful or challenging about this?
iv)	Inform the design/redesign of trauma-related training within [the service] accordingly.	How helpful was your training in in assessing traumatic events?

	• Is there anything you would change about this training? What are your thoughts on how [the service] support the emotional impacts of assessing traumatic events? • What, if anything, do you think could [the service] do to support you more emotionally during this process? What are your thoughts on how [the service] support the practical difficulties of assessing traumatic events? • What, if anything, do you think could [the service] do to support you more practically during this process?

Appendix 2.3: In-Service Project Approval

NHS
Oxford Health
NHS Foundation Trust

Clinical audit - Approval confirmation

Hi John,

The audit facilitator has approved a clinical audit, which can be accessed in YOUR AUDITS within the Clinical Audit & Improvement section on the AMaT system.

Audit code: Talking Space Plus Oxfordshire/SE/2023-24/01

Audit title: Exploring the PWP experience of assessing traumatic events.

Speciality: Talking Space Plus Oxfordshire

Lead participant: John Kerr

Date approved: 14/07/2023

Approved by: Angela Ward

Audit Facilitator name: Jelena Ampofo

Audit Lead name: Angela Ward

Audit lead approval comment:

None provided

Audit facilitator approval comments:

Can you check the action plan date, the system flags as overdue from that date if the action plan tab of the project hasn't been completed and will send notifications.

Your role in this audit: Lead participant

This notification is sent to: Facilitator, Audit lead, Lead Participants, Participants and Mentor.

Appendix 2.4: Participant Quotes

Navigating Ambiguity Makes Assessments More Difficult

Difficulties Defining Trauma Problems

"People say oh, that was really traumatic and they don't mean that they're experiencing trauma. They just mean that was a really difficult thing for me and and this is the language that is now accepted and used for that… so I think even if that was what we learnt like about when, how to distinguish between someone saying this was traumatic and meaning this was big and eventful and actually what trauma itself is, I think that would be helpful as a like starting point I guess". [P2]

Not Treating PTSD Makes Assessing For It Harder

"When I think of complexity, it normally tends to sit out for the things that I feel we've not had sufficient training for. Things like personality disorders… that's not something we've had specific training on in terms of knowing what to look for or how to assess or how that can come into play… Greater understanding and like assessing PTSD or trauma when there isn't PTSD, or the difference between complex PTSD versus I guess regular PTSD…. I guess it's all the things that are outside the remit of what we're expected to as a PWP, but we're still expected to assess and are exposed to frequently is what I feel like I would define as complexity. " [P1]

A Perceived Lack Of Training Leaves PWPs Feeling Underprepared To Assess Trauma

"[What I would change about training is]*... guidance on how much we need to know. Yeah, how much should we be asking about? What should we stay away from?"* [P7]

"I think it would be really helpful to have, and it might sound silly, but to have training on the decision-making within that call, because you are trying to make a lot of decisions whilst you're trying to think of these questions". [P8]

"What can we do to help kind of package it back up? Because even if you're only touching the surface, it's still going to bring things to the surface within that person." [P8]

"How much do I explore that area? That trauma for that patient when they're saying it's not, it's not relevant… I guess we haven't had specific training in that." [P2]

"I think it would be nice to just have maybe just half a day discussing, OK well what to do during a traumatic event if someone discloses to you what they've gone through, what to do maybe during that moment of time, you know, possible scenarios, but also what to do for a PWP afterwards. What tips and tricks would you suggest, you know, take a walk, speak to someone, and do some self-care, etc." [P10]

"I can't even remember the training. I don't remember when I had it. I don't remember who did it. I don't remember what it was like and I know it was quite recent in like the last few months. So that's probably not very good. But yeah, normally I remember things quite well, but I feel like I if I don't remember it's probably, I didn't get anything from it." [P4]

"*In terms of training there's only been just that one instance that I can remember. I do remember finding it helpful at the time, but I'm not sure how much of that has stayed in* [their head]" [P6].

I'm just not sure if I'm qualified enough to assess these people… I suppose that is why we can always step them up and they can have their own assessment at Step 3 if they feel there is a need for that." [P6]

Assessing Traumatic Events Is Emotionally Overwhelming

Assessment Calls Involving Trauma Invoke Intense Emotions

"I'm aware of the limitations of low intensity CBT, so I think it it's almost a bit disheartening in a way because I know that myself as an individual, I can't make a difference to that person in terms of treatment." [P2]

"Sometimes there's people you are assessing who have maybe gone round a few different services and are still coming back for similar difficulties, similar issues, similar experience. It's quite disheartening to an extent because it, you know, it's saddening to hear their experience… that's a really difficult cycle for them to be going through." [P11]

"I feel that we're not gonna make a difference. And that's what I'm here for. I'm here to make a difference to people and that's what I want for them and for myself. So when we have difficult conversations and I know it's not going to be low intensity, it feels a bit like I'm redundant in this process or the low intensity side of it is redundant in the assessment of trauma." [P2]

"I think I try and put myself in their shoes… think, well, that's what it would be like. Makes you feel quite… sad, I think." [P3]

"*Yes. And there are definitely calls where you will feel low and deflated after hearing about what someone has been through and or even upset or angry at the world."* [P1]

"Feeling pretty sort of… how on earth this person has got to this point" [P8]

"That's terrifying to me to hear that. So emotionally I get quite stressed during it and after it as well." [P4]

"It's just horrible to hear what people have been through or what people have done to other people, and that never gets easier" [P1]

"I think that was a hard reality to grasp that every kind of person can experience it and does experience it" [P4]

"Try to be very sensitive, your tone of voice immediately changes, you try and be a bit more soft spoken. There are no other things that are going through my mind, it's just how do I make this as comfortable as possible for them" [P6]

"I think the patients that I find more difficult are the patients that are finding it difficult to go back.. to speak about" [P3]

<u>*Lingering Emotional Impacts*</u>

"Whether it's for safeguarding or risk was part of the trauma presentation… the high-volume work is challenging because it's hard to find that capacity and which ultimately normally

means that you have to work longer hours and overwork in order to get everything sorted." [P1]

"You maybe don't have as much time as you would like… you might go on to that assessment with the next patient still thinking about the one you just spoke to." [P3]

Desensitisation

"It is really exhausting when you have almost the same conversation with different people every week about very similar topics, and you sort of think to yourself, wow, well, this happens way too often." [P4]

"Sometimes, you would go through those weeks where a lot of people report trauma all at once… it just makes you feel a bit burnt out, when you are hearing it from different people." [P9]

"Obviously, a lot of these traumatic events are horrible things that you wouldn't normally discuss with anyone. It sounds bad, but you become a bit desensitized to it" [P5]

"I've become more resilient, and I can take on board what patients are explaining to me, but also be able to separate you know, this is work, try not to let it impact my personal life, and how I'm personally feeling" [P10]

"I guess it comes back to the desensitisation thing… when I'm like watching a film or something or hear on a telly program that people have been through these traumatic events, I almost feel like I'm not as shocked by it… So, like for other people, they might cry when they're watching that. But I always just think people are going through this all the time." [P5]

Confluence of Personal and Professional Distress

"I've done a few assessments where people had literally gone through the fires in Greece and they like described it like grabbing their children and getting in a car, having like flames around them, feeling the heat like you could almost live it with them because it's so recent and it's so publicized that you almost can imagine it… this was an assessment I did months ago and I still remember it very clearly -or speaking to people who have gone through the war and like left their family behind. Like you kind of imagine. If I had to leave my family behind and stuff like that… if it comes up on the news, I might think about that person I spoke with and how they're doing. So they don't leave me if that makes sense." [P10]

"It probably makes me more aware of these traumatic things that might have happened to people… you kind of have that more skewed perception of what people then go through." [P11]

"I barely read the news because I always say that I hear enough depressing stuff during my workday I feel sad or upset or annoyed at what this person is has had to go through and how much it's impacting them and kind of taking on some of that." [P1]

Assessing Traumatic Events is Pressurising

"I think you're aware of these pressures in the service. And these targets and pressures that are on everybody else" [P3]

"I want to get it right. So, there's no delays in getting them the right support. I guess you are conscious as well about the waiting times at different levels." [P8]

"I think everything that I've said like you know, not having enough time between appointments, having a caseload of very different things and that obviously to come up. I personally don't think that's a service issue. I think it's more of like uh, across service issue… I think it's just the PWP role" [P5]

"*A slight reduction in caseload* [would make the role easier]… *but that sort of goes, not goes against, but it defeats the purpose of IAPT which is high volume caseload."*[P10]
"We only have 40 minutes for an assessment… sometimes it is enough time, sometimes it's not. Because you do have to do a lot more kind of building the rapport with the patient for them to feel kind of comfortable enough for you to have that conversation… sometimes when you're going through an initial assessment, it's like 'bam, bam, bam, bam'. I'm trying to get through all of that kind of tick, boxy information. And then you're like, OK, so tell me about this horrible thing that's happened then. And it feels not genuine" [P5]

"There's more time that you need to spend on things when you're already in a busy role." [P3]

"I think the main one, quite a lot of it, is time. Especially with an assessment where you are going through lots of information that might not necessarily be relevant to the traumatic event itself. Whether it's the questionnaires, whether it's risk, talking about the past itself, and just all the other things that you fill in to an assessment that's supposed to be 40 minutes." [P11]

"I would say in terms of the time management in your assessment… that can be really difficult to manage" [P8]

"Definitely the timing is tough because you know, let's say you're in an assessment, this individual's talking about trauma. They are quite distressed, you are trying to be empathetic, but at the same time, you've got so much of your template that you need to gather from that patient." [P9]

"I've got so much going on through the day, it's hard to think about other things that could be put in place to make this all better." [P6]

"You don't have a lot of time. Especially if you're back to back, you don't have that much time if you have a case, you'll probably have about 5-10 minutes before you have to write up the notes, and you've got your next patient. You don't get a lot of time, so in some cases I just have to just stop what I'm doing, quickly type up my notes and start my next case because yeah, you just don't get that much time." [P10]

"In a trauma assessment, I feel like there's so much more in there to explore, but we don't have time to do that." [P4]

"Pragmatic things that would get in the way… it takes time to call people back" [P2]

"There is two types of impact. The one that's just about you hearing that an individual whose unfortunately had to go through really unpleasant events. But I think the second thing is the

time of you trying to gather all the necessary information and safeguarding comes into that. Because you then have to say, ok, is that perpetrator still a risk to others? And then if they are, what are they currently doing to others? and then you have to follow up with speaking to safeguarding. And so I think all of that, that burns you out." [P9]

"I take a step away, get a cup of tea or give myself a breather before having to jump on the next call. But you know, it's trauma that sometimes can be coupled with complexity or risk. Sometimes that wasn't an option and you had to immediately be responding to it" [P1]

In-Service Support Is Invaluable

Peer Support Is Close To Hand

"In the moment, if I'm in the office I'll turn around and talk to someone and express how I'm feeling or how that made me feel." [P1]

"Because I'm very lucky with the people that I work with, they'll turn around and be like 'that sounds really tricky. Are you OK? Like do you need to take a moment to decompress or like do you wanna talk about it?'. So it's really nice sort of having that support around me. To be able to talk about those types of things, because I know it would probably feel a lot different, say for example, if I was just working from home on my own and not being able to talk about it." [P5]

"I think the advantages of the role is that everyone in the office in the same position as you, everyone is going through the same difficulties as you or etc so they are able to empathize, they are able to share their own techniques." [P10]

"I think just the natural fact that you train in cohorts, … you've got people you can turn to, other people are going through the same experience of "I don't know what I'm doing" at the same time. But also actually pretty much everyone on the team has gone through that same thing… they all know exactly how you're feeling and have been through that themselves and I think that really helps in terms of being able to offer support and empathise with each other. Knowing the ups and downs that comes with being a PWP" [P1]

"My training year was fully remote because of COVID and so that was more difficult for sure… it is definitely much easier when you're in the office to just turn around and talk to someone." [P1].

<u>*Supervisors Shape The PWP Experience*</u>

"I have a good relationship with my supervisor. So I feel able to say to her this is what happened and this is what came up and with that particular instance… I was able to talk her through the like the whole journey for me… I feel supported in that." [P2]

"On the whole, the team are pretty good.. if a case has been difficult, if you wanted to talk through with someone from DS or Duty, there is that option… because they're often able to recognize that this was not an easy call for you to go through" [P1]

"I feel like you can speak to anyone you know however senior they are." [P8]

"I sent it through to Duty to get advice on next steps, and I think something that was really nice was when they replied back, they did ask if I wanted like a little chat. Which I thought was just, I don't know…I've not had that… I never had that in my last service"[P9]

Appendix 2.5: Published Service Improvement Project

The Cognitive Behaviour Therapist (2025), vol. 18, e29, page 1 of 16 doi:10.1017/S1754470X25000170

ORIGINAL RESEARCH

'You never know who you're gonna speak to': exploring Psychological Wellbeing Practitioners' experiences of assessing traumatic events

John Kerr[1,2], Hjördis Lorenz[3,4], Samantha Sadler[1], Victoria Roberts[1,2], Craig Steel[1,2] and Graham R Thew[1,3]

[1]Oxford Health NHS Foundation Trust, Oxford, UK, [2]Oxford Institute of Clinical Psychology Training and Research, University of Oxford, Oxford, UK, [3]Department of Experimental Psychology, University of Oxford, Oxford, UK and [4]Berkshire Traumatic Stress Service, Berkshire Healthcare NHS Foundation Trust, UK

Corresponding author: John Kerr; Email: john.kerr@gtc.ox.ac.uk

(Received 28 November 2024; revised 18 March 2025; accepted 23 March 2025)

Abstract

This study explored junior mental health workers' experiences of conducting assessments involving traumatic events. Semi-structured interviews with 11 junior mental health workers from a UK primary care mental health service were analysed using reflexive thematic analysis. Participants discussed themes of ambiguity in distinguishing trauma and PTSD, high levels of pressure, management of personal distress, appropriate training, and personal support in-service. Findings corroborate previous research regarding challenges experienced by junior mental health workers and offer novel insight into the challenges faced when assessing service-users' experiences of traumatic events. Recommendations regarding future training, service design and emotional outlets for junior mental health workers are offered.

Key learning aims

(1) Following reading this paper, readers will better understand the diagnostic and practice-based complexities involved in assessing traumatic events as a Psychological Wellbeing Practitioner (PWP) in an NHS Talking Therapies service.
(2) Readers will also be aware of the emotional challenges PWPs in this service have reported experiencing as a result of assessing service users that report having experienced traumatic events.
(3) The reader will also learn about PWPs' perspectives on what could improve this NHS Talking Therapies service's processes involved in assessing traumatic events and reflect on whether this might be generalisable across other, similar services.

Keywords: assessment; NHS-TT; PTSD; PWP; qualitative; trauma

Introduction

NHS Talking Therapies for anxiety and depression (NHS-TT, formerly Improving Access to Psychological Therapies (IAPT)) was established in the United Kingdom (UK) in 2008 to deliver treatment for common mental health issues such as anxiety and depression (Clark, 2018) within the National Health Service (NHS). NHS-TT operates a stepped care framework, in which treatment resources are allocated based on condition severity and National Institute for Health

© The Author(s), 2025. Published by Cambridge University Press on behalf of British Association for Behavioural and Cognitive Psychotherapies. This is an Open Access article, distributed under the terms of the Creative Commons Attribution licence (https:// creativecommons.org/licenses/by/4.0/), which permits unrestricted re-use, distribution and reproduction, provided the original article is properly cited.

and Care Excellence (NICE) guidelines regarding the treatment of particular conditions (NHS Talking Therapies, 2024). Most service users initially receive a 'low-intensity' treatment

(ranging from use of self-help books or computer platforms to receiving short-term manualised cognitive behavioural therapy (CBT) sessions), then if clinically indicated, go on to receive a 'high-intensity' treatment, which typically involves 12–20 therapy sessions based on an individualised formulation (Chan and Adams, 2014; Richards et al., 2012). For some clinical conditions such as post-traumatic stress disorder (PTSD) and social anxiety disorder, low intensity interventions are not recommended by NICE, so some service users start with a high intensity intervention.

Upon presenting to NHS-TT services, service users are typically assessed by Psychological Wellbeing Practitioners (PWPs), a junior workforce within NHS-TT that conduct assessments and deliver cognitive behaviourally informed low-intensity interventions. During assessments, the PWP and service user discuss current difficulties and consider the main problem the service user would like to work on. Based on this, the PWP selects a 'problem descriptor' (descriptions of psychological difficulty derived from ICD-10 codes) in the electronic patient care record, and allocates the service-user to an appropriate low-intensity (sometimes called 'Step 2') or high intensity ('Step 3') treatment (NHS Talking Therapies, 2024). NHS-TT uses problem descriptors to match service-users to appropriate, disorder-specific cognitive behavioural therapy (CBT) protocols (Saunders et al., 2020). NHS-TT services using problem descriptors frequently and accurately achieve higher rates of recovery and reliable improvement (Clark, 2018; Skelton et al., 2023).

The NHS-TT assessment process poses challenges for PWPs given that large amounts of clinical, safety, and practical information must be collected in short time periods, while simultaneously conveying empathy, understanding and openness to patients (Scott, 2018). PWPs must also be able to assess service users who are experiencing conditions they are not trained to treat; one such condition is PTSD. PWPs need to be able to discuss traumatic events with service users, identify if PTSD is present and the main presenting difficulty, and consider the most appropriate intervention, which may include NHS-TT interventions or referral to other services if service-user needs cannot be met within NHS-TT (NHS Talking Therapies, 2024).

NHS service users frequently report experience of traumatic events (Finch et al., 2020; Sandford, 2023). Prevalence research in this area indicates that between 50 and 75% of primary mental healthcare service users in the UK have experienced clinically significant threatening events in the year preceding assessments; furthermore, 67% report at least one experience of childhood trauma (Hepgul et al., 2016; Thomlinson et al., 2017). Experiencing a traumatic event is Criterion A of a PTSD diagnosis, according to the Diagnostic and Statistical Manual of Mental Disorders (5th edn; DSM-5; American Psychatric Association, 2013); the American Psychatric Association (2013) defines a traumatic event as actual or threatened, death, serious injury or sexual violence, directly experienced, witnessed or learned about happening to a close relative or close friend. While traumatic events are often distressing and subsequently distressing to discuss openly in therapy (Boterhoven de Haan et al., 2021), experiencing a traumatic event is not synonymous with a PTSD diagnosis; PTSD is just one of many potential psychological reactions to trauma (Ehrenreich, 2003).The prevalence of PTSD in the UK is estimated at 4.4% (Baker and Kirk-Wade, 2021).

Clinician capacity to distinguish between PTSD and other psychological experiences involving traumatic events can be limited, particularly in primary care settings (Cowlishaw et al., 2021; Ehlers et al., 2009). Several factors complicate such recognition (Frissa et al., 2016). Firstly, information regarding trauma exposure is not always disclosed during initial assessments (Spoont et al., 2015). Secondly, service users with experience of trauma may perceive somatic symptoms as indicators of physical illness rather than mental distress (American Psychatric Association, 2013); conversely, colloquial use of terms such as

'traumatic' can contribute to both professionals and patients conflating difficult life experiences with PTSD (Tully et al., 2021). Finally, diagnostic measures of trauma disorders may be susceptible to pathologising contextually normal reactions as trauma symptoms (Rosen and Lilienfeld, 2008). Such ambiguities highlight the importance of clinician knowledge and competency in identifying and appropriately responding to disclosure of traumatic event experience (Hall and Hall, 2007).

How cases involving experience of traumatic events are assessed in mental health services can influence service user outcomes (Sweeney et al., 2019). Furthermore, the effectiveness of various PTSD treatments is influenced by assessment quality (Ehlers and Wild, 2022; Laliotis and Shapiro, 2022; Schnyder and Cloitre, 2022). Robust assessment procedures in psychological services can guard against longitudinal harm to service users and encourage treatment engagement (Hardy et al., 2019). Quality of such assessments is somewhat dependent on factors including clinician training provision, service culture, bureaucratic pressures, idiosyncratic skill application and therapeutic alliance strength (Nakash and Alegría, 2013). Despite the importance of the accurate assessment of traumatic events, particularly in distinguishing experience of traumatic events from meeting diagnostic thresholds for PTSD, how clinicians in UK mental health services conduct such assessments in practice remains unclear in literature (Turner et al., 2018).

Additionally, it is well documented that working with service users who have experienced trauma can prove stressful for clinicians (Voss Horrell et al., 2011). Junior mental health workers are particularly susceptible to such stress (Clemons, 2020). PWPs are provided weekly supervision, designed to offer case management, clinical oversight and wellbeing restoration. They can also access 'duty supervision' for support managing issues of clinical risk and safeguarding concerns. However, research surrounding CBT supervision indicates that experiences of supervisory practice can vary widely (Roscoe et al., 2022).

The present study therefore aimed to explore PWPs' experiences of assessments featuring the discussion of traumatic events within an NHS-TT service.

Method

This study's scope was established through collaboration between the authors and an NHS-TT service's clinical leadership team, following staff feedback regarding challenges associated with assessing traumatic events. The service anticipated that thorough exploration of PWPs' experiences of assessments featuring discussion of traumatic events would culminate in deeper understanding of challenges within the role, and eventual development of future training for PWPs. It was envisioned that the study's results could help inform support for PWPs to manage the emotional impacts of such assessments, enhancement of PWPs' PTSD identification and greater understanding of what future supports might benefit PWPs most.

Design

The study used individual semi-structured qualitative interviews. A semi-structured interview guide (see Supplementary material) was developed by the research team. Questions examined the emotional impact of assessing service users' experience of traumatic events, the practical feasibility of conducting assessment calls featuring patient experience of traumatic events, and satisfaction with training regarding assessments featuring discussion of traumatic events. Data were analysed inductively according to the principles of reflective thematic analysis, outlined through a six-stage approach recommended by Braun and Clarke (2021).

Participants

Twelve participants were recruited. All were 18 years old or above, capable of providing informed consent, and currently employed as a PWP in the participating NHS-TT service.

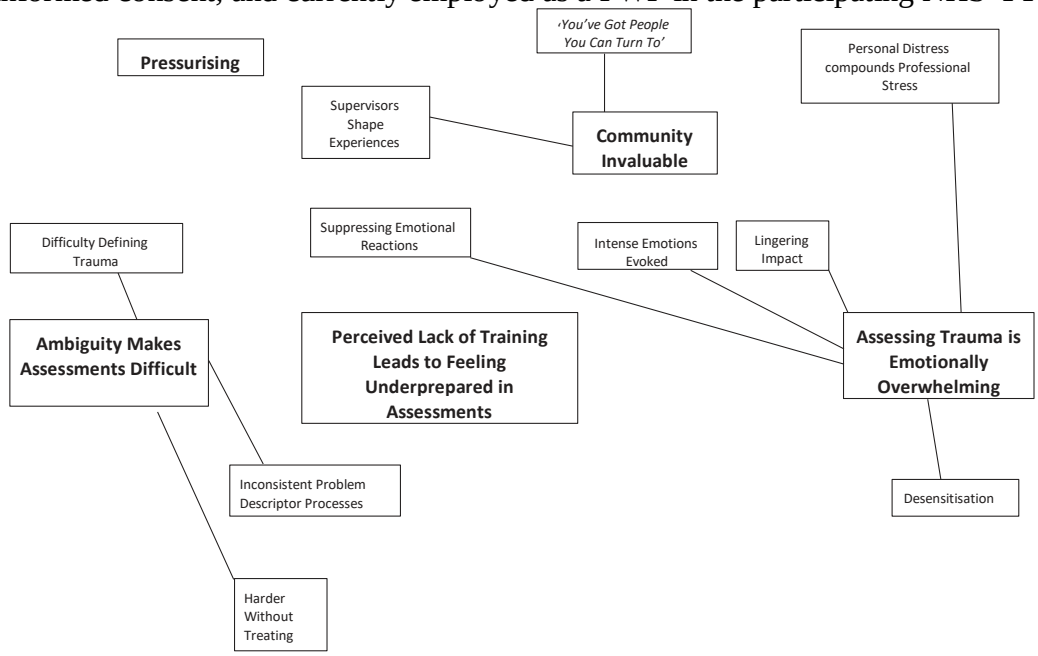


Figure 1. Thematic map.

Procedure

All participants received study information and provided informed consent before participating. Interviews were conducted by the first author between August and September 2023. Technological issues led to missing data from one interview, which was excluded from analysis. Of the 11 interviews included, 10 were conducted via Microsoft Teams and one was conducted face-to-face due to participant preference. Interviews lasted an average of 50 minutes. They were audio- and video-recorded using Microsoft Teams and transcribed verbatim.

Analysis

Data from 11 participants were included in analysis. In line with recommendations from Braun and Clarke (2021), the data gathered was agreed upon as sufficiently rich and multi-faceted by the research team. Following multiple readings of each transcript to facilitate familiarisation (Stage 1), transcripts were broken down into individual items of meaning based on content and labelled with codes (Stage 2). An inductive orientation to coding was taken, with semantic coding used throughout the dataset. The first author coded with a critical realist ontology, aligned to the reflexive element of reflective thematic analysis, allowing the research team to reflect on their personal biases. Initial themes were then generated from these codes (Stage 3) using thematic mapping, and through reflexive conversation with supervisors were reviewed and developed. The first author's perceptions as informed by experiences, society and culture were explored in the context of trauma within NHS-TT (Stage 4). Themes were subsequently refined, defined, and named (Stage 5). A thematic map detailing relationships between themes and subthemes was designed (see Fig. 1). Finally, analysis was written (Stage 6). Following initial analysis, two PWPs working for a different NHS-TT service were interviewed regarding the results as a means of triangulating data

analysis. Their perspectives regarding themes, subthemes and quotes outlined in the Results section were explored and alterations were made accordingly.

Table 1. Participant demographics

Characteristics	Mean (SD)	Percentage (n)
Age (years)	28.5 (5.31), range 23-42	
Gender (female)		81.8 (9)
Ethnicity White		
British		54.5 (6)
White Other		18.2 (2)
Black Caribbean British		9 (1)
Arabic		9 (1)
1 British Indian/Asian		9 (1)
PWP role Lead		
PWP		9 (1)
Qualified PWP		63.6 (7)
Trainee		27.3 (3)
Average time as PWP (months)	23.5 (9.8), range 5-36	
Average number of assessments Featuring traumatic events in service:	81 (62.7)	

PWP, Psychological Wellbeing Practitioner.

Reflexivity

The first author spent one year on a DClinPsych placement at this service in a separate workstream from PWPs. They approached this research mindful of the systemic challenges experienced by NHS-TT professionals. Additionally, they had prior experience in publishing qualitative research and were thus mindful of biases this could create.

Results

Nine women and two men were interviewed. Table 1 outlines their demographic information. Six themes, consisting of 13 subthemes, were established (see Fig. 1). These themes and respective subthemes are explored in sequence below. Further participant quotes substantiating these themes and subthemes are available in this paper's Supplementary material.

Navigating ambiguity makes assessments more difficult

Difficulties in fitting the life experiences reported by service users into NHS-TT problem descriptor criteria were described throughout the dataset. Among such challenges were navigating ambiguity regarding diagnostic criteria, inconsistent processes in assignment of problem descriptors, and uncertain discernment of appropriate referrals in a role untrained for PTSD treatment.

Difficulties distinguishing trauma from PTSD

Participants reported difficulties in distilling service users' experiences of traumatic events into concrete problem descriptors and accordant treatment pathways. Numerous respondents explained challenges in identifying appropriate thresholds upon which trauma could be assigned to a problem descriptor:

> 'In terms of descriptors within PCMIS, unless it's PTSD ::: it feels hard to know what the right problem descriptor is.' [P1]

Feeling lost upon encountering some patients reporting traumatic experiences was described:

> 'When people don't have those classic symptoms of PTSD, I think that's when ::: I'm not sure whether I'm asking the right questions. I'm not sure if I'm gathering enough information to assess whether it is actual trauma.' [P2]

Patients' understanding of their experiences as traumatic sometimes contravened service trauma definitions:

> 'You have patients who say trauma just because they've gone through something stressful.' [P4]

Recognising symptoms as those of trauma, rather than simply difficult life experiences, was also depicted as challenging by various participants:

> 'Probably got quite a lot of people that sort of would say they've experienced trauma or experienced like childhood trauma or ::: different trauma from the workplace. And it feels like it's a word that's used quite a lot.' [P5]

Service users themselves can struggle to recognise trauma-related symptoms, complicating assessments further:

> 'Do they know they are experiencing some kind of trauma symptom? ::: some others that don't even know that they are experiencing some kind of trauma.' [P6]

Inconsistent process for assigning problem descriptors

Reported decision-making processes for trauma-related problem descriptors varied widely between participants. Some PWPs believed that choice of problem descriptor should be led by patients:

> 'I think I would still be led by the patient and choose the problem descriptor that I think matches their sort of presentation, their goals, what they want to focus on.' [P8]

Others felt dependent on measures that identified symptoms concretely:

> 'Maybe I've done the PCL-5 [PTSD measure] with them and that, sort of, is scoring in caseness ::: then I would put PTSD as the problem descriptor there.' [P7]

Some believed supervisors should decide whether trauma-related problem descriptors were appropriate:

> 'I personally ::: would not put trauma as a descriptor unless my supervisor said to do that.' [P2]

Beliefs that handling traumatic events was unfeasible for PWPs were managed differently by different participants. Some attempt to conceptualise issues workable at Step 2:

> 'If they have traumatic events from the past and it doesn't actually seem like PTSD, I suppose my go to is ::: what step 2 problem does it associate with? I would probably just

fall back on that ::: 'cause I don't think trauma is just one that we can put on the problem descriptor.' [P7]

Others defer to Step 3:

'I don't think I'm qualified enough to say, is this trauma appropriate for IAPT [NHS-TT] or not? ::: I think it's so good that it's ran by those Step 3 therapists and not just left to us to decide.' [P9]

Not treating PTSD makes assessing for it harder

Assessing for PSTD in a role not designed to treat it presents significant challenges:

'I didn't know necessarily what questions to ask ::: We're trained to an extent how to assess PTSD and trauma, but obviously we're not trained in how to treat it ::: I also don't necessarily know how that treatment's going to look for them either.' [P5]

Some felt they lacked sufficient understanding of PTSD to assign its problem descriptor:

'I don't feel very confident putting a PTSD descriptor on because I can't diagnose that or assess that really because I don't treat it.' [P4]

A perceived lack of training leaves PWPs feeling underprepared

Describing formal and in-service training interchangeably, various participants shared beliefs that they were not sufficiently prepared to conduct assessments of traumatic events. PWPs felt that training did not address distinctions between PTSD and other trauma problems:

'In the training, they didn't really mention anything between like the differences between trauma and PTSD ::: So you do feel a bit left in the dark.' [P5]

PWPs also sought guidance in balancing patient boundaries with the accumulation of necessary information:

'How much do I explore that area? That trauma for that patient when they're saying ::: it's not relevant ::: we haven't had specific training in that.' [P2]

Overall, some relayed that their training on assessing traumatic events had been scant:

'I think in those 2 years there's only been one instance of PTSD training that I remember.' [P9]

Knowledge regarding assessment of traumatic events stemmed from learning gained while working, rather than from formal training:

'In assessing traumatic events ::: I don't think we necessarily went over anything with that in training, even recognising ::: I think that's something we've made picked up from service.' [P7]

Such experiential learning contributed to feeling under-prepared, especially given PWP roles are typically junior:

'It does feel like there's almost a bit of a gap there, I suppose. Where we're sort of thrown in to the deep end.' [P5]

Assessing traumatic events is emotionally overwhelming

Assessment of traumatic events were consistently described by participants as an emotionally overwhelming experience.

Assessment calls involving trauma invoke intense emotions

PWPs described a multitude of powerful emotions following assessment calls:

> 'I do feel quite drained ::: can feel a little bit down as well because it's not the nicest thing to hear.' [P10]

The emotional weight of being the first to hear disclosure of traumatic experiences is particular to such assessments:

> 'Some patients have come to me and disclosed that I would be the first person that they've ever disclosed this information to ::: It's upsetting to feel that, you know, they've gone through this and I'm the only person that they've ever spoken to.' [P10]

Some ruminated upon service users' circumstances:

> 'I think you can't help but think about this person's sort of life picture.' [P8]

Memories of such assessments caused physical distress:

> 'Two years ago ::: I can still feel it now. I could just feel something in my stomach.' [P3]

Not being able to help some service users invoked frustration and disillusionment:

> 'I'm aware of the limitations of low intensity CBT, so I think it it's almost a bit disheartening in a way because I know that myself as an individual, I can't make a difference to that person in terms of treatment.' [P2]

Supressing emotional reactions

Various participants detailed their suppression of emotional distress caused by assessments of traumatic events. For some, such suppression was practically necessary:

> 'You have to put your feelings aside for a minute to focus on your next patient. Because sometimes you just don't have that time to deal with your own emotions.' [P10]

Often, time constraints perpetuate avoidance of processing such distress:

> 'I guess the reality is ::: you normally just say oh yeah fine, because you don't have enough time in case management supervision to discuss about half your patients anyway.' [P5]

Lingering emotional impacts

Such assessments can lead to adverse emotional effects for some PWPs. These include carrying traumatic events in memory for months due to their emotional intensity:

> 'Even now a year on, I can recall a good amount of cases that have had traumatic events :::
> that's how traumatic they were.' [P10]

Difficult memories can lead to PWPs feeling nervous when trauma is mentioned in future assessments:

> 'If they pull it out quite early, then I guess I'm a little bit more tense as to what are they gonna talk about next.' [P2]

Or struggling to empathise with other patients who are experiencing less intense issues:

> 'It's more Step 2 straightforward cases, I might struggle with the empathy more because I've given it for the other more difficult ones and those just become a bit more routine.' [P1]

Desensitisation

Participants described becoming desensitised to discussion of traumatic events following multiple assessments of such:

> 'I think as the role [progresses] you do get desensitised; you get used to hearing quite unpleasant things. Quite quickly.' [P1]

Some view such detachment as positive, conceptualising it as evidence of resilience:

> 'To an extent it's good, it's almost like if you're ::: if you were to take a lot of that with you to the next call, it might impact how you go through with the next call. So, in that sense it can be quite helpful.' [P11]

Others found themselves numbed in their personal lives:

> 'I guess it comes back to the desensitisation thing ::: when I'm like watching a film or something or hear on a telly program that people have been through these traumatic events, I almost feel like I'm not as shocked by it.' [P5]

Personal distress compounds professional stress

Some participants' personal and professional difficulties impacted one another. Such impacts could directly complicate assessment of traumatic experiences. Assessments added to personal strife:

> 'If you have difficult times in your personal life, it ::: just adds to any personal stress.'

[P8] Personal issues made assessments more difficult:

> 'There are other times where maybe you come to work, and you haven't had a particularly good day or there's other things going on in your life ::: and then you get hit with this ::: hearing these traumatic things.' [P5]

Various participants reported imagining themselves in similar situations and becoming distressed at such a prospect:

> 'The thought oh God, what if this happened to me or someone I cared about, that will cross your mind, that thought.' [P6]

Many felt that they took assessments of traumatic events home with them more than they would other assessments:

> 'It's probably on those days that I'd ::: think more about work maybe when I went home.' [P11]

Ultimately, assessing service users that reported traumatic events changed the way that some PWPs engaged with the world:

> 'I barely read the news because I always say that I hear enough depressing stuff during my workday ::: kind of taking on some of that.' [P1]

Assessing traumatic events is pressurising

Multi-faceted, relentless pressure was described by participants throughout the dataset. Time limits complicated assessments for PWPs:

> 'When it comes to assessing trauma, given everything else we also have to explore, that can become quite tight timing wise. And often the appointments will need to overrun if you're going to gather sufficient information.' [P1]

Such constraints sometimes prevented PWPs from self-care following difficult assessments:

> 'I take a step away, get a cup of tea or give myself a breather before having to jump on the next call. But you know, it's trauma that sometimes can be coupled with complexity or risk. Sometimes that wasn't an option and you had to immediately be responding to it.' [P1]

Calls involving risk to service users further can add further pressure to PWPs during assessments featuring traumatic events:

> 'I would say we're probably trained not to panic, but ::: I need to, sort of, follow as many steps as I can remember in that sort of chaotic moment ::: You feel that pressure to ::: remain calm.' [P8]

These constraints were suggested to affect PWPs performances of their roles:

> 'It can sometimes feel ::: a bit muddled as well because you ::: weigh up, in the short amount of time that you've got, you know, what do I concentrate on?' [P8]

Participants contextualised relentless pressure within NHS-TT's focus on meeting service-wide targets:

> 'You don't have that space to destress ::: It's just, having these targets you have to meet per day.' [P9]

In-service support is invaluable

The camaraderie, guidance and comfort of colleagues was regularly depicted as central to PWPs' experience of assessing traumatic events.

'You've got people you can turn to'

Informal peer support during and after assessments of traumatic events was consistently described. Fellow PWPs provide mutual understanding to one another:

> 'Sometimes just getting that off your chest that really helps and having that sort of supportive person who knows what it's like because they probably experienced the same.' [P11]

Training in cohorts creates a sense of solidarity:

> ‘I think just the natural fact that you train in cohorts ::: you’ve got people you can turn to, other people are going through the same experience of “I don’t know what I’m doing” at the same time.’ [P1]

The invaluable nature of peer support in crisis situations was also described:

> ‘When my colleague had a sort of active, you know, someone ::: tried to end their life ::: I could go and find a Duty worker in the building to come over and support with that.’ [P8]

‘Feeling that you’re not supported is not a good place to begin’

Such experiences contrast with some PWPs’ experiences of isolation, whether working from home or on-site. Participants described distance from colleagues as a barrier to accessing impromptu emotional support:

> ‘I’ve always got the option to like work from home ::: but I’ve always thought that it’s better for me to be here and be around people.’ [P3]

In an expanding service, some PWPs described being physically isolated while on-site, and the additional stressors this can present:

> ‘If you’re working where there aren’t many people in the office or you’re at home, that can sometimes be more difficult because you’ve gotta rely on ::: finding teams yourself.’ [P8]

Some PWPs described assessments as beginning with a sense of isolation in the face of uncertainty; a sense that such assessments were struggles they faced alone. Such feelings can make assessments emotionally difficult from the offset:

> ‘When we answer the phone, we don’t know what someone’s experience is gonna be. Starting that with uncertainty and feeling that you’re not supported is not a good place to begin.’ [P2]

A sense that more space could be cultivated in-service to support PWPs feeling isolated was felt:

> ‘Give more of a space for people to be able to talk about that ::: It’s encouraging people to speak up if they’re struggling. I guess you never know who you’re gonna speak to, what problem are they going to present with? It’s just encouraging people to ask if they need support.’ [P3]

Supervisors shape PWPs’ emotional experiences

The quality of support provided by supervisors was also recognised as a pivotal variable by participants:

> ‘I think supervisors are an incredibly important part of your experience. And if you have one that isn’t quite working so well, then that has a huge impact on the day-to-day work ::: But I think if it’s all working then that support is there.’ [P1]

Equally, substandard supervisory experiences compounded the emotional challenges of assessing traumatic events. These included focusing on case management without fully acknowledging PWPs’ emotional needs:

> ‘[My] supervisor was like ::: must have been difficult for you ::: And then on to the next one.

Yeah, it was quite quick. I might not have spoke about as much as I would have liked.'

[P3] Or having their own stress compounded by supervisors' stress:

'Like you can tell when someone's really stressed ::: particularly if that person is a supervisor ::: they're there to support the people that are lower down and if they're not there and present, how am I being supported?' [P2]

Similarly, the wider Talking Therapies system was regarded as a pivotal emotional support in the context of assessing traumatic event. Informal support from Duty was appreciated:

'If a case has been difficult, if you wanted to talk through with someone from Duty, there is that option ::: they're often able to recognise that this was not an easy call for you to go through.' [P1]

Instances in which senior staff members were perceived as emotionally invalidating compounded PWPs' emotional duress:

'They've approached all of the people in senior management ::: they feel like they've been fobbed off and told to suck it up and get on with it.' [P2]

However, a sense of support throughout the system was also reported:

'I feel like you can speak to anyone you know however senior they are.' [P8]

Discussion

This study aimed to explore PWPs' experiences of conducting assessments involving discussions of traumatic events within an NHS-TT service, and to develop an understanding that may contribute to service and PWP training improvements. The study was designed collaboratively with the participating NHS-TT service's research team. Following this study, recommendations regarding service adaptation were made to the service (see Supplementary material).

Factors important to improving service

Participants highlighted difficulties in identifying appropriate problem descriptors for many patients that reported experiencing traumatic events, inconsistencies in how such descriptors were identified, and the challenging nature of recognising a problem that they themselves were not qualified to treat. These represent novel findings within NHS-TT research. Awareness of the specific processes complicating assignment of appropriate problem descriptors is particularly pertinent given findings that identification of problem descriptors in NHS-TT achieves better clinical outcomes (Clark, 2018; Saunders et al., 2020).

Participants identified knowledge gaps regarding trauma, PTSD and the distinction thereof, and noted that their experiences of learning experientially created a sense of unpreparedness in assessing trauma-related problems. Such findings substantiate Murray (2017)'s recognition of NHS-TT therapists' minimal training in working with trauma-related problems and NHS-TT's efforts to disseminate training programmes specifically designed to develop staff understanding of trauma problems.

Participants described how assessing trauma-related problems could produce long-standing emotional impacts, exacerbated confluences between personal and professional distress and occasionally result in emotional detachment. These descriptions are consistent with a growing body of research depicting NHS-TT staff's experience of burnout, compassion fatigue and

secondary traumatic stress (Owen et al., 2021) and, in turn, the overall experience of working in psychological professions (McCormack et al., 2018).

While research consistently illustrates the PWP role as pressurised, this study provided novel findings regarding the pressures experienced whilst assessing trauma. Supplementary processes such as safeguarding, implementing disorder-specific questionnaires and gathering information with appropriate sensitivity were described as burdensome for PWPs. Additionally, feelings of isolation amidst such pressures that PWPs can experience working remotely are worthy of further research.

Participants highlighted the importance of peer relationships, supervisors and on-call duty clinicians as support structures when assessing traumatic events. Such findings corroborate those of Harper et al. (2020). However, insight into the specific benefits of peer support following PWP assessment of traumatic events are novel, as are those identifying duty supervision as valuable support.

Dissemination of results

Findings were shared with the NHS-TT service's clinical leadership team. A joint meeting was held with the service to discuss key findings and recommendations and an executive summary of the study's findings was produced and shared with staff. It has been planned that this study's findings would be disseminated with the wider staff team before provision of training based on this study's recommendations.

Limitations

Given that this study relied on PWPs using their limited spare time to participate, it is possible that a sampling bias led to more polarised feedback in the data. Furthermore, only staff views were represented in discussing assessments featuring traumatic events; service user perspectives on such assessments were beyond the scope of this study but would doubtlessly contribute valuable insight to inform service recommendations.

Key practice points

(1) Psychological Wellbeing Practitioners (PWPs) can find it more difficult to identify the main clinical problem in assessments that include discussion of traumatic events.
(2) PWP training courses should consider providing further training on discussing and assessing traumatic events and identifying PTSD. NHS-TT services could consider offering additional training on these topics.
(3) Assessments featuring traumatic events can have long-standing emotional repercussions for PWPs. Supervisor training on such assessments could help supervisors' provision of restorative emotional support to PWPs.
(4) Assessments featuring traumatic events often involve supplementary tasks that add substantial pressure to PWP workloads.
(5) Peers, supervisors, duty supervisors and the clinical leadership team shape PWPs' emotional experience.

Further reading

This project offered thorough exploration of PWPs' experiences of assessing traumatic events and generated recommendations towards the improvement of clinical knowledge, emotional wellbeing, and NHS-TT service design. Murray (2017) offers evidence that training PWPs to recognise PTSD can improve their felt sense of knowledge and competency in conducting such assessments. Findings from Verbist et al. (2021) indicated that trauma-specific screening tools, trauma-related case formulation and trauma-informed supervision could facilitate more precise distinction of PTSD from trauma. Owen et al. (2022) depicted the stress PWPs experience in exploring the unknown, and how their perceived responsibility within their frontline role can act as a significant stressor.

Supplementary material. The supplementary material for this article can be found at https://doi.org/10.1017/ S1754470X25000170

Data availability statement. The data that support the findings of this study are available in the Supplementary material.

Acknowledgements. Thank you to the Oxford Institute of Clinical Psychology Training and Research for their facilitation of this research. Gratitude must also be expressed to each participant.

Author contributions. John Kerr: Conceptualization (lead), Formal analysis (lead), Investigation (lead), Methodology (lead), Project administration (lead), Writing - original draft (lead); Hjordis Lorenz: Conceptualization (supporting), Formal analysis (supporting),

Methodology (supporting), Supervision (lead), Writing - original draft (supporting), Writing - review & editing (supporting); Samantha Sadler: Conceptualization (supporting), Data curation (supporting), Investigation (supporting), Methodology (supporting), Project administration (supporting), Resources (supporting), Software
(supporting), Supervision (supporting), Writing - review & editing (supporting); Victoria Roberts: Conceptualization (supporting), Methodology (supporting), Supervision (supporting); Craig Steel: Supervision (supporting), Writing - review & editing (supporting); Graham Thew: Conceptualization (supporting), Formal analysis (supporting), Methodology (supporting), Supervision (supporting), Writing - review & editing (supporting).

Financial support. This project is supported by the National Institute for Health and Care Research (NIHR) Oxford Health Biomedical Research Centre. The views expressed are those of the authors and not necessarily those of the NIHR or the Department of Health and Social Care.

Competing interests. Graham Thew is as Associate Editor for the Cognitive Behaviour Therapist. He was not involved in the review or editorial process for this paper, on which he is listed as an author. The remaining authors have no competing interests related to this publication.

Ethical standards. Authors abided by the Ethical Principles of Psychologists and Code of Conduct as set out by the BPS and BABCP. Ethical approval was not required for this research, according to the NHS Health Research Authority Tool (Health Research Authority, 2025). The project was approved by an NHS Clinical Audit department, and ethical oversight throughout the project was managed through the service's AMaT (Audit Management and Tracking) system. Participants provided informed consent to participate and for results to be published.

References

American Psychatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders: DSM-5 (5th edn). Arlington, VA.

Baker, C., & Kirk-Wade, E. (2021). Mental health statistics: prevalence, services and funding in England. The House of Commons Library.

Boterhoven de Haan, K. L., Lee, C. W., Correia, H., Menninga, S., Fassbinder, E., Köehne, S., & Arntz, A. (2021). Patient and therapist perspectives on treatment for adults with PTSD from childhood trauma. Journal of Clinical Medicine, 10, 954. Braun, V., & Clarke, V. (2021). Thematic Analysis: A Practical Guide. Sage.

Chan, S. W., & Adams, M. (2014). Service use, drop-out rate and clinical outcomes: a comparison between high and low intensity treatments in an IAPT service. Behavioural and Cognitive Psychotherapy, 42, 747–759.

Clark, D. M. (2018). Realizing the mass public benefit of evidence-based psychological therapies: the IAPT program. Annual Review of Clinical Psychology, 14, 159–183. https://doi.org/10.1146/annurev-clinpsy-050817-084833

Clemons, B. (2020). Systematic Literature Review: Burnout, Compassion Fatigue, Vicarious Trauma, and Secondary Trauma Amongst MSW Student Interns and Entry Level Professionals. California State University, Northridge. https://books.google. co.uk/books?id = b8STzgEACAAJ

Cowlishaw, S., Metcalf, O., Stone, C., O'Donnell, M., Lotzin, A., Forbes, D., Hegarty, K., & Kessler, D. (2021). Posttraumatic stress disorder in primary care: a study of general practices in England. Journal of Clinical Psychology in Medical Settings, 28, 427–435. https://doi.org/10.1007/s10880-020-09732-6

Ehlers, A., Gene-Cos, N., & Perrin, S. (2009). Low recognition of posttraumatic stress disorder in primary care. London Journal of Primary Care, 2, 36–42.

Ehlers, A., & Wild, J. (2022). Cognitive therapy for PTSD: updating memories and meanings of trauma. In U. Schnyder & M. Cloitre (eds), Evidence Based Treatments for Trauma-Related Psychological Disorders: A Practical Guide for Clinicians (pp. 181–210). Springer International Publishing. https://doi.org/10.1007/978-3-030-97802-0_9

Ehrenreich, J. H. (2003). Understanding PTSD: forgetting 'trauma'. Analyses of Social Issues and Public Policy, 3, 15–28.

Finch, J., Ford, C., Lombardo, C., & Meiser-Stedman, R. (2020). A survey of evidence-based practice, training, supervision and clinician confidence relating to post-traumatic stress disorder (PTSD) therapies in UK child and adolescent mental health professionals. European Journal of Psychotraumatology, 11, 1815281.

Frissa, S., Hatch, S. L., Fear, N. T., Dorrington, S., Goodwin, L., & Hotopf, M. (2016). Challenges in the retrospective assessment of trauma: comparing a checklist approach to a single item trauma experience screening question. BMC Psychiatry, 16, 1–9.

Hall, R. C. W., & Hall, R. C. W. (2007). Detection of malingered PTSD: an overview of clinical, psychometric, and physiological assessment: where do we stand? Journal of Forensic Sciences, 52, 717–725. https://doi.org/10.1111/j.15564029.2007.00434.x

Hardy, G. E., Bishop-Edwards, L., Chambers, E., Connell, J., Dent-Brown, K., Kothari, G., O'hara, R., & Parry, G. D. (2019). Risk factors for negative experiences during psychotherapy. Psychotherapy Research, 29, 403–414. https://doi.org/ 10.1080/10503307.2017.1393575

Harper, K., Bhutani, G., Rao, A. S., & Clarke, J. (2020). Wellbeing matters in IAPT practitioners: identity vs system. International Journal of Stress Prevention and Wellbeing, 4, 1–12.

Health Research Authority (2025). Is My Study Research? National Health Service. https://www.hra-decisiontools.org.uk/ research/

Hepgul, N., King, S., Amarasinghe, M., Breen, G., Grant, N., Grey, N., Hotopf, M., Moran, P., Pariante, C. M., Tylee, A., Wingrove, J., Young, A. H., & Cleare, A. J. (2016). Clinical characteristics of patients assessed within an Improving Access to Psychological Therapies (IAPT) service: results from a naturalistic cohort study (Predicting Outcome Following Psychological Therapy; PROMPT). BMC Psychiatry, 16, 52. https://doi.org/10.1186/s12888-016-0736-6

Laliotis, D., & Shapiro, F. (2022). EMDR therapy for trauma-related disorders. In U. Schnyder & M. Cloitre (eds), Evidence Based Treatments for Trauma-Related Psychological Disorders: A Practical Guide for Clinicians (pp. 227–254). Springer International Publishing. https://doi.org/10.1007/978-3-030-97802-0_11

McCormack, H. M., MacIntyre, T. E., O'Shea, D., Herring, M. P., & Campbell, M. J. (2018). The prevalence and cause (s) of burnout among applied psychologists: a systematic review. Frontiers in Psychology, 9, 376988.

Murray, H. (2017). Evaluation of a trauma-focused CBT training programme for IAPT services. Behavioural and Cognitive Psychotherapy, 45, 467–482.

Nakash, O., & Alegría, M. (2013). Examination of the role of implicit clinical judgments during the mental health intake. Quality Health Research, 23, 645–654. https://doi.org/10.1177/1049732312471732

NHS Talking Therapies (2024). NHS Talking Therapies for Anxiety and Depression Manual. https://www.england.nhs.uk/wpcontent/uploads/2018/06/NHS-talking-therapies-manual-v7-1.pdf

Owen, J., Cross, S., Mergia, V., & Fisher, P. (2022). Stress, resilience and coping in psychological wellbeing practitioner trainees: a mixed-methods study. the Cognitive Behaviour Therapist, 15, e38. https://doi.org/10.1017/S1754470X22000356

Owen, J., Crouch-Read, L., Smith, M., & Fisher, P. (2021). Stress and burnout in Improving Access to Psychological Therapies (IAPT) trainees: a systematic review. the Cognitive Behaviour Therapist, 14, e20.

Richards, D. A., Bower, P., Pagel, C., Weaver, A., Utley, M., Cape, J., Pilling, S., Lovell, K., Gilbody, S., & Leibowitz, J. (2012). Delivering stepped care: an analysis of implementation in routine practice. Implementation Science, 7, 1–11.

Roscoe, J., Taylor, J., Harrington, R., & Wilbraham, S. (2022). CBT supervision behind closed doors: supervisor and supervisee reflections on their expectations and use of clinical supervision. Counselling and Psychotherapy Research, 22, 1056–1067.

Rosen, G. M., & Lilienfeld, S. O. (2008). Posttraumatic stress disorder: an empirical evaluation of core assumptions. Clinical Psychology Review, 28, 837–868. https://doi.org/10.1016/j.cpr.2007.12.002

Sandford, D. M. (2023). Understanding the factors associated with mental health practitioners' engagement in effective suicide prevention activities within an Improving Access to Psychological Therapies (IAPT) service. University of Glasgow.

Saunders, R., Cape, J., Leibowitz, J., Aguirre, E., Jena, R., Cirkovic, M., Wheatley, J., Main, N., Pilling, S., & Buckman, J. E. (2020). Improvement in IAPT outcomes over time: are they driven by changes in clinical practice? the Cognitive Behaviour Therapist, 13, e16.

Schnyder, U., & Cloitre, M. (2022). Introduction. In U. Schnyder & M. Cloitre (eds), Evidence Based Treatments for Trauma-Related Psychological Disorders: A Practical Guide for Clinicians (pp. 1–9). Springer International Publishing. https://doi.org/10.1007/978-3-030-97802-0_1

Scott, M. J. (2018). Improving Access to Psychological Therapies (IAPT) – the need for radical reform. Journal of Health Psychology, 23, 1136–1147.

Skelton, M., Carr, E., Buckman, J. E., Davies, M. R., Goldsmith, K. A., Hirsch, C. R., Peel, A. J., Rayner, C., Rimes, K. A., & Saunders, R. (2023). Trajectories of depression and anxiety symptom severity during psychological therapy for common mental health problems. Psychological Medicine, 53, 6183–6193.

Spoont, M. R., Williams, J. W., Kehle-Forbes, S., Nieuwsma, J. A., Mann-Wrobel, M. C., & Gross, R. (2015). Does this patient have posttraumatic stress disorder?: rational clinical examination systematic review. JAMA, 314, 501–510.

Sweeney, A., Clement, S., Gribble, K., Jackson, E., Carr, S., Catty, J., & Gillard, S. (2019). A systematic review of qualitative studies of adults' experiences of being assessed for psychological therapies. Health Expectations, 22, 133–148. https://doi.org/10.1111/hex.12844

Thomlinson, R., Muncer, S., & Dent, H. (2017). Comorbidity between PTSD and anxiety and depression: implications for IAPT services. Archives of Depression and Anxiety, 3, 14–17.

Tully, J., Bhugra, D., Lewis, S. J., Drennan, G., & Markham, S. (2021). Is PTSD overdiagnosed? BMJ, 373.

Turner, J., Brown, J. C., & Carpenter, D. T. (2018). Telephone-based CBT and the therapeutic relationship: the views and experiences of IAPT practitioners in a low-intensity service. Journal of Psychiatric and Mental Health Nursing, 25, 285–296. https://doi.org/10.1111/jpm.12440

Verbist, I. L., Allsopp, K., Huey, D., & Varese, F. (2021). Frequency and impact of childhood sexual and physical abuse on people using IAPT services. British Journal of Clinical Psychology, 60, 504–512.

Voss Horrell, S. C., Holohan, D. R., Didion, L. M., & Vance, G. T. (2011). Treating traumatized OEF/OIF veterans: how does trauma treatment affect the clinician? Professional Psychology: Research and Practice, 42, 79.

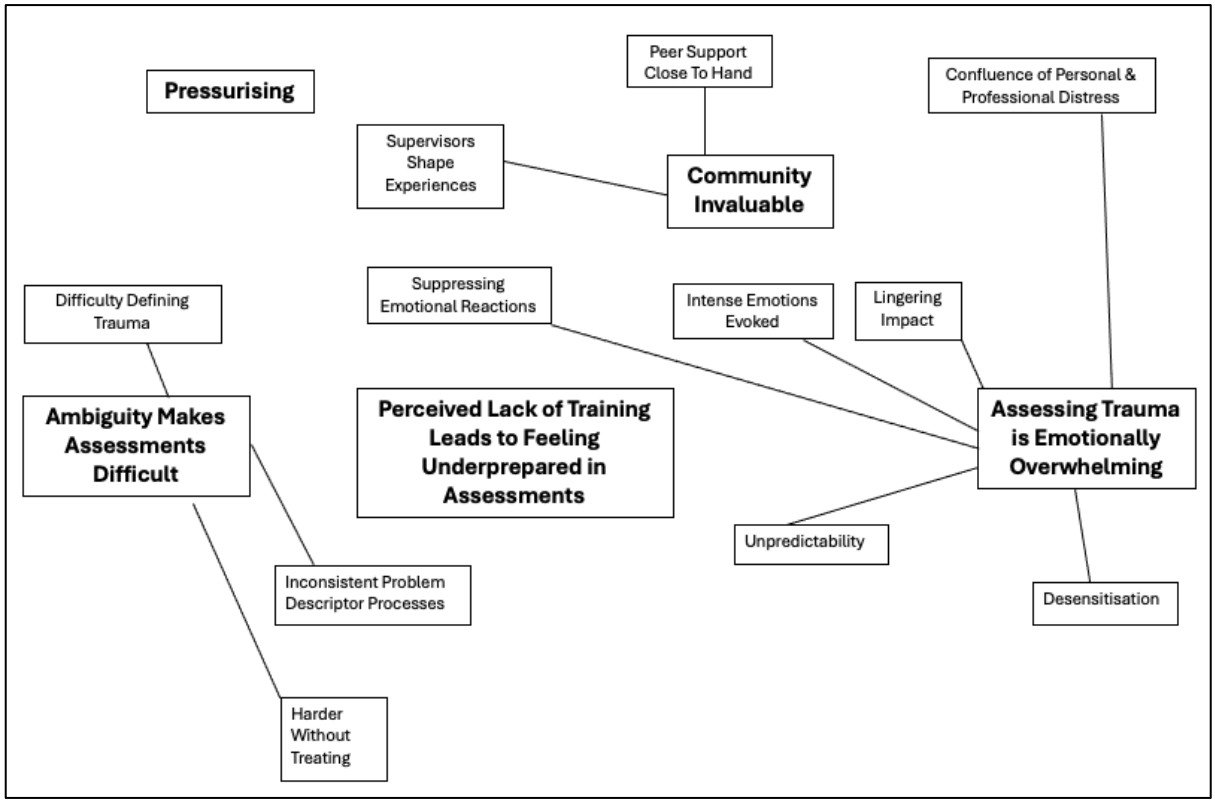
Cite this article: Kerr J, Lorenz H, Sadler S, Roberts V, Steel C, and Thew GR (2025). 'You never know who you're gonna speak to': exploring Psychological Wellbeing Practitioners' experiences of assessing traumatic events. The Cognitive Behaviour Therapist 1–16. https://doi.org/10.1017/S1754470X25000170

Appendix 2.6: SIP Lay Summary

Title: ***You never know who you're gonna speak to": Exploring Psychological Wellbeing Practitioners' Experiences of Assessing Traumatic Events.***

Research Team: John Kerr (Trainee), Professor Craig Steel (Internal Supervisor), Dr Hjördis Lorenz, Dr Graham Thew (External Supervisors), Dr Samantha Sadler (Consultant).

Themes:



Themes that emerged from thus study included ambiguity in trauma assessments creating difficulties, perceived lack of training leading to PWPs feeling underprepared in such assessments, the emotionally overwhelming aspect of conducting assessments featuring traumatic events, the importance of colleagues in supporting one another, and the pressure experienced when assessing patients who reported having experienced trauma.

Rationale:

Nationally, NHS Talking Therapies service-users frequently report experience of traumatic life events. Clinicians face several challenges in assessing reports of traumatic events upon

service users' initial referral/presentation, including relevant information, patients' lack of awareness regarding relevant symptoms, or conflation of experiencing trauma with having PTSD. Assessment of traumatic events can impact service user outcomes. Yet, factors affecting PWP assessment within NHSTT specifically remains unclear in research literature, despite recognition of the service's assessment limitations.

Method:

11 PWPs were interviewed for up to an hour. Participants were given information & consent forms, were anonymised, and answered questions from a semi-structured interview schedule. Reflexive thematic analysis was used to establish themes and subthemes within the dataset. Data was password-protected, stored on Oxford Health One-Drive and restricted to the study's research team.

Recommendations:

1. *Staff training to support PWPs with:*
    - 1.1. Trauma, PTSD and distinguishing these phenomena clinically.
    - 1.2. How trauma problems, particularly PTSD, are treated.
    - 1.3. Decision-making in emotionally intense situations
    - 1.4. Grounding patients following discussion of traumatic events.
    - 1.5. Eliciting diagnostically relevant information sensitively
2. *Service policy guidance regarding:*
    - 2.1. A clear & uniform process about how trauma-related problem descriptors are decided.
3. *Supplement assessment of traumatic events by:*
    - 3.1. Screening referrals for experience of traumatic events prior to assessment calls.
    - 3.2. Providing PWPs with a pro forma document outlining necessary questions and considerations (e.g. risk, signposting)
4. *Support PWP's emotional processes through:*
    - 4.1. Stipulating that line managers should consistently encourage PWPs to use available in-service reflective practice spaces.
    - 4.2. Visually advertising in-service reflective practice spaces on-site
    - 4.3. Highlighting PWPs' appropriate processes of escalation following unsatisfactory interactions with management figures
    - 4.4. Formally providing debriefs for PWPs following assessments featuring discussion of traumatic events.

Governance:

As this study was part of a service evaluation, ethical approval was not needed through IRAS. The project was approved by Oxford University's Institute of Clinical Psychology Training and Research, and was managed through Oxford Health's AMAT service.

Appendix 3.1: Author Guidelines

Submission process

Once the submission materials have been prepared in accordance with the author guidelines, new submissions should be made via the Research Exchange submission portal: https://wiley.atyponrex.com/journal/CAMH. Please be advised that if your paper is submitted via the ReX portal and unsubmitted for corrections to be made, or you otherwise wish to manage your paper, you may do so through the same link. If your paper was submitted using the previous portal (prior to September 23, 2024), please access your paper via the following link: ScholarOne Manuscripts (manuscriptcentral.com).

You may check the status of your submission at any time by logging on to submission.wiley.com and clicking the "My Submissions" button. **For technical help with the submission system**, please review our FAQs or contact submissionhelp@wiley.com.

For editorial enquiries, please contact the *Child and Adolescent Mental Health* Editorial Office at publications@acamh.org.

Why submit to *Child and Adolescent Mental Health*?

- An international journal with a growing reputation for publishing work of clinical relevance to multidisciplinary practitioners in child and adolescent mental health
- Ranked in ISI: 67/129 (Paediatrics); 121/156 (Psychiatry); 100/143 (Psychiatry (Social Science)); 89/131 (Psychology, Clinical).
- 7,319 institutions with access to current content, and a further 6,696 institutions in the developing world
- High international readership - accessed by institutions globally, including North America (34%), Europe (34%) and Asia-Pacific (11%)
- Excellent service provided by editorial and production offices
- Opportunities to communicate your research directly to practitioners
- Every manuscript is assigned to one of the Joint Editors as decision-making editor; rejection rate is around 82%
- Acceptance to Early View publication averages 5 weeks
- Simple and efficient online submission
- Early View – articles appear online before the paper version is published. Click here to see the articles currently available
- Authors receive access to their article once published as well as a 25% discount on virtually all Wiley books
- All articles published in CAMH are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF)

1. Contributions from any discipline that further clinical knowledge of the mental life and behaviour of children are welcomed. Papers need to clearly draw out the clinical implications for mental health practitioners. Papers are published in English. As an international journal, submissions are welcomed from any country. Contributions should be of a standard that merits presentation before an international readership. Papers may assume any of the following forms: Original Articles; Review Articles; Innovations in Practice; Narrative Matters; Debate Articles.

CAMH considers the fact that services are looking at treating young adults up until the age of 25, with the evidence that brains continue to develop until the age of 25, as well as the fact that a lot of issues that affect young adults and students are also relevant and topical to older adolescents. CAMH offers a discretionary approach and will take into consideration papers that extend into young adulthood, if they are pertinent developmentally to the younger population and contribute further to a developmental perspective across adolescence and early adult years.

Authors are asked to remember that CAMH is an international journal and therefore clarification should be provided for any references that are made in submitted papers to the practice within the authors' own country. This is to ensure that the meaning is clearly understandable for our diverse readership. Authors should make their papers as broadly applicable as possible for a global audience.

Original Articles: Original Articles make an original contribution to empirical knowledge, to the theoretical understanding of the subject, or to the development of clinical research and practice.

Review Articles: These papers offer a critical perspective on a key body of current research relevant to child and adolescent mental health. The journal requires the pre-registration of review protocols on any publicly accessible platform (e.g. The International Prospective Register of Systematic Reviews, or PROSPERO).

Short Research Articles: Short Research Articles should consist of original research of any design that presents succinct findings with topical, clinical or policy relevance. For example, preliminary novel findings from pilot studies, important extensions of a previous study, and topical surveys.

Letters to the Editor: These are short articles that offer readers the opportunity to respond to articles published in CAMH. Letters must only discuss issues directly relevant to the content of the original article such as to add context, correction, offer a different interpretation, or extend the findings.

Innovations in Practice: These papers report on any new and innovative development that could have a major impact on evidence-based practice, intervention and service models.

Narrative Matters: These papers describe important topics and issues relevant to those working in child and adolescent mental health but considered from within the context and framework of the Humanities and Social Sciences.

Debate Articles: These papers express opposing points of view or opinions, highlighting current evidence-based issues, or discuss differences in clinical practice.

Technology Matters: These papers provide updates on emerging mental health technologies and how they are being used with and by children and young people.

2. Submission of a paper to *Child and Adolescent Mental Health* will be held to imply that it represents an original submission, not previously published; that it is not being considered for publication elsewhere; and that if accepted for publication it will not be published elsewhere without the consent of the Editors.

3. Manuscripts should be submitted online. Check for an existing account if you have submitted via Research Exchange before, or have forgotten your details. If you are new to Research Exchange, please create a new account.

4. Authors' professional and ethical responsibilities

Disclosure of interest form
All authors will be asked to download and sign a full Disclosure of Interests form and acknowledge this and sources of funding in the manuscript.

Ethics
Authors are reminded that the *Journal* adheres to the ethics of scientific publication as detailed in the *Ethical principles of psychologists and code of conduct* (American Psychological Association, 2010). These principles also imply that the piecemeal, or fragmented publication of small amounts of data from the same study is not acceptable. The Journal also generally conforms to the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors (ICJME) and is also a member and subscribes to the principles of the Committee on Publication Ethics (COPE).

Informed consent and ethics approval
Authors must ensure that all research meets these ethical guidelines and affirm that the research has received permission from a stated Research Ethics Committee (REC) or Institutional Review Board (IRB), including adherence to the legal requirements of the study county. Within the Methods section, authors should indicate that 'informed consent' has been appropriately obtained and state the name of the REC, IRB or other body that provided ethical approval. When submitting a manuscript, the manuscript page number where these statements appear should be given.

Preprints
CAMH will consider for review articles previously available as preprints. Authors may also post the submitted version of a manuscript to a preprint server at any time. Authors are requested to update any pre-publication versions with a link to the final published article. Please find the Wiley preprint policy here.

Note to NIH Grantees
Pursuant to NIH mandate, Wiley-Blackwell will post the accepted version of contributions authored by NIH grant-holders to PubMed Central upon acceptance. This accepted version will be made publicly available 12 months after publication. For further information, see www.wiley.com/go/nihmandate.

Recommended guidelines and standards
The Journal requires authors to conform to CONSORT 2010 (see CONSORT Statement) in relation to the reporting of randomised controlled clinical trials; also recommended is the Extensions of the CONSORT Statement with regard to cluster randomised controlled trials). In particular, authors must include in their paper a flow chart illustrating the progress of subjects through the trial (CONSORT diagram) and the CONSORT checklist. The flow diagram should appear in the main paper, the checklist in the online Appendix. Trial registry name, registration identification number, and the URL for the registry should also be included at the end of the methods section of the Abstract and again in the Methods section of

the main text, and in the online manuscript submission. Trials must be registered in one of the ICJME-recognised trial registries:

Australian New Zealand Clinical Trials Registry
Clinical Trials
Netherlands Trial Register
ISRCTN Registry
UMIN Clinical Trials Registry

Manuscripts reporting systematic reviews or meta-analyses will only be considered if they conform to the PRISMA Statement. We ask authors to include within their review article a flow diagram that illustrates the selection and elimination process for the articles included in their review or meta-analysis, as well as a completed PRISMA Checklist. The journal requires the pre-registration of review protocols on any publicly accessible platform (e.g. The International Prospective Register of Systematic Reviews, or PROSPERO).

The Equator Network is recommended as a resource on the above and other reporting guidelines for which the editors will expect studies of all methodologies to follow. Of particular note are the guidelines on qualitative work http://www.equator-network.org/reporting-guidelines/evolving-guidelines-for-publication-of-qualitative-research-studies-in-psychology-and-related-fields and on quasi-experimental http://www.equator-network.org/reporting-guidelines/the-quality-of-mixed-methods-studies-in-health-services-research and mixed method designs http://www.equator-network-or/reporting-guidelines/guidelines-for-conducting-and-reporting-mixed-research-in-the-field-of-counseling-and-beyond.

CrossCheck
An initiative started by *CrossRef* to help its members actively engage in efforts to prevent scholarly and professional plagiarism. The journal to which you are submitting your manuscript employs a plagiarism detection system. By submitting your manuscripts to this journal you accept that your manuscript may be screened for plagiarism against previously published works.

5. Manuscripts should be double spaced and conform to the house style of *CAMH*. The title page of the manuscript should include the title, name(s) and address(es) of author(s), an abbreviated title (running head) of up to 80 characters, a correspondence address for the paper, and any ethical information relevant to the study (name of the authority, data and reference number for approval) or a statement explaining why their study did not require ethical approval.

Summary: Authors should include a structured Abstract not exceeding 250 words under the sub-headings: Background; Method; Results; Conclusions.

Key Practitioner Message: Below the Abstract, please provide 1-2 bullet points answering each of the following questions:

- **What is known?** - What is the relevant background knowledge base to your study? This may also include areas of uncertainty or ignorance.
- **What is new?** - What does your study tell us that we didn't already know or is novel regarding its design?

- **What is significant for clinical practice?** - Based on your findings, what should practitioners do differently or, if your study is of a preliminary nature, why should more research be devoted to this particular study?

Keywords: Please provide 4-6 keywords use MeSH Browser for suggestions

6. Papers submitted should be concise and written in English in a readily understandable style, avoiding sexist and racist language. Articles should adhere to journal guidelines and include a word count of their paper; occasionally, longer article may be accepted after negotiation with the Editors.

7. Authors who do not have English as a first language may choose to have their manuscript professionally edited prior to submission; a list of independent suppliers of editing services can be found at http://authorservices.wiley.com/bauthor/english_language.asp. All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

8. Headings: Original articles should be set out in the conventional format: Methods, Results, Discussion and Conclusion. Descriptions of techniques and methods should only be given in detail when they are unfamiliar. There should be no more than three (clearly marked) levels of subheadings used in the text.

9. All manuscripts should have an Acknowledgement section at the end of the main text, before the References. This should include statements on the following:

Study funding: Please provide information on any external or grant funding of the work (or for any of the authors); where there is no external funding, please state this explicitly.

Contributorships: Please state any elements of authorship for which particular authors are responsible, where contributorships differ between author group. (All authors must share responsibility for the final version of the work submitted and published; if the study include original data, at least one author must confirm that they had full access to all the data in the study and take responsibility for the integrity of the data in the study and the accuracy of the data analysis). Contributions from others outside the author group should also be acknowledged (e.g. study assistance or statistical advice) and collaborators and study participants may also be thanked).

Conflicts of interest: The journal requires that all authors disclose any potential sources of conflict of interest. Any interest or relationship, financial or otherwise that might be perceived as influencing an author's objectivity is considered a potential source of conflict of interest. These must be disclosed when directly relevant or directly related to the work that the authors describe in their manuscript. Potential sources of conflict of interest include, but are not limited to: patent or stock ownership, membership of a company board of directors, membership of an advisory board or committee for a company, and consultancy for or receipt of speaker's fees from a company, in the past 5 years. The existence of a conflict of interest does not preclude publication. If the authors have no conflict of interest to declare, they must also state this at submission. It is the responsibility of the corresponding author to review this policy with all authors and collectively to disclose with the submission ALL pertinent commercial and other relationships.

10. For referencing, *CAMH* follows a slightly adapted version of APA Style http:www.apastyle.org/. References in running text should be quoted showing author(s) and date. For up to three authors, all surnames should be given on first citation; for subsequent citations or where there are more than three authors, 'et al.' should be used. A full reference list should be given at the end of the article, in alphabetical order.

References to journal articles should include the authors' surnames and initials, the year of publication, the full title of the paper, the full name of the journal, the volume number, and inclusive page numbers. Titles of journals must not be abbreviated. References to chapters in books should include authors' surnames and initials, year of publication, full chapter title, editors' initials and surnames, full book title, page numbers, place of publication and publisher.

11. Tables: These should be kept to a minimum and not duplicate what is in the text; they should be clearly set out and numbered and should appear at the end of the main text, with their intended position clearly indicated in the manuscript.

12. Figures: Any figures, charts or diagrams should be originated in a drawing package and saved within the Word file or as an EPS or TIFF file.
See http://authorservices.wiley.com/bauthor/illustration.asp for further guidelines on preparing and submitting artwork. Titles or captions should be clear and easy to read. These should appear at the end of the main text.

13. Footnotes should be avoided, but end notes may be used on a limited basis.

Data Sharing and Supporting Information

CAMH encourages authors to share the data and other artefacts supporting the results in the paper by archiving them by uploading it upon submission or in an appropriate public repository. Examples of possible supporting material include intervention manuals, statistical analysis syntax, and experimental materials and qualitative transcripts.

1. If uploading with your manuscript please call the file 'supporting information' and reference it in the manuscript.
2. Please note supporting files are uploaded with the final published manuscript as supplied, they are not typeset.
3. On publication your supporting information will be available alongside the final version of the manuscript online.
4. If uploading to a public repository please provide a link to supporting material and reference it in the manuscript. The materials must be original and not previously published. If previously published, please provide the necessary permissions. You may also display your supporting information on your own or institutional website. Such posting is not subject to the journal's embargo date as specified in the copyright agreement. Supporting information is made free to access on publication.

Full guidance on Supporting Information including file types, size and format is available on the Wiley Author Service website.

For information on Sharing and Citing your Research Data see the Author Services website here.

Original Articles

Original Articles make an original contribution to empirical knowledge, to the theoretical understanding of the subject, or to the development of clinical research and practice. Adult data is not usually accepted for publication unless it bears directly on developmental issues in childhood and adolescence.

Your Original Article should be no more than 5,000 words including tables, figures and related captions, excluding only references. Please note that for our own calculation of word counts, we include all text in the submitted paper, excluding only the references. Please note that for our own calculation of word counts, we include all text in the submitted paper, excluding only the references.

Review Articles

Research Articles offer our readers a critical perspective on a key body of current research relevant to child and adolescent mental health and maintain high standards of scientific practice by conforming to systematic guidelines as set out in the PRISMA statement. These articles should aim to inform readers of any important or controversial issues/findings, as well as the relevant conceptual and theoretical models, and provide them with sufficient information to evaluate the principal arguments involved. All review articles should also make clear the relevancy of the research covered, and any findings, for clinical practice.

Research Articles offer our readers a critical perspective on a key body of current research relevant to child and adolescent mental health and maintain high standards of scientific practice by conforming to systematic guidelines as set out in the PRISMA statement. These articles should aim to inform readers of any important or controversial issues/findings, as well as the relevant conceptual and theoretical models, and provide them with sufficient information to evaluate the principal arguments involved. All review articles should also make clear the relevancy of the research covered, and any findings, for clinical practice.

Your Review Article should be no more than 6,000 words excluding tables, figures and references and no more than 8,000 including tables, figures and references. For Systematic Reviews, your paper should be no more than 6,000 words excluding tables, figures and references. Qualitative papers should instead be no more than 8000 words, including quotes and figures, but excluding references.

Short Research Articles

Short Research Articles should consist of original research of any design that presents succinct findings with topical, clinical or policy relevance. For example, preliminary novel findings from pilot studies, important extensions of a previous study, and topical surveys. Short Research Articles will be peer reviewed and authors might be asked to revise and edit their article to acceptable standards for publication. Short Research Articles should follow standard guidelines, such as STROBE for observational studies, CONSORT extension for pilot trials etc.

Your Short Research Article should be 1500 words, excluding references, tables and graphs/figures. Your article should be structured, including the subheadings

Introduction/Methods/Results/Discussion. There is a maximum of 1 table and 1 graph/figure. Please do not include more than 12 references.

Narrative Matters: The Medical Humanities in CAMH

These articles are both submissions and directly commissioned papers. They will be peer-reviewed. The articles should be on a humanities topic relevant to those working in child and adolescent mental health. The topics can include but are not restricted to: aspects of child mental health service history; representations of abnormal mental states or mental illness in children and teenagers in film, literature or drama; depictions of child mental health clinicians within popular culture; ethical dilemmas in the speciality. Interest and originality are valued. If in doubt, please contact the section editor: Gordonbates@virginmedia.com.

The essays should be between 1500 and 2000 words and written for an audience of child mental health professionals. For publishing reasons, there is an upper limit of 8 references for the article. Additional references may be given in the text if necessary.

Letters to the Editor

Letters to the Editor are short articles that offer readers the opportunity to respond to articles published in CAMH. Letters must only discuss issues directly relevant to the content of the original article such as to add context, correction, offer a different interpretation, or extend the findings. Letters will be evaluated for relevance to the index paper, scientific merit, and importance.

Letters should be submitted not later than 2 weeks after publication of the print issue of the Journal containing the paper of interest. Please note - all papers are published on Early View as soon as they are accepted. The letters should avoid personal attacks and unscholarly communication.

Letters will not be peer reviewed. However, the section Editor will review the letters and might consult another Editor before acceptance or rejection.

Due to the short length of this article type, your Letter should be between 500 and 700 words with a maximum of one figure or table. If in doubt, please contact the section editor at c.ani@imperial.ac.uk.

Innovations in Practice

Innovations in Practice promote knowledge of new and interesting developments that have an impact on evidence-based practice, intervention and service models. These might have arisen through the application of careful, systematic planning, a response to a particular need, through the continuing evolution of an existing practice or service, or because of changes in circumstances and/or technologies. Submissions should set out the aims and details of the innovation including any relevant mental health, service, social and cultural contextual factors, and give a close, critical analysis of the innovation and its potential significance for the practice of child and adolescent mental health.

Due to the short length of this article type, your Innovations in Practice article should be no

more than 2,200 words including tables, figures and references and contain no more than 8 references.

Debate Articles

Our debate articles express opposing points of view or opinions, highlighting current evidence-based issues, or discuss differences in clinical practice. Although discussion of evidence is welcome, these articles generally do not include primary data. The evidence on which your arguments are based and how that was sourced should be explicit and referenced, and the quality of your evidence made clear.

Due to the short length of this article type, your Debate article should be no more than 1,000 words and contain no more than 10 references. If in doubt, please contact the section editor Rachel.Elvins@mft.nhs.uk.

Technology Matters

Technology Matters provides updates on emerging mental health technologies and how they are being used with and by children and young people. We aim to cover established technologies such as computer-assisted psychological interventions as well as more novel technologies (e.g. mobile apps, therapeutic games, virtual reality). We will present the evidence base for their use, showcase how they can complement other interventions and are being used in practice and address wider cross-cutting issues (such as technology accreditation, regulation, cost etc.) relevant to practitioners and service funders.

Your paper should be between 1000 and 1500 words. Please do not include more than 7 references. If in doubt, please contact the section editors Kapil.Sayal@nottingham.ac.uk or Jennifer.Martin@nottingham.ac.uk.

Manuscript Processing

Peer Review Process: All material submitted to CAMH is only accepted for publication after being subjected to external scholarly peer review, following initial evaluation by one of the Editors. Both original and review-type articles will usually be single-blind reviewed by a minimum of two external referees and only accepted by the decision Editor after satisfactory revision. Any appeal of an editorial decision will first be considered by the initial decision Editor, in consultation with other Editors. Editorials and commissioned editorial opinion articles will usually be subject to internal review only, but this will be clarified in the published Acknowledgement section. Editorial practices and decision making will conform to COPE http://publicationethics.org/resources/guidelines and ICMJE http://icmje.org/ best practice.

Proofs
Authors will receive an e-mail notification with a link and instructions for accessing HTML page proofs online. Page proofs should be carefully proofread for any copyediting or typesetting errors. Online guidelines are provided within the system. No special software is required, all common browsers are supported. Authors should also make sure that any renumbered tables, figures, or references match text citations and that figure legends correspond with text citations and actual figures. Proofs must be returned within 48 hours of

receipt of the email. Return of proofs via e-mail is possible in the event that the online system cannot be used or accessed.

Offprints: Free access to the final PDF offprint of your article will be available via Wiley's Author Services only. Please therefore sign up for Author Services if you would like to access your article PDF offprint and enjoy the many other benefits the service offers. Should you wish to purchase additional copies of your article, please visit http://offprint.cosprinters.com/cos/bw/ and follow the instructions provided. If you have queries about offprints please email:offprint@cosprinters.com.

Copyright: If your paper is accepted, the author identified as the corresponding author for the paper will receive an email prompting them to log into Author Services where, via the Wiley Author Licensing Service (WALS), they will be able to complete a license agreement on behalf of all co-authors of the paper.

Correction to Authorship

In accordance with Wiley's Best Practice Guidelines on Research Integrity and Publishing Ethics and the Committee on Publication Ethics' guidance, *CAMH* will allow authors to correct authorship on a submitted, accepted, or published article if a valid reason exists to do so. All authors – including those to be added or removed – must agree to any proposed change. To request a change to the author list, please complete the Request for Changes to a Journal Article Author List Form and contact either the journal's editorial or production office, depending on the status of the article. Authorship changes will not be considered without a fully completed Author Change form. Correcting the authorship is different from changing an author's name; the relevant policy for that can be found in Wiley's Best Practice Guidelines under "Author name changes after publication."

Wiley's Author Name Change Policy

In cases where authors wish to change their name following publication, Wiley will update and republish the paper and redeliver the updated metadata to indexing services. Our editorial and production teams will use discretion in recognizing that name changes may be of a sensitive and private nature for various reasons including (but not limited to) alignment with gender identity, or as a result of marriage, divorce, or religious conversion. Accordingly, to protect the author's privacy, we will not publish a correction notice to the paper, and we will not notify co-authors of the change. Authors should contact the journal's Editorial Office with their name change request.

Article Preparation Support

Wiley Editing Services offers expert help with English Language Editing, as well as translation, manuscript formatting, figure illustration, figure formatting, and graphical abstract design – so you can submit your manuscript with confidence. Also, check out our resources for Preparing Your Article for general guidance about writing and preparing your manuscript.

Article Promotion Support

Wiley Editing Services offers professional video, design, and writing services to create shareable video abstracts, infographics, conference posters, lay summaries, and research news stories for your research – so you can help your research get the attention it deserves.

For authors who do not choose open access

If the open access option is not selected, the corresponding author will be presented with the Copyright transfer Agreement (CTA) to sign. The terms and conditions of the CTA can be previewed in the Copyright FAQs here.

For authors choosing open access

If the open access option is selected, the corresponding author will have a choice of the following Creative Commons License Open Access Agreements (OAA):

Creative Commons Attribution License OAA

Creative Commons Attribution Non-Commercial License OAA

Creative Commons Attribution Non-Commercial-NoDerivs License OAA

To preview the terms and conditions of these Open Access Agreements please visit the Copyright FAQs here and click here for more information.

If you select the open access option and your research is funded by certain Funders [e.g. The Wellcome Trust and members of the Research Councils UK (RCUK) or the Austrian Science Fund (FWF)] you will be given the opportunity to publish your article under a CC-BY license supporting you in complying with your Funders requirements.

For more information on this policy and the journal's compliant self-archiving policy please click here.

Liability

Whilst every effort is made by the publishers and editorial board to see that no inaccurate or misleading data, opinion or statement appears in this journal, they wish to make it clear that the data and opinions appearing in the articles and advertisements herein are the sole responsibility of the contributor or advertiser concerned. Accordingly, the publishers, the editorial board and editors, and their respective employees, officers and agents accept no responsibility or liability whatsoever for the consequences of any such inaccurate or misleading data, opinion or statement.

Appendix 3.2: CUREC Approval Letter

MEDICAL SCIENCES INTERDIVISIONAL RESEARCH ETHICS COMMITTEE
Research Services, Boundary Brook House, Churchill Drive, Headington, Oxford, OX3 7GB
Tel: +44(0)1865 616575
ethics@medsci.ox.ac.uk

CONFIDENTIAL

Dr Louise Johns & John Kerr
Oxford Institute for Clinical Psychology Training & Research (OxICPTR)
Isis Education Centre
Warneford Hospital
Oxford

12 March 2024

Dear Dr Johns and John,

Research Ethics Approval - CUREC 1

Ethics Approval Reference: R91444/RE001

Study title: Examining the effectiveness of a single-session school-based outreach intervention to increase help-seeking intentions for anxiety problems in adolescence

Short title: Help-seeking for anxiety in school students

The above application has been considered on behalf of the Medical Sciences Interdivisional Research Ethics Committee (MS IDREC) in accordance with the University's procedures for ethical approval of all research involving human participants.

I am pleased to inform you that, on the basis of the information provided to the IDREC, the proposed research has been judged as meeting appropriate ethical standards, and approval has been granted from **12th March 2024** until **11th September 2025.**

Insurance-provided indemnity arrangements are in place for the duration of the approval stated above. It is your responsibility to ensure that you request an extension to the end date for indemnity to remain in place should you continue the research beyond the dates covered.

Amendments
Should there be any subsequent changes to the study, you should submit details to the MS IDREC for consideration and approval. Details of changes must be listed on an amendment form.

Yours Sincerely
DocuSigned by:
Leah Butts
Mrs Leah Butts
Research Ethics Administrator

for
Dr Helen Barnby-Porritt
Research Ethics Manager

Appendix 3.3: Child Assent Form

ASSENT FORM FOR CHILDREN UNDER 16

Examining the effectiveness of a single-session school-based outreach intervention to increase help-seeking intentions for anxiety problems in adolescence.

Child/Young Person (or if unable, parent/researcher/teacher on their behalf) to circle all they agree with:

- Has somebody else 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, that's OK! No one will be cross with you.

Appendix 3.4: Anxiety Literacy Questionnaire

Anxiety Literacy Questionnaire

Each correct response receives one point.

- Worrying a lot of the time can be a sign of anxiety problems. (**True**/False/Don't Know)
- Anxiety can affect people physically, mentally, or both (**True/**False/Don't Know)
- Anxiety problems are very rare in young people (True/**False**/Don't Know)
- People with anxiety problems always look worried (True/**False/**Don't Know)
- Everybody with an anxiety problem feels scared all the time (True/**False/**Don't Know)
- Anxiety feels physically similar to anger (**True/**False/Don't Know)
- Getting worried about things means I have an anxiety problem (True/**False**/Don't Know)
- Having a symptom of anxiety (dry mouth, overthinking) means I definitely have an anxiety problem (True/**False/**Don't Know)
- All symptoms of anxiety need treatment from a mental health professional (True/**False**/Don't Know)
- Being easily tired may be a symptom of anxiety problems. (**True**/False/Don't Know)
- Being annoyed lots of the time may be a symptom of anxiety problems. (**True**/False/Don't Know)
- People with anxiety problems often hear voices that are not there. (True/**False**/Don't Know)
- People always know whether they have anxiety problems or not (True/**False**/Don't Know)
- People's problems are always best dealt with by themselves (True/**False**/Don't Know)
- Having an anxiety problem would mean that you're crazy (True/**False**/Don't Know)
- Serious anxiety problems can't be fixed (True/**False**/Don't Know)
- Anxiety problems disappear quickly if you don't think about your worries (True/**False/**Don't Know)
- A dry mouth can be a symptom of anxiety problems. (**True**/False/Don't Know)
- Mental health professionals would tell my parents/guardians everything I tell them about my anxiety problems (True/**False**/Don't

Know)

- Most people, even people who seem confident, worry about things from time to time (**True/**False/Don't Know)
- Anxiety is always easy to see in other people (True/**False/**Don't Know)
- Getting help for anxiety is never worth the stress (True/**False/**Don't Know)
- Even simple things can help reduce anxious feelings a lot (**True/**False/Don't Know)
- There are lots of ways to find help if I had a serious anxiety problem (**True/**False/Don't Know)

Appendix 3.5: General Help Seeking Questionnaire

General Help Seeking Questionnaire

If you were having a problem with anxiety, how likely is it that you would seek help from the following people?

Please indicate your response by putting a line through the number that best describes your intention to seek help from each help source that is listed.

1= Extremely Unlikely 3 = Unlikely 5 = Likely 7 = Extremely Likely

a. Romantic Partner	1	2	3	4	5	6	7
b. Friend (not related to you)	1	2	3	4	5	6	7
c. Parent	1	2	3	4	5	6	7
d. Another relative/family member	1	2	3	4	5	6	7
e. Mental health professional (e.g. psychologist, social worker, counsellor)	1	2	3	4	5	6	7
f. Phone helpline (e.g. Childline)	1	2	3	4	5	6	7
g. Doctor/GP	1	2	3	4	5	6	7
h. Religious Leader (e.g. Priest, Rabbi, Chaplain)	1	2	3	4	5	6	7
i. I would not seek help from anyone	1	2	3	4	5	6	7
j. I would seek help from another not listed above (please list in the space provided – if no, leave blank). _____	1	2	3	4	5	6	7

Appendix 3.6: Stress Appraisal Measure for Adolescents

Please indicate your response by putting a circle around the number that best describes how you generally think and feel when encountering stressful events.

0 = Not at all 4 = a great amount

I have the ability to overcome anxiety problems.	0	1	2	3	4
I perceive anxiety problems as threatening.	0	1	2	3	4
There is someone I can turn to for help with anxiety problems.	0	1	2	3	4
I can positively address things that make me anxious.	0	1	2	3	4
I have what it takes to overcome anxiety.	0	1	2	3	4
I feel anxious	0	1	2	3	4
Events that make me worried will impact me greatly.	0	1	2	3	4
There is help available to me for anxiety issues if I need it	0	1	2	3	4
Events that worry me will end badly.	0	1	2	3	4
Anxiety-provoking events have serious implications for my life.	0	1	2	3	4
I have the resources available to me to overcome ~~stress~~ anxiety.	0	1	2	3	4
I have the skills necessary to overcome ~~stress~~ anxiety.	0	1	2	3	4
Anxiety has a negative impact on me.	0	1	2	3	4
There are long-term consequences as the result of ~~stress~~ anxiety.	0	1	2	3	4

Appendix 3.7: Mental Help Seeking Attitudes Scale

INSTRUCTIONS: For the purposes of this survey, “mental health professionals” include psychologists, psychiatrists, clinical social workers, and counsellors. Think of “anxiety concerns” as any issue that may cause distressing levels of anxiety or cause anxiety that interferes with your life.

Please tick the boxes that best represent your opinion. For example, if you feel that your seeking help would be extremely useless, you will mark the box closest to "useless." If you are undecided, you would mark the "0" box. If you feel that your seeking help would be slightly useful, you will mark the "1" box that is closer to "useful."

If I had anxiety concerns, seeking help from a mental health professional would be...

	3	2	1	0	1	2	3	
Useless								Useful
Important								Unimportant
Unhealthy								Healthy
Ineffective								Effective
Good								Bad
Healing								Hurting
Disempowering								Empowering
Satisfying								Unsatisfying
Desirable								Undesirable

Appendix 3.8: Generalised Anxiety Stigma Scale

Generalised Anxiety Stigma Scale (GASS)
Now, we would like you to please read through the following description.
Most days over the last six months, Nicole has felt very anxious and worried about a lot of different things in her life. She finds it difficult to control how worried she gets. Most days Nicole feels 'on edge' and has difficulty concentrating. She is irritable and her muscles feel tense. Although she feels tired all of the time, she has difficulty sleeping. These feelings are so bad that Nicole has trouble doing 'normal' things. Nicole is really upset about the way she has been feeling lately. Nicole has an anxiety disorder.

The following statements are about anxiety disorders. Please indicate how strongly you personally agree or disagree with each statement.

1. An anxiety disorder is not a real medical illness.
   - □ Strongly agree.
   - □ Agree
   - □ Neither agree nor disagree.
   - □ Disagree
   - □ Strongly disagree.

2. An anxiety disorder is a sign of personal weakness.
   - □ Strongly agree.
   - □ Agree
   - □ Neither agree nor disagree.
   - □ Disagree
   - □ Strongly disagree.

3. People with an anxiety disorder could snap out of it if they wanted to.
   - □ Strongly agree.
   - □ Agree
   - □ Neither agree nor disagree.
   - □ Disagree
   - □ Strongly disagree.

4. People with an anxiety disorder should be ashamed of themselves.
   - □ Strongly agree.
   - □ Agree
   - □ Neither agree nor disagree.
   - □ Disagree
   - □ Strongly disagree.

5. People with an anxiety disorder do not make suitable employees.
   - □ Strongly agree.
   - □ Agree
   - □ Neither agree nor disagree.
   - □ Disagree
   - □ Strongly disagree.

6. People with an anxiety disorder are unstable.

□ Strongly agree.
□ Agree
□ Neither agree nor disagree.
□ Disagree
□ Strongly disagree.

7. People with an anxiety disorder are to blame for their problem.
□ Strongly agree.
□ Agree
□ Neither agree nor disagree.
□ Disagree
□ Strongly disagree.

8. People with an anxiety disorder are just lazy.
□ Strongly agree.
□ Agree
□ Neither agree nor disagree.
□ Disagree
□ Strongly disagree.

9. People with an anxiety disorder are a danger to others.
□ Strongly agree.
□ Agree
□ Neither agree nor disagree.
□ Disagree
□ Strongly disagree.

10. People with an anxiety disorder are self-centered.
□ Strongly agree.
□ Agree
□ Neither agree nor disagree.
□ Disagree
□ Strongly disagree.

Now we would like you to tell us what you think most other people believe. Please indicate how strongly you agree or disagree with the following statements.

11. Most people think that an anxiety disorder is not a real medical illness.
□ Strongly agree.
□ Agree
□ Neither agree nor disagree.
□ Disagree
□ Strongly disagree.

12. Most people think that an anxiety disorder is a sign of personal weakness.
□ Strongly agree.
□ Agree
□ Neither agree nor disagree.
□ Disagree
□ Strongly disagree.

13. Most people think that people with an anxiety disorder could snap out of it if they wanted to.

 Strongly agree.
 Agree
 Neither agree nor disagree.
 Disagree
 Strongly disagree.

14. Most people think that people with an anxiety disorder should be ashamed of themselves.
 Strongly agree.
 Agree
 Neither agree nor disagree.
 Disagree
 Strongly disagree.

15. Most people think that people with an anxiety disorder do not make suitable employees.
 Strongly agree.
 Agree
 Neither agree nor disagree.
 Disagree
 Strongly disagree.

16. Most people think that people with an anxiety disorder are unstable.
 Strongly agree.
 Agree
 Neither agree nor disagree.
 Disagree
 Strongly disagree.

17. Most people think that people with an anxiety disorder are to blame for their problem.
 Strongly agree.
 Agree
 Neither agree nor disagree.
 Disagree
 Strongly disagree.

18. Most people think that people with an anxiety disorder are just lazy.
 Strongly agree.
 Agree
 Neither agree nor disagree.
 Disagree
 Strongly disagree.

19. Most people think that people with an anxiety disorder are a danger to others.
 Strongly agree.
 Agree
 Neither agree nor disagree.
 Disagree
 Strongly disagree.

20. Most people think that people with an anxiety disorder are self-centered.
 Strongly agree.
 Agree
 Neither agree nor disagree.
 Disagree
 Strongly disagree.

Appendix 3.9: Visual Analog Scale

Feedback

Please circle the numbers that best represent how you feel in response to each question.

How helpful was this workshop?

0 1 2 3 4 5 6 7 8 9 10

How understandable was this workshop?

0 1 2 3 4 5 6 7 8 9 10

How relevant was this workshop to Year 8?

0 1 2 3 4 5 6 7 8 9 10

Would you recommend this workshop to someone else?

0 1 2 3 4 5 6 7 8 9 10

Appendix 3.10: Descriptive Statistics

	Whole Sample		Intervention		Control	
	M(SD)	% missing	M(SD)	%missing	M(SD)	%missing
Pre-ALQ						
Worrying a lot of the time can be a sign of anxiety problems	.78(.42)	1.1	.89(.4)	0	.8(.4)	0
Anxiety can affect people physically, mentally, or both	.85(36)	1.1	.88(33)	0	.87(.34)	0
Anxiety problems are very rare in young people	.68(.47)	1.1	.71(.45)	0	.69(.47)	0
People with anxiety problems always look worried	.74(.44)	1.1	.75(.43)	0	.76(.43)	0
Everybody with an anxiety problem feels scared all the time	.64(48)	1.1	.72(.45)	0	.58(.5)	0
Anxiety feels physically similar to anger	.2(.4)	1.1	.2(.4)	0	.22(.41)	0
Getting worried about things means I have an anxiety problem	.62(.49)	1.1	.66(.47)	0	.61(.49)	0
Having a symptom of anxiety (dry mouth, overthinking) means I definitely have an anxiety problem	.56(.5)	1.1	.61(.49)	0	.54(.5)	0
All symptoms of anxiety need treatment from a mental health professional	.45(.5)	1.1	.5(.5)	0	.42(.5)	0
Being easily tired may be a	.31(.46)	1.1	.32(.47)	0	.32(.47)	0

symptom of anxiety problems.						
Being annoyed lots of the time may be a symptom of anxiety problems.	.36(.48)	1.1	.38(.49)	0	.35(.48)	0
People with anxiety problems often hear voices that are not there.	.11(.31)	1.1	.1(.3)	0	.12(.32)	0
People always know whether they have anxiety problems or not	.65(.48)	1.1	.7(.46)	0	.63(.48)	0
People's problems are always best dealt with by themselves	.7(.46)	1.1	.74(.44)	0	.69(.47)	0
Having an anxiety problem would mean that you're crazy	.78(42)	1.1	.82(.38)	0	.77(.42)	0
Serious anxiety problems can't be fixed	.56(.5)	1.1	.6(.49)	0	.53(.5)	0
Anxiety problems disappear quickly if you don't think about your worries	.5(.5)	1.1	.56(.5)	0	.48(.5)	0
A dry mouth can be a symptom of anxiety problems.	.29(45)	1.1	.33(.47)	0	.25(.44)	0
Mental health professionals would tell my parents/guardians everything I tell them about my anxiety problems	.39(49)	1.1	.43(.5)	0	.35(.48)	0
Most people, even people who seem confident, worry about things from time to time	.77(.42)	1.1	.85(.36)	0	.73(.44)	0
Anxiety is always easy to see in other people	.66(47)	1.1	.76(.43)	0	.58(.5)	0

Getting help for anxiety is never worth the stress	.5(.5)	1.1	.53(.5)	0	.5(.5)	0
Even simple things can help reduce anxious feelings a lot	.65(.48)	1.1	.7(.46)	0	.64(.48)	0
There are lots of ways to find help if I had a serious anxiety problem	.69(46)	1.1	.73(.45)	0	.7(.46)	0
Pre-GHSQ						
Romantic Partner	3.6(1.87)	13.6	3.52(1.87)	11.8	3.69(1.88)	8.7
Friend	4.38(1.8)	9.2	4.37(1.8)	7.4	4.39(1.81)	3.9
Parent	4.95(2.06)	10.6	5(.19)	9.6	4.88(2.2)	4.7
Another relative/family member	4.07(1.8)	9.5	4.15(1.83)	7.4	3.98(1.77)	4.7
Mental Health Professional	4.2(2.09)	10.3	4.31(2.05)	8.1	4.1(2.14)	5.5
Phone Helpline	2.87(1.88)	10.3	3.05(1.92)	7.4	2.67(1.83)	6.3
Doctor/GP	3.43(1.84)	10.3	2.66(1.98)	7.4	3.29(1.84)	6.3
Religious Leader	2.82(2.04)	10.6	3.56(1.83)	9.6	2.99(2.09)	4.7
I would not seek help from anyone	4.27(2.22)	11.4	4.14(2.25)	8.8	4.41(1.18)	7.1
Post-ALQ						
Worrying a lot of the time can be a sign of anxiety problems	.84(.36)	15.4	.87(.34)	16.2	.83(.48)	11.8
Anxiety can affect people physically, mentally, or both	.9(30)	16.1	.96(.21)	16.2	.84(.37)	13.4
Anxiety problems are very rare in young people	.79(.41)	16.1	.85(.36)	17.6	.75(.43)	14.2
People with anxiety problems always look worried	.78(.42)	16.1	.81(.39)	17.6	.76(.43)	14.2
Everybody with an anxiety		16.1	.75(.43)	17.6	.66(.48)	14.2

problem feels scared all the time	.7(.46)					
Anxiety feels physically similar to anger	.48(.5)	16.1	.71(.45)	17.6	.24(.48)	16.5
Getting worried about things means I have an anxiety problem	.62(.49)	17.2	.69(.47)	17.6	.58(.5)	16.5
Having a symptom of anxiety (dry mouth, overthinking) means I definitely have an anxiety problem	.59(.5)	17.2	.68(.47)	18.4	.5(.5)	16.5
All symptoms of anxiety need treatment from a mental health professional	.55(.5)	17.6	.61(.49)	18.4	.49(5)	16.5
Being easily tired may be a symptom of anxiety problems.	.51(.5)	17.6	.57(.5)	18.4	.47(.5)	16.5
Being annoyed lots of the time may be a symptom of anxiety problems.	.54(.5)	17.6	.64(.48)	18.4	.14(.35)	16.5
People with anxiety problems often hear voices that are not there.	.19(.4)	17.6	.24(.43)	18.4	.68(.47)	17.3
People always know whether they have anxiety problems or not	.76(.43)	18.3	.86(.35)	18.4	.73(.45)	18.1
People's problems are always best dealt with by themselves	.7(.46)	18.7	.78(.41)	19.1	.79(.41)	18.1
Having an anxiety problem would mean that you're crazy	.82(.38)	18.7	.88(.32)	19.9	.63(.49)	18.1

Serious anxiety problems can't be fixed	.67(.47)	18.7	.74(.44)	20.6	.55(.5)	18.1
Anxiety problems disappear quickly if you don't think about your worries	.6(.49)	19	.66(.48)	20.6	.37(.48)	18.1
A dry mouth can be a symptom of anxiety problems.	.57(.5)	19.4	.79(.41)	20.6	.79(.41)	18.1
Mental health professionals would tell my parents/guardians everything I tell them about my anxiety problems	.52(.5)	19.8	.69(.46)	20.6	.37(.48)	18.1
Most people, even people who seem confident, worry about things from time to time	.81(.39)	19.8	.86(.35)	20.6	.79(.41)	18.1
Anxiety is always easy to see in other people	.72(.45)	19.8	.8(.4)	20.6	.65(.48)	18.1
Getting help for anxiety is never worth the stress	.63(.48)	19.8	.72(.45)	20.6	.58(.5)	18.1
Even simple things can help reduce anxious feelings a lot	.74(.44)	19.8	.77(.42)	20.6	.74(.44)	18.1
There are lots of ways to find help if I had a serious anxiety problem	.76(.43)	19.8	.8(.4)	20.6	.74(.44)	18.1
Post-GHSQ						
Romantic Partner	3.5(2.04)	22.3	3.46(2.03)	24.3	3.64(.2)	19.7
Friend	4.57(1.84)	19	4.6(1.75)	22.1	4.62(1.84)	15
Parent	4.82(2.10)	20.9	4.9(2)	23.5	4.72(2.1)	15.7
Another relative/family member	3.94(2.03)	20.9	3.9(2)	22.8	3.88(2.04)	16.5
Mental Health Professional	4.2(2.09)	21.2	4.64(1.9)	22.8	3.7(1.98)	17.3

Phone Helpline	2.99(1.97)	20.9	3.42(2.08)	22.8	2.45(1.68)	16.5
Doctor/GP	3.64(1.99)	21.6	3.88(2.02)	23.5	3.37(1.93)	17.3
Religious Leader	2.84(2.19)	21.2	2.78(2.15)	23.5	2.87(2.22)	16.5
I would not seek help from anyone	4.74(2.16)	21.2	4.5(2.21)	22.8	4.9(2.11)	16.5
	Whole Sample		Intervention		Control	
	M(SD)	% missing	M(SD)	%missing	M(SD)	%missing
FU-ALQ						
Worrying a lot of the time can be a sign of anxiety problems	.79(.41)	51.3	.78(.42)	60.3	.79(.41)	39.4
Anxiety can affect people physically, mentally, or both	.9(.3)	51.3	.9(3)	60.3	.88(.32)	39.4
Anxiety problems are very rare in young people	.74(.44)	51.6	.75(.43)	61	.72(.49)	39.4
People with anxiety problems always look worried	.80(.4)	51.3	.78(.42)	60.3	.82(.39)	39.4
Everybody with an anxiety problem feels scared all the time	.68(.47)	51.3	.72(.45)	60.3	.65(.48)	39.4
Anxiety feels physically similar to anger	.34(.49)	51.3	.37(49)	60.3	.3(.49)	39.4
Getting worried about things means I have an anxiety problem	.69(.46)	51.3	.72(.45)	60.3	.66(.48)	39.4
Having a symptom of anxiety (dry mouth, overthinking) means I definitely have an anxiety problem	.56(.5)	51.3	.56(.5)	60.3	.57(.5)	39.4
All symptoms of anxiety need	.52(.5)	51.3	.57(.5)	60.3	.47(.5)	39.4

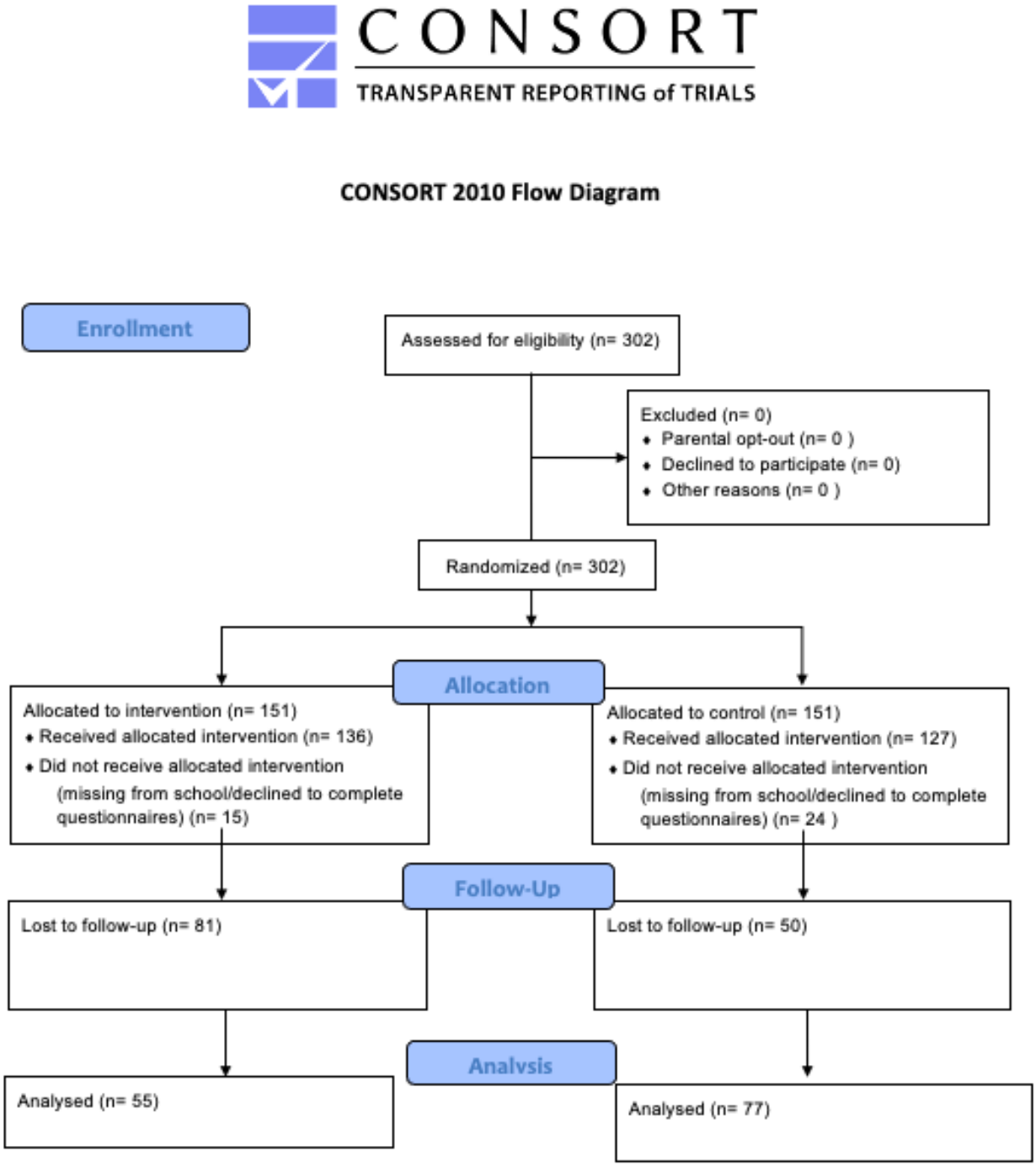
treatment from a mental health professional						
Being easily tired may be a symptom of anxiety problems.	.41(.5)	51.3	.33(.48)	60.3	.45(.5)	39.4
Being annoyed lots of the time may be a symptom of anxiety problems.	.40(.49)	51.3	.39(.49)	60.3	.4(.49)	39.4
People with anxiety problems often hear voices that are not there.	.11(.32)	51.3	.17(.38)	60.3	.08(.27)	39.4
People always know whether they have anxiety problems or not	.75(.44)	52	.79(.41)	61	.71(.46)	39.4
People's problems are always best dealt with by themselves	.7(.46)	52	.68(.47)	61	.71(.46)	40.2
Having an anxiety problem would mean that you're crazy	.82(.39)	52	.83(.38)	61	.8(.4)	40.2
Serious anxiety problems can't be fixed	.63(.49)	53.1	.63(.49)	61.8	.6(.49)	40.2
Anxiety problems disappear quickly if you don't think about your worries	.58(.5)	52	.57(.5)	61	.58(.5)	41.7
A dry mouth can be a symptom of anxiety problems.	.48(.5)	52.4	.53(.5)	61	44(.5)	40.2
Mental health professionals would tell my parents/guardians everything I tell them about my anxiety problems	.5(.5)	52	.66(.48)	61	.37(.49)	40.9
Most people, even people who seem confident, worry	.78(.42)	52.7	.79(.41)	61	.76(.43)	41.7

about things from time to time						
Anxiety is always easy to see in other people	.73(.45)	52.7	.74(.44)	61	.71(.45)	41.7
Getting help for anxiety is never worth the stress	.53(.5)	52.7	.57(.5)	61	.51(.5)	41.7
Even simple things can help reduce anxious feelings a lot	.71(.46)	53.1	.64(.48)	61	.75(.43)	42.5
There are lots of ways to find help if I had a serious anxiety problem	.74(.44)	52.7	.74(.45)	61	.73(.48)	41.7
FU-GHSQ						
Romantic Partner	3.83(1.65)	55.3	3.75(1.66)	61.8	3.87(1.67)	46.5
Friend	4.33(1.55)	53.8	4.34(1.56)	61	4.28(1.57)	44.1
Parent	4.55(.2.04)	54.2	4.7& (1.94)	61.8	4.39(2.09)	44.1
Another relative/family member	3.53(1.8)	53.8	3.51(1.85)	61	3.52(1.8)	44.1
Mental Health Professional	4.38(1.92)	54.6	4.81(1.97)	61.8	4.09(1.85)	44.9
Phone Helpline	2.9(1.79)	54.6	3.27(1.9)	62.8	2.61(1.66)	44.9
Doctor/GP	3.38(1.82)	54.2	3.51(1.97)	61	3.27(1.7)	44.9
Religious Leader	2.65(1.96)	54.6	2.7(1.89)	61	2.59(2.05)	45.7
I would not seek help from anyone	4.17(2)	54.9	4.17(2)	61	4.18(2)	46.5

Appendix 3.11: Measure Baseline Characteristics

	Whole Sample		Intervention		Control			
Measure	M	SD	M	SD	M	SD	t(p-value)	d
ALQ	13.44	6	14.43	5.78	13.12	5.58	1.865(.032)	5.68
GHSQ	34.64	9.99	34.78	9.84	34.5	10.2	.217(.414)	10.01
MHSA	4.72	1.04	4.78	1.12	4.66	.84	.802(.212)	1.04
SAMA	2.06	.53	2.11	.5	2.01	.57	1.366(.09)	.53
GASS	50.1	11.73	49.52	.12.63	50.61	10.77	-.67(.51)	11.75
Acceptability								

Appendix 3.12: Participant Flow Diagram



Appendix 3.13: Predictive odds of completing each study questionnaire.

	Pre Exp (B)(significance)	Post Exp (B)(significance)	Follow-Up Exp (B)(significance)
ALQ			
Condition	1.38(.6)	1.13(.73)	2.3(.001)
Sex	11.49(.02)	5.7(<.001)	1.07(.78)
Ethnic Group	.82 (.75)	.41(.34)	.99(.25)
GHSQ			
Condition	1.15(.8)	1.29(.44)	2 (.007)
Sex	2.83(.08)	3.43(<.001)	1.34(.25)
Ethnic Group	2.45(.54)	.68 (.67)	1.13(.63)
SAMA			
Condition	.92(.84)	1.13(.69)	1.76(.027)
Sex	2.84(.017)	2.91(<.001)	1.25(.39)
Ethnic Group	1.3 (.53)	.86 (.64)	1.16 (.57)
MHSA			
Condition	.67(.2)	1.26(.42)	1.46(.14)
Sex	3.79(<.001)	3.85(<.001)	1.5(.11)
Ethnic Group	1.22(.54)	.93 (.8)	1.19(.51)
GASS			
Condition	1.11(.75)	1.20 (.52)	1.68(.044)
Sex	2.62(.003)	2 (.016)	1.28 (.34)
Ethnic Group	1.01(.8)	.72 (.26)	1(.99)

Appendix 3.14: Subgroup Analyses

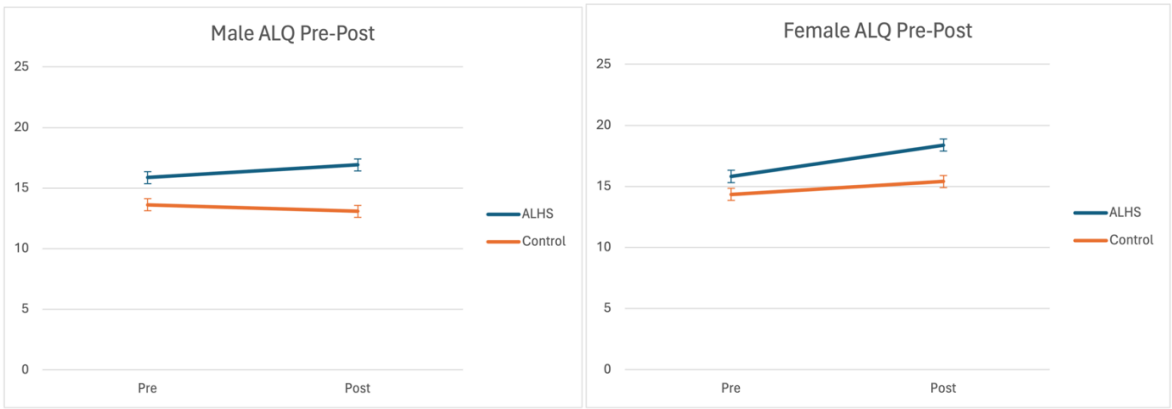
Sex

ALQ

2 (groups: intervention vs control) x2 (time: T1vs T2) x2 (sex: boys vs girls) ANOVA revealed significant main effects for time ($F(1,208)=14.131$, $p<.001$, $\eta^2=.06$) and condition ($F(1, 208)=18.73$, $p<.001$, $\eta^2=.08$) and significant interactions between time and condition ($F(1, 208)=7.9$, $p=.005$, $\eta^2=.04$) and time and sex ($F(1,208)=8$, $p=.005$, $\eta^2=.04$). Girls' anxiety literacy improved significantly over time compared to boys', and ALHS participants' anxiety literacy improved significantly compared to control participants (see Figure 3.14.1).

Figure 3.14.1

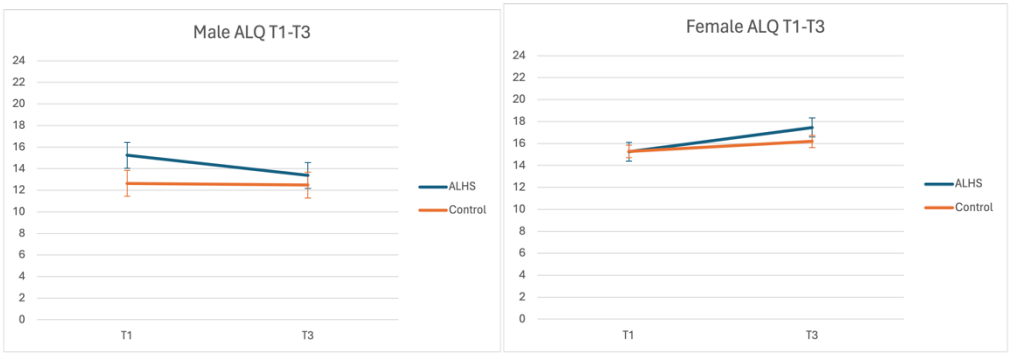
Participant Changes in Anxiety Literacy between Time 1-2 by sex



In 2(groups)x2(sex)x2(time: T1 vs T3) ANOVA (see Figure 3.14.2), significance for main effects of time, $F(1,125)=.84$, $p=.36$, $\eta^2=.01$) and condition ($F(1, 125)=1.46$ $p=.23$, $\eta^2=.01$) were not found. A main effect for sex, $F(1, 125) = 8.24$, $p<.05$, $\eta^2=.06$, was found. Interaction between sex and condition, $F(1, 125) = .29$, $p = .59$, $\eta^2=0$, was not significant, nor was interaction of time and condition ($F(1,125)=.02$, $p=.0$, $\eta^2=0$). However, interaction between time and sex were still significant at follow-up ($F(1, 125)=10.79$, $p<.05$, $\eta^2=.08$). Interaction between time, sex and condition was not significant, $F(1, 125) = 3.438$, $p = .07$, $\eta^2= .03$.

Figure 3.14.2

Participant Changes in Anxiety Literacy between T1-T3 by sex

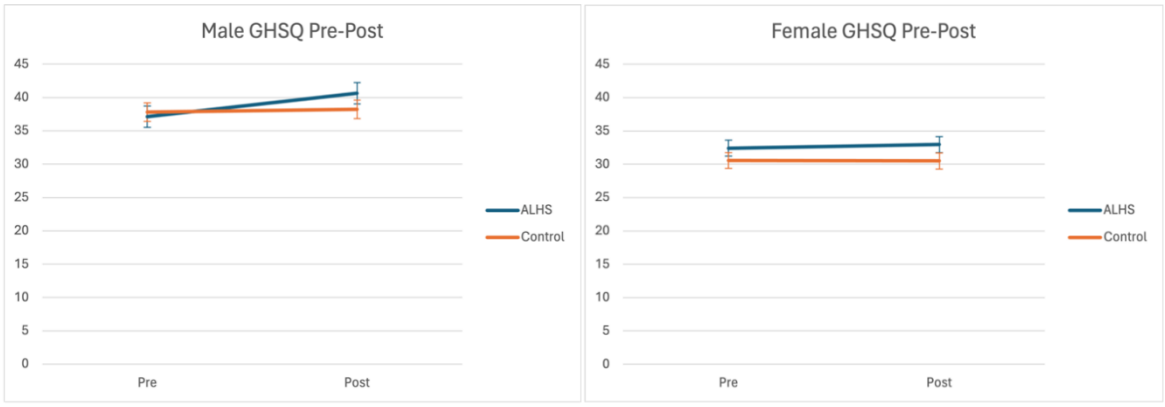


GHSQ

2x2x2 ANOVA revealed significant main effects for time (F (1,206) =6.32, p<.05, η^2=.03) and sex (F (1, 206) =27.97, p<.001, η^2=.12). In this analysis, there was significant interaction between time and condition (F (1,206) =4.47, p<.05, η^2=.02) but not between time and sex (F (1, 206) =3.83, p=.052, η^2=.02) (see Figure 3.14.3).

Figure 3.14.3

Participant Changes in Help-Seeking Intentions across Time 1-2 by sex

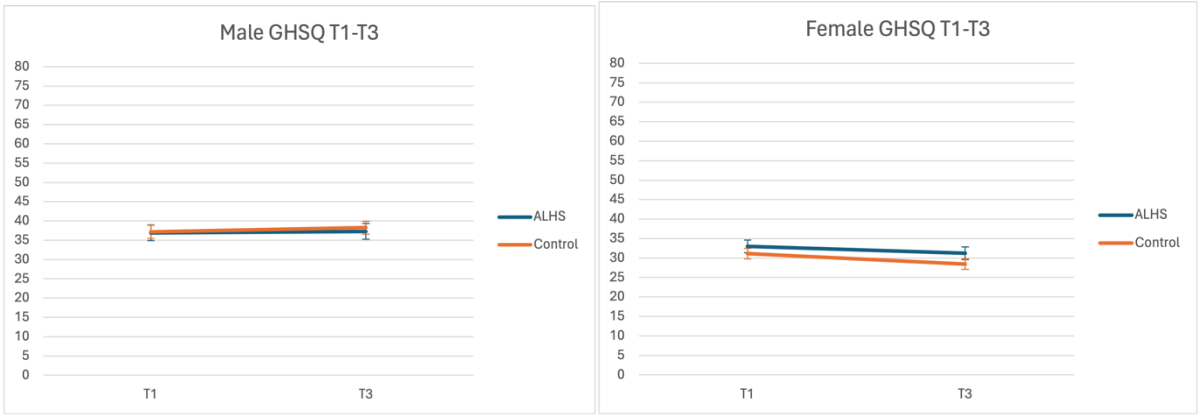


In 2(groups)x2(sex)x2(time: T1 vs T3) ANOVA (see Figure 3.14.4), there was a significant main effect for sex, F (1, 116) = 15.55, p<.001, η^2=.12, but not time, F (1, 116) = 1.26, p = .27, η^2=.01, or condition, F (1, 116) = .27, p=.6, η^2=0. There was significant interaction between time and sex, F (1, 116) = 4.83, p<.05, η^2=.04, but not time and condition, F (1, 116)

= .01, p=.91, η^2=0, condition and sex, F (1, 116) = .8, p=.37, η^2=.01, or time, condition and sex, F (1, 116) = .364, p = .55, η^2=0).

Figure 3.14.4

Participant Changes in Help-Seeking Intentions between T1-T3 by sex.

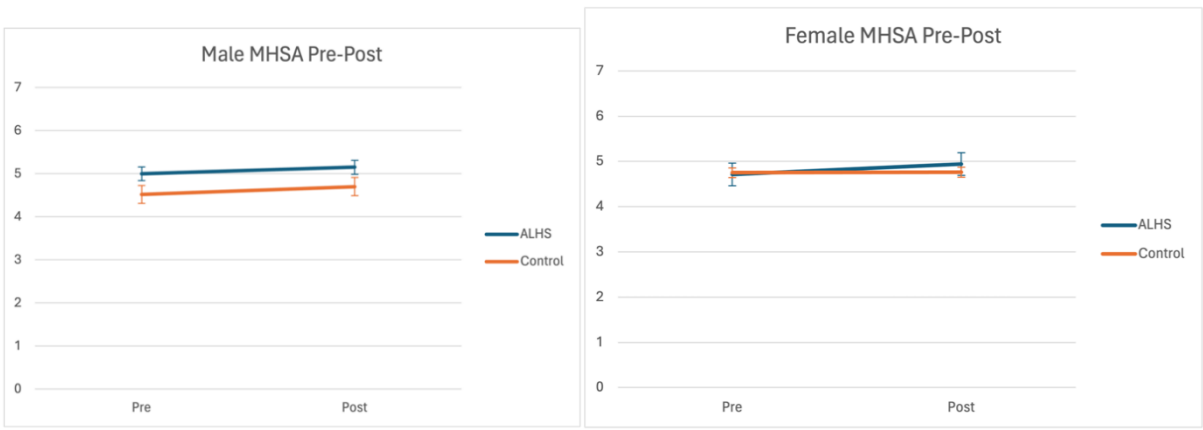


MHSA

2x2x2 ANOVA (see Figure 3.14.5) revealed significant main effects for time (F (1,173) =5.528, p<.05, η^2=.3) but not condition (F (1,173) =2.97, p=.09, η^2=.02) or sex (F (1,173) =.118, p=.73, η^2=.001). There were no significant interactions between time and condition (F (1,173) = .578, p=.45, η^2=.003), time and sex (F (1,173) =.110, p=.74, η^2=.001), condition and sex (F (1,173) =1.69, p=.2, η^2=.01) or time, condition, and sex (F (1,173) =1.07, p=.3, η^2=.006).

Figure 3.14.5

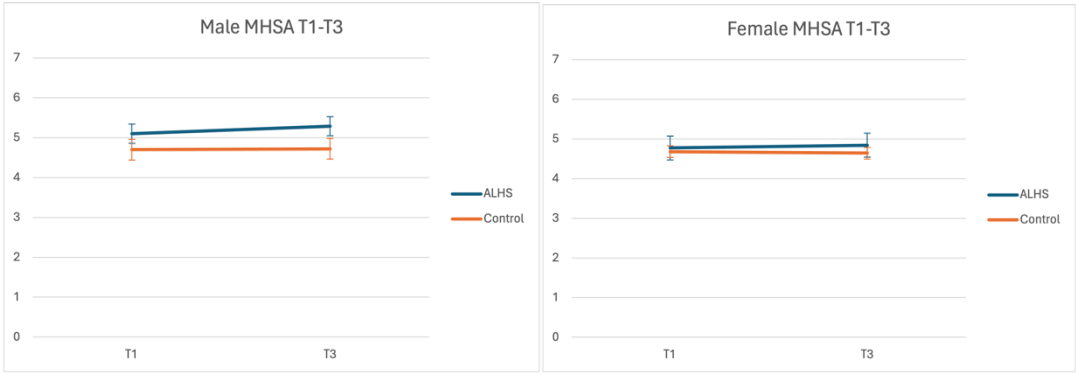
Participant Changes in Help-Seeking Attitudes across Time 1-2 by sex.



2(groups)x2(sex)x2(time: T1 vs T3) ANOVA (see Figure 3.14.6) revealed no significant effect for time, F (1, 91) = .37, p = .54, η^2=0), condition, F (1, 91) = 2.21, p = .14, η^2=.02) or sex (F (1, 91) = 1.03, p = .31, η^2=.01. Similarly, there were no significant interactions between time and condition, F(1, 91) = .5, p = .48, η^2=.01, time and sex, F(1, 91) = .22, p=.64, η^2=0, , condition and sex, F(1, 91) = .60, p = .44, η^2=.01, or time, condition and sex, F (1, 91) = .02, p = .9, η^2= 0.

Figure 3.14.6

Participant Changes in Help-Seeking Attitudes between T1-T3 by sex.

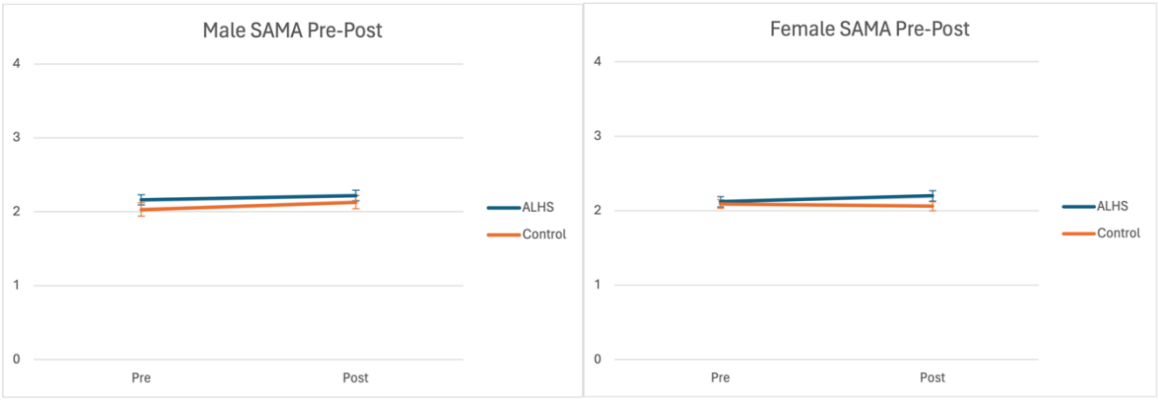


SAMA

2x2x2 ANOVA (see Figure 3.14.7) revealed significant main effect for time (F1,190) =4.13, p<.05, η^2=.02), but not condition (F (1,190) =2.1, p=.15, η^2=.01) or sex (F (1,190) =.08, p=.78, η^2=0). There were no significant interactions between time and condition (F (1,190) =.4, p=.53, η^2=.002), time and sex (F (1,190) =1.14, p=.29, η^2=.006), condition and sex (F (1,190) =.06, p=.8, η^2=.0) or time, condition, and sex (F (1,190) =2.01, p=.16, η^2=.01).

Figure 3.14.7

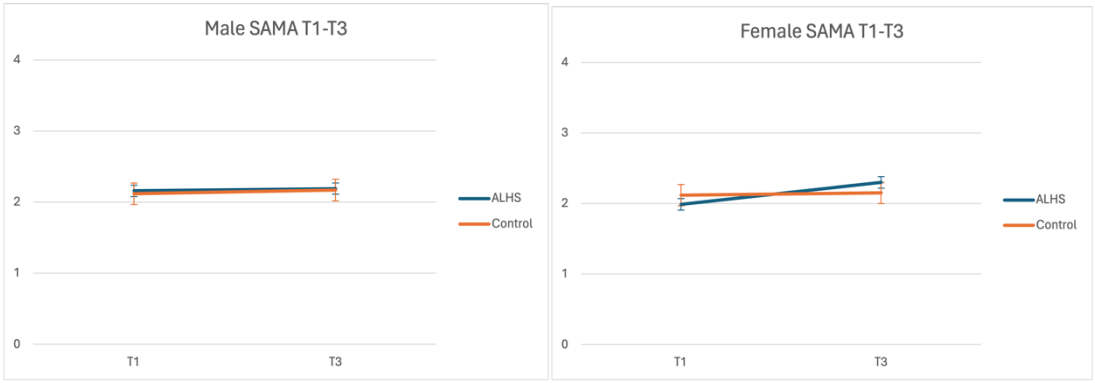
Participant Changes in Anxiety Appraisal between Time 1-2 by sex.



2(groups)x2(sex)x2(time: T1 vs T3) ANOVA (see Figure 3.14.8) revealed a significant main effect for time, F (1, 103) = 5.91, p<.05, η^2=.05, but not condition, F (1, 103) = .05, p = .83, η^2=0, or sex, F (1, 103) = .06, p = .82, η^2=0. There were no significant interactions between time and condition, F (1, 103) = 2.3, p = .13, η^2=.02, time and sex, F (1, 103) = 2.41, p = .12, η^2=.02, condition and sex, F (1, 103) = .11, p = .89, η^2=0, or time, condition and sex, F (1, 103) = 2,99, p = .09, η^2=.03.

Figure 3.14.8

Participant Changes in Anxiety Appraisal between T1-T3 by sex.



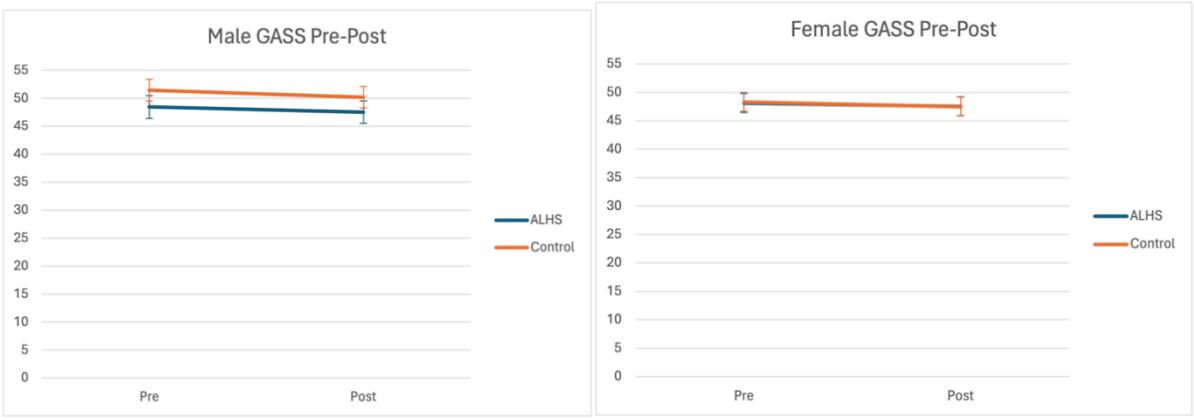
GASS

2x2x2 ANOVA (see Figure 3.14.9) revealed no significant main effect for time (F(1,171)=.51, p=.48, η^2=.003), condition (F(1,171)=.15, p=.7, η^2=.001) or sex (F(1,171)=1.21, p=.27, η^2=.01).There was no significant interaction between time and condition (F(1,171)=1.6, p=.21, η^2=.02) or sex and condition (F(1,171)=3.54, p=.06, η^2=.02), although there was significant interaction between time and sex (F(1,171)=4.02. p<.05,

η^2=.02). There was no significant three-way interaction between time, condition, and sex (F (1,171) =.33, p=.57, η^2=.002).

Figure 3.14.9

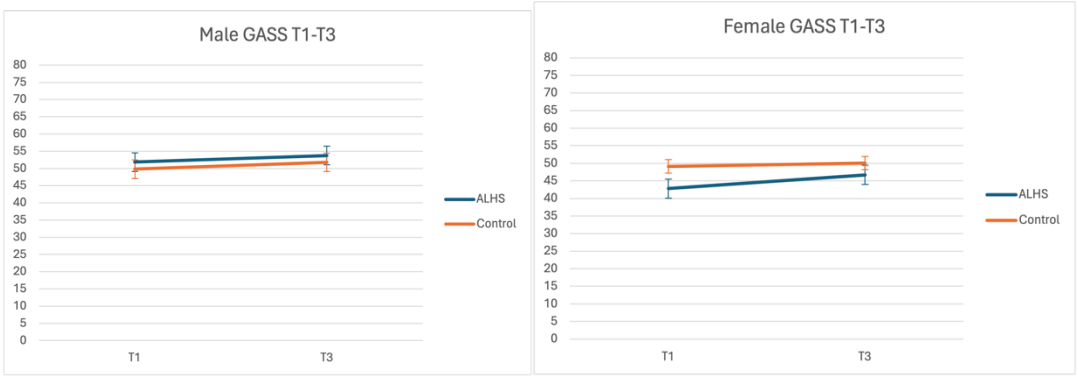
Participant Changes in Anxiety-Related Stigma between Time 1-2 by sex.



2(groups)x2(sex)x2(time: T1 vs T3) ANOVA (see Figure 3.14.10) revealed significant main effects for time, F (1, 85) = 4.15, p<.05, η^2=.05, and sex, F (1, 85) = 3.99, p<.05, η^2=.05, but not condition, F (1, 85) = .37, p = .54, η^2=0. There were no significant interactions between time and condition, F (1, 85) = .433, p = .51, η^2=.01, time and sex, F (1, 85) = .05, p = .83, η^2=0, condition and sex, F (1, 85) = 2.2, p = .14, η^2=.03, or time, condition and sex, F (1, 85) = .47, p = .49, η^2= .01.

Figure 3.14.10

Participant Changes in Anxiety-Related Stigma between T1-T3 by sex.



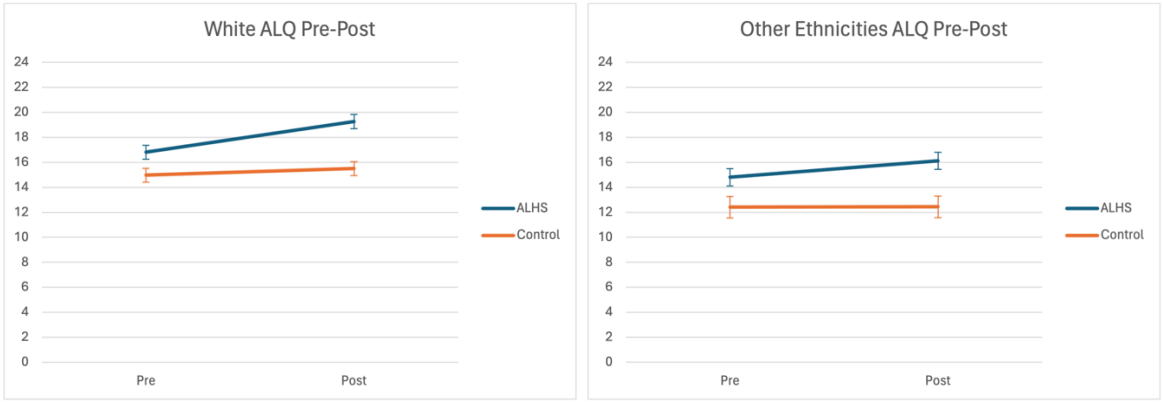
Ethnicity

ALQ

2x2x2 ANOVA revealed significant main effects for time (F (1, 206=14.6, p<.001, η^2=.07), condition (F (1, 206) =24.11, p<.001, η^2=.11) and ethnicity (F (1, 206) =20.54, p<.001, η^2=.09) (see Figure 3.14.11). However, no significant interactions were observed. Of these, only ethnicity maintained significant effect in 2x2x3 ANOVA (F (1,103) =7.19, p<.05, η^2=.07).

Figure 3.14.11

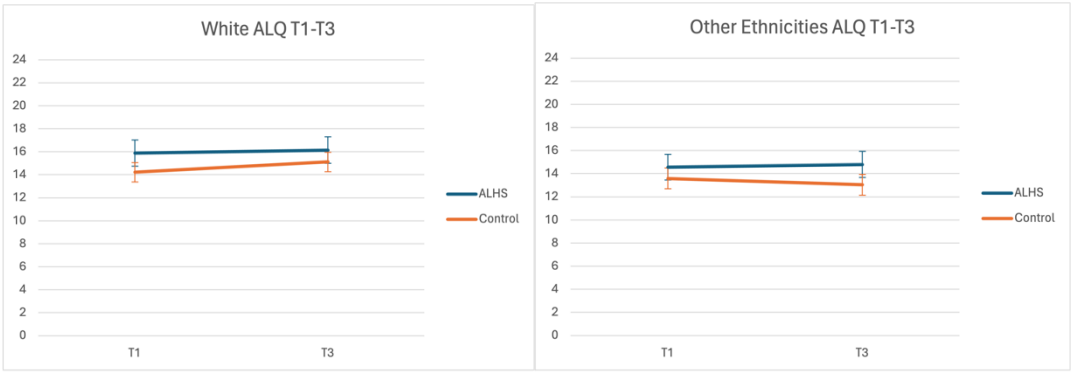
Participant Changes in Anxiety Literacy between Time 1-2 by ethnic group



2(groups)x2(sex)x2(time: T1 vs T3) revealed no significant main effect for ethnic group, F (1, 123) = 1.893, p=.17, η^2 = .02, time, F (1, 123) = .29, p = .59, η^2=0, or condition, F (1, 123) = 1.92, p = .17, η^2= .02 (see Figure 3.14.12). There were no significant interactions between time and condition, F (1, 123) = .01, p = .92, η^2=0, time and ethnic group, F (1, 123) = .83, p = .36, η^2=.01, condition and ethnic group, F (1, 123) = .81, p = .37, η^2=.01, or time, condition and ethnic group, p (1, 123) = .81, p = .37, η^2=.01.

Figure 3.14.12

Participant Changes in Anxiety Literacy between T1-T3 by ethnic group.

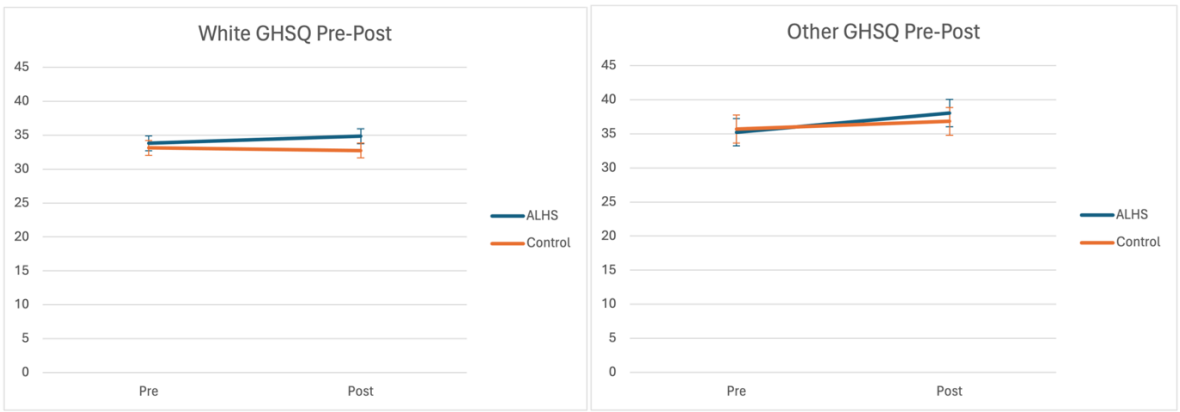


GHSQ

2x2x2 ANOVA revealed significant main effects for time ($F(1,205)=6.53$, $p<.05$, , $\eta^2=.03$) and ethnic group ($F(1,205)=4.19$, $p<.05$, , $\eta^2=.2$), but not condition ($F(1,205)=.4$, $p=.53$, , $\eta^2=.0$) (see Figure 3.14.13). There were no significant interactions between time and ethnic group ($F(1,205)=3.29$, $p=.07$, $\eta^2=.02$), time and condition ($F(1, 205)=2.93$, $p=.09$, , $\eta^2=.01$), ethnic group and condition ($F(1,205)=.14$, $p=.71$, , $\eta^2=0$) or time, ethnic group and condition ($F(1,205)=.02$, $p=.89$, , $\eta^2=0$).

Figure 3.14.13

Participant Changes in Help-Seeking Intentions between Time 1-2 by ethnic group.

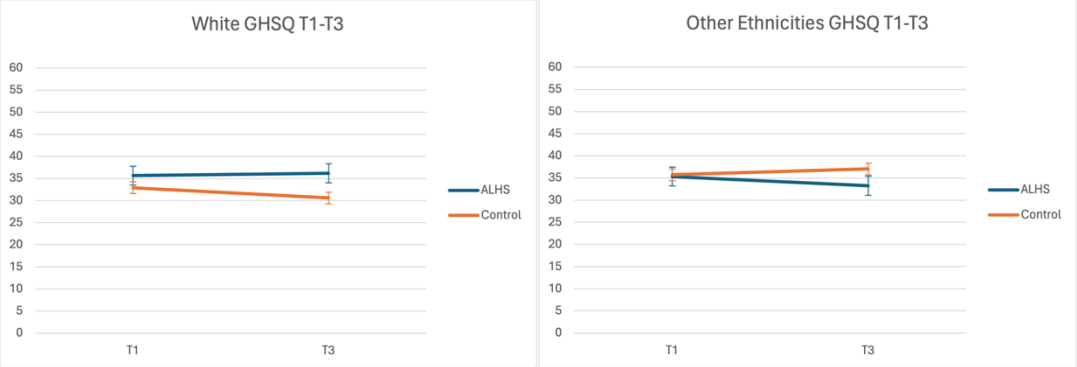


2(groups)x2(sex)x2(time: T1 vs T3) revealed a significant interaction between time, condition, and ethnic group ($F (1, 114) = 5.35$, $p < .05$, $\eta^2=.05$) (see Figure 3.14.14). There

was no significant effect for time, F (1, 114) = .9, p = .35, η^2=.01, condition, F (1, 114) = .34, p = .56, η^2=0, or ethnic group, F (1, 114) = .73, p = .4, η^2=.01. There were no significant interactions between time and condition, F (1, 114) = .04, p = .84, η^2=0, time and ethnic group, F (1, 114) = .14, p = .71, η^2=0, or condition and ethnic group, F (1, 114) = 3.11, p = .08, η^2=.03.

Figure 3.14.14

Participant Changes in Help-Seeking Intentions between T1-T3 by ethnic group

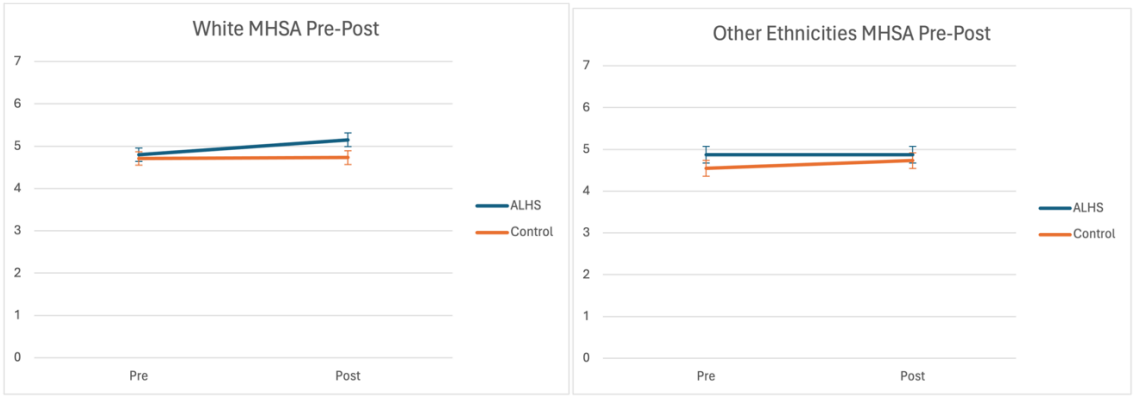


MHSA

2x2x2 ANOVA revealed a significant main effect for time (F (1,172) =5.67, p<.05, η^2=.03), but not condition (F (1,172) =2.18, p=.142, η^2=.01) or ethnic group (F (1,172) =.309, p=.58, η^2=.002) (see Figure 3.14.15). No significant interactions were found between time and condition (F (1,172) =.3, p=.59, η^2=.002), time and ethnic group (F (1,172) =.48, p=.49, η^2=.003) or condition and ethnic group (F (1,172) =.02, p=.9, η^2=0). A significant three-way interaction between time, condition and ethnic group was found (F (1,172) =5.03, p<.05, η^2=.03).

Figure 3.14.15

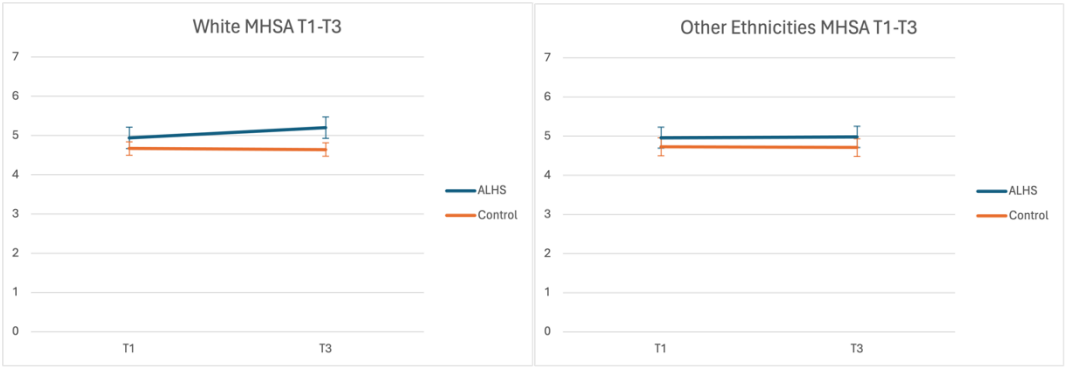
Participant Changes in Help-Seeking Attitudes between Time 1-2 by ethnic group.



2(groups)x2(sex)x2(time: T1 vs T3) ANOVA (see Figure 3.14.16) revealed no significant main effects for time, F (1, 90) = .33, p = .57, η^2=0, condition, F (1,90) =2.34, p=.13, η^2=.03) or ethnic group (F (1,90) =.01, p=.69, η^2= 0). Similarly, there were no significant interactions between time and condition, F (1, 90) = .74, p = .39, η^2=.01, time and ethnic group, F (1, 90) = .35, p = .56, η^2=0, ethnic group and condition, F (1, 90) = .16, p = .69, η^2=0, or time, ethnic group and condition, F (1, 90) = .39, p = .54, η^2=0.

Figure 3.14.16

Participant Changes in Help-Seeking Attitudes between T1-T3 by ethnic group.



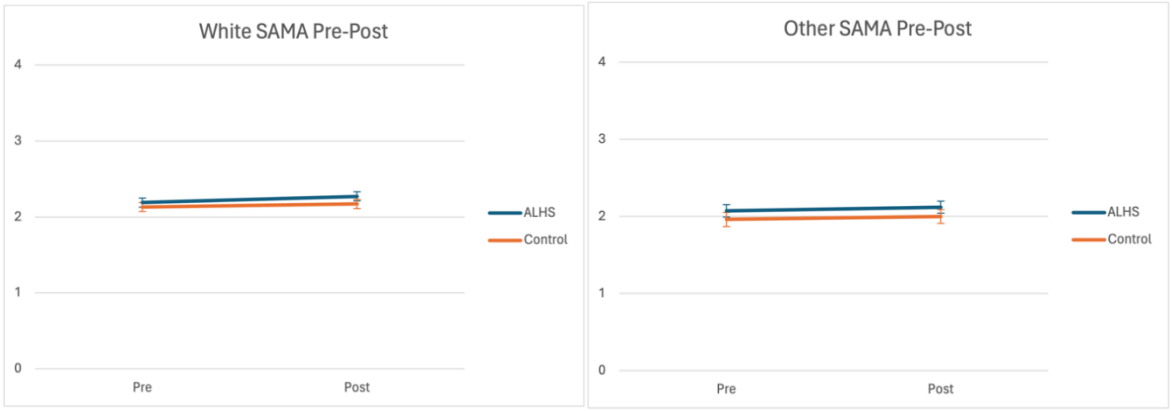
SAMA

2x2x2 ANOVA revealed a significant main effect for time (F (1,189) =4.36, p<.05, η^2=.02) and ethnic group (F (1,189) =5.06, p<.05, η^2=.03), but none for condition (F (1,189) =2.12, p=.15, η^2=.01) (see Figure 3.14.17). No significant interactions were found between time and condition (F(1,189)=.26, p=.61, η^2=.001), time and ethnic group (F(1,189)= 005, p=.95,

η^2=0), condition and ethnic group (F(1,189)=.07, p=.79, η^2=0) or time, condition and ethnic group (F(1,189)=.21, p=.65, η^2=.001).

Figure 3.14.17

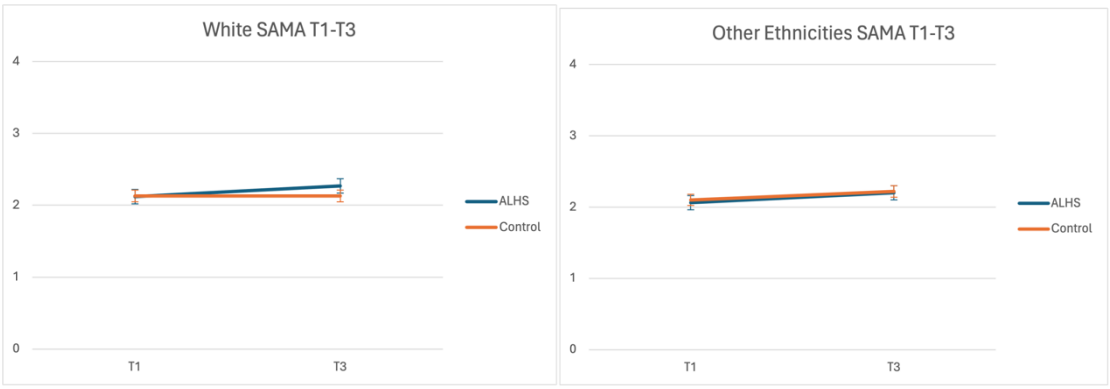
Participant Changes in Anxiety Appraisal between Time 1-2 by ethnic group.



2(groups)x2(sex)x2(time: T1 vs T3) ANOVA (see Figure 3.14.18) revealed a significant main effect for time, F (1, 102) = 5.4, p<.05, η^2=.05. There were no significant main effects for condition, F (1, 102) = .03, p=.86, η^2=0, or ethnic group, F (1, 102) = .05, p = .83, η^2= 0. There were no significant interactions between time and condition, F (1, 102) = 1.23, p = .27, η^2=.01, time and ethnic group, F (1, 102) = .31, p = .58, η^2=0, condition and ethnic group, F (1, 102) = .46, p = .5, η^2= 0, or time, condition and ethnic group, F (1, 102) = .48, p=.5, η^2=0.

Figure 3.14.18

Participant Changes in Anxiety Appraisal across three timepoints by ethnic group.

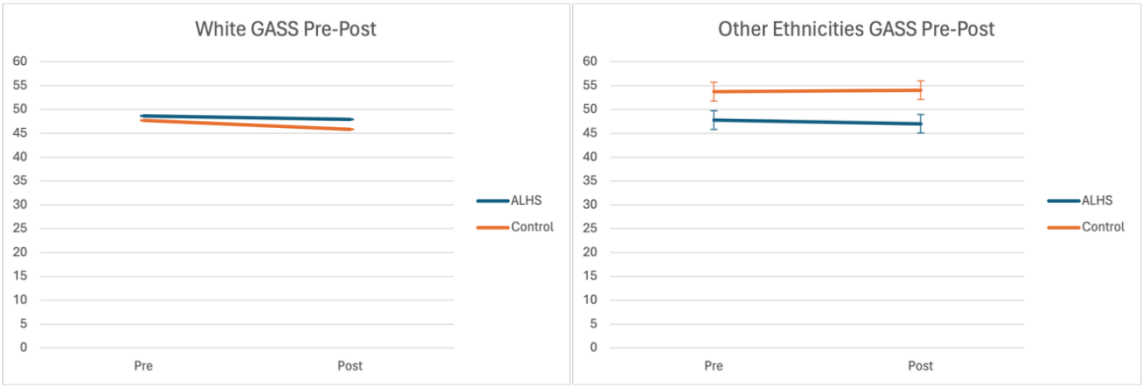


GASS

2x2x2 ANOVA revealed no significant main effects for time (F (1,166) =1.26, p=.26, η^2=.008), condition (F (1,166) =2.11, p=.15, η^2=.01) or ethnic group (F (1,166) =3.32), p=.07, η^2=.02) (see Figure 3.14.19). There was significant interaction between condition and ethnic group (F(1,166)=5.47, p<.05, η^2=.03), but not time and condition (F(1,166)=0, p=.99, η^2=0), time and ethnic group (F(1,166)=.64, p=.42, η^2=.004) or time, condition and ethnic group (F(1,166)=.71, p=.41, η^2=.004).

Figure 3.14.19

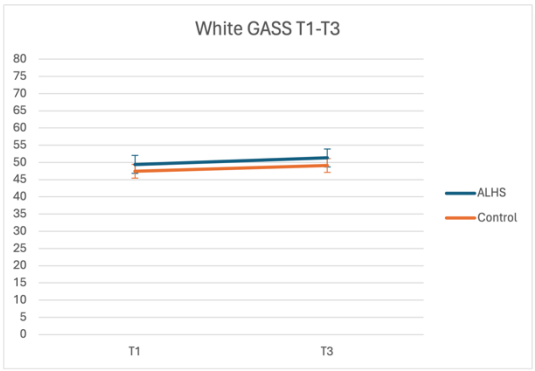
Participant Changes in Anxiety-Related Stigma between Time 1-2 by ethnic group.

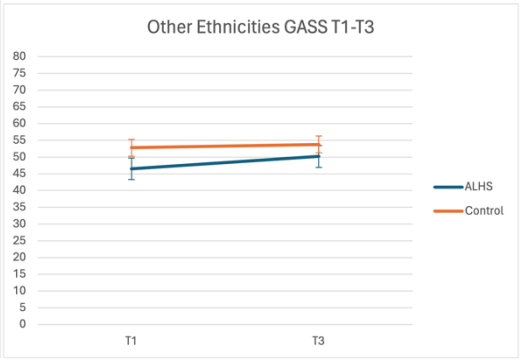


2(groups)x2(sex)x2(time: T1 vs T3) ANOVA (see Figure 3.14.20) revealed no significant main effects for time, F (1, 84) = 3.65, p = .06, η^2=.04, condition, F (1, 84) = .37, p=.55, η^2=0, or ethnic group, F (1, 84) = .41, p = .52, η^2=.01. There were no significant interactions between time and condition, F (1, 84) .46, p = .5, η^2=.01, time and ethnic group, F (1, 84) = .07, p = .8, η^2=0, condition and ethnic group, F (1, 84) = 2.23, p = .14, η^2=.03, or time, condition and ethnic group, F (1, 84) = .33, p = .57, η^2=0.

Figure 3.14.20

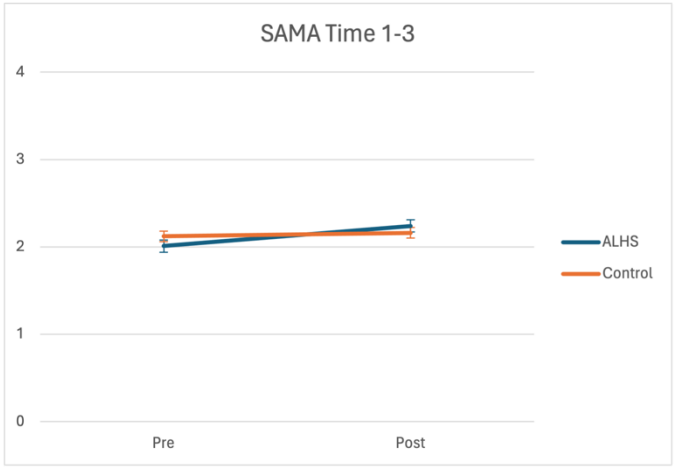
Participant Changes in Anxiety-Related Stigma between T1-T3 by ethnic group.


White GASS T1-T3
80
75
70
65
60
55
50
45
40
35
30
25
20
15
10
5
0
T1
T3
ALHS
Control

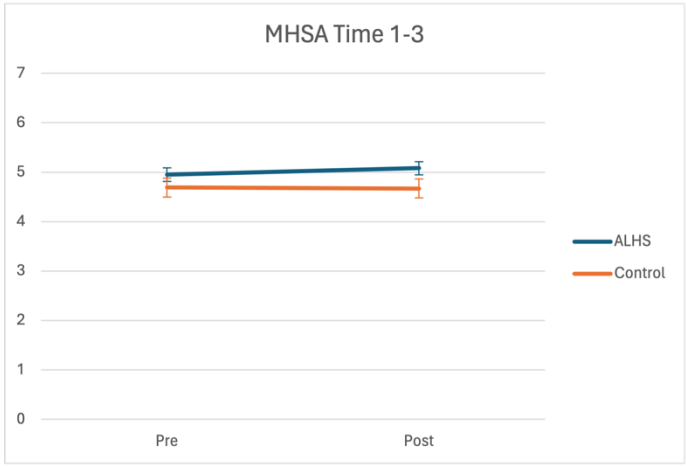

Other Ethnicities GASS T1-T3
80
75
70
65
60
55
50
45
40
35
30
25
20
15
10
5
0
T1
T3
ALHS
Control

Appendix 3.15: ANOVAs of potential mediators

Participant Changes in Anxiety Appraisal between Time 1-3.



Participant Changes in Anxiety Attitudes between Time 1-3.



Participant Changes in Anxiety-Related Stigma between Time 1-3.

