Understanding the role of the therapist in trauma-focussed CBT treatments for children and young people

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Thesis portfolio abstract

The aim of this research was to understand the role therapists play in the treatment of children and young people who have experienced trauma. The project looked firstly to understand whether the type of clinician delivering trauma focussed cognitive behavioural therapy (TF-CBT) impacts treatment outcomes for young people with PTSD. This was explored through a systematic review and meta-analysis which included 35 relevant studies. A synthesis of the literature provided a summary of the characteristics of therapists who are delivering TF-CBT to children and young people in clinical trials and the results of moderator analyses concluded that there were no significant differences in treatment outcomes between therapists of different professional backgrounds or education levels.

The current research also looked to understand the experiences of therapists delivering TF-CBT treatments for children and young people. This was explored through a qualitative project where 10 NHS clinicians were interviewed about their experiences of delivering cognitive therapy for PTSD (CT-PTSD). Thematic analysis revealed four key topic domains relating to the research question: “the experience of being a trauma therapist”; “CT-PTSD treatment”; “supporting services to deliver CT-PTSD in the future” and “involvement in research”. The current research findings are discussed in relation to the evidence base, and recommendations for clinical practice and future research are explored.

Chapter One: Systematic Review and Meta-Analysis

Prepared for submission to Child & Adolescent Mental Health

Therapist characteristics and their relationship to efficacy in randomised controlled trials of trauma-focussed CBT for children and young people: A systematic review and meta-analysis.

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Abstract

Background & Objectives

Previous research suggests that the effect of therapist factors on patient outcomes is significant, yet there have so far been no reviews exploring the effect that therapist characteristics may have on treatment outcomes for children and young people with post-traumatic stress disorder (PTSD). This systematic review and meta-analysis aims to summarise the professional characteristics of trial therapists delivering trauma-focussed cognitive behavioural interventions (TF-CBT) for child and adolescent PTSD in clinical trials and understand the association between treatment efficacy and therapist factors.

Method

Systematic searches for randomised controlled trials (RCTs) completed by Hoppen & Morina (2020) were updated to include publications since 2019. Thirty-five RCTs addressing TF-CBT in children and adolescents were included in the full review. PTSD treatment outcome data was extracted from each publication, along with any available data regarding trial therapists. Sub-group analyses compared the outcomes of interventions conducted by different types of therapists.

Results

All therapist groups yielded significant effects for TF-CBT relative to control conditions, with the largest effect size (g=-1.22) was found for RCTs using clinical psychologists and psychiatrists as therapists. A significant moderating effect was found when comparing the treatment outcomes of clinical psychologists and psychiatrists versus other professionals (p=0.03), however this effect was no longer apparent when only studies utilising an *active* control arm were included. Further moderator analyses found no significant difference between therapist profession or education level and PTSD treatment outcomes.

Conclusion

On the basis of the current RCT evidence we have for TF-CBT for children and young people with PTSD, there is no reason to believe that therapist educational or professional background influences treatment efficacy. Limitations and implications for future research are discussed.

Key Practitioner Message:

What is known?

There is a growing evidence base for the use of trauma-focussed CBT interventions for children and young people with PTSD, however, few studies have explored the effect of therapist factors on treatment outcomes.

What is new?

The current study summarises the professional characteristics of therapists who are delivering TF-CBT for children and young people in clinical trials. Sub-group analyses suggest there is no significant difference in PTSD treatment outcomes between different types of therapists.

What is significant for clinical practice?

The results of this study suggest that TF-CBT can be delivered successfully by therapists from a variety of professional backgrounds in the context of the RCTs studied, although further research in this area is essential.

Keywords: PTSD, children and adolescents, therapist factors, trauma-focussed CBT, Meta-analysis, systematic review.

Introduction

The impact of the therapist on treatment outcomes for common mental health difficulties is something which has been previously documented but is still not yet fully understood (Castonguay & Hill, 2017; Norcross & Lambert, 2019; Wampold & Imel, 2015). Previous research, although mainly conducted in adult populations, suggests that the clinical implications of therapist factors on patient outcomes is significant and affects many areas of patient experience. For example, patient drop-out rates have been found to be four times higher in those treated by less effective therapists (Saxon et al., 2017) and patient recovery rates of the most effective therapists have been shown to be twice as high as those achieved by the least effective therapists (Okiishi et al., 2003).

A number of therapist variables have been previously investigated, such as therapist theoretical orientation (Anderson et al., 2009; Bergler et al., 2016; Okiishi et al., 2006), age (Anderson et al., 2009; Shauenburg et al., 2005) and gender (Shiner et al., 2017; Zorzella et al., 2015). However, results from these studies frequently contradict one another. For example, therapist competency has been found to be a predictor of symptom change in treatments for depression (Strunk et al., 2010) and was found to account for 48% of variance in patient outcomes for social anxiety disorder (Ginzburg et al., 2012). However, in a meta-analysis conducted by Webb and colleagues (2010) there appeared to be no relationship between therapist competence and patient outcomes. These mixed findings highlight the need for further investigation into the impact of therapist variables on patient outcomes. A recent review concluded that the ongoing investigation of therapist effects is vital so that the characteristics of effective therapists can be identified, and more efficient matching of therapist and patient could be facilitated (Johns et al., 2019).

An area of growing clinical interest in the literature is that of evidence-based therapies for children and young people who are experiencing post-traumatic stress disorder (PTSD). PTSD is a highly distressing psychiatric disorder, characterised by pervasive reliving of traumatic events through flashbacks and nightmares, as well as hypervigilance to threat and avoidance of any reminders of the traumatic event (American Psychiatric Association, 2013). With surveys suggesting that only one in five young people with PTSD in the UK has accessed support from a mental health professional (Lewis et al., 2019) there is growing demand for services providing effective and timely treatments. Both NICE guidelines (2018) and International Society for Traumatic Stress Studies (2018) recommend that the primary provision for trauma-exposed young people should be psychological therapy, in particular trauma-focussed cognitive behavioural therapy (TF-CBT).

It has been noted in the literature that trauma therapies are an area where therapists commonly feel lacking in competence and experience, which can be a barrier to evidence-based practice (Finch et al., 2020a). Despite this, few studies have focussed on TF-CBT therapists and even fewer in child populations (Baldwin & Imel, 2013; Johns et al., 2019; Fjermestad et al., 2016). Pfeiffer and colleagues (2020) recently collated therapist data from two randomised controlled trials (RCTs) examining the effectiveness of TF-CBT for children and young people and found no evidence of a relationship between therapists' theoretical background or clinical experience and patient outcome. Whilst there is a significant evidence base for trauma-focussed therapies for children and young people, particularly for TF-CBT, Pfeiffer and colleagues' (2020) paper is, to the authors knowledge, the only study so far to examine the impact of therapist factors in TF-CBT for this population. However, no reviews have yet provided a summary of who is delivering TF-CBT in the research trials on which clinical guidelines are based, therefore making it difficult to understand the effect of therapist factors on trial outcomes more widely. It has been argued that the importance of identifying therapist factors which promote effective treatment outcomes is particularly important in youth populations, as, typically, young people are less likely to refer themselves for therapy than

adults as they are frequently referred by parents or guardians (Podell et al., 2013); young people may, therefore, look more to the therapeutic relationship for motivation to engage in therapy.

The aims of the current meta-analysis were to understand the characteristics of the therapists that are delivering TF-CBT for children and young people in clinical trials and investigate whether these therapist factors moderate efficacy of TF-CBT.

Method

The review was prospectively registered on PROSPERO register of systematic reviews (6th November 2020, CRD42020218106). The present study utilised and updated previous searches conducted by Hoppen & Morina (2020). The utilization of this methodology felt most appropriate due to the present study's focus on the RCT data utilised to inform clinical-practice guidelines. The aim of the current study was not to manipulate therapist variables but instead to understand whether therapist factors had a moderating role within RCTs, therefore utilization of Morina & Hoppen's search strategy for RCTs investigating trauma interventions felt most appropriate. Given the exclusive focus on the current meta-analysis on TF-CBT interventions, only studies including this kind of intervention at least one arm of the trial were included. The term TF-CBT encompassed cognitive-behavioural interventions with a focus on trauma memories such as cognitive therapy and prolonged exposure. If a publication reported two active TF-CBT treatment groups, they were excluded due to lack of a meaningful control. To be considered eligible, trials had to meet the following inclusion criteria: a) random allocation of participants; b) at least one arm with a TF-CBT intervention for child and adolescent PTSD in comparison to a passive or active control group or to another psychological intervention; c) average age of the full sample below 18 years; and d) at least 10 participants per group at post-treatment and/or follow-up. In line with Hoppen & Morina's (2020) protocol, trials

which examined interventions not specifically designed as PTSD treatment interventions, such as classroom-based interventions, were excluded.

Searches completed by Hoppen and Morina (2020) were updated on 3rd November 2020 to include publications since 2019 using similar search criteria and using the databases MEDLINE and PsycINFO using the following terms: Posttraumatic Stress Disorder (Posttraumatic stress OR post-traumatic stress OR Posttraumatic syndrome* OR post traumatic syndrome* OR PTSD OR PTSS OR trauma OR psychological distress OR psychotraumatology) and Children (child* OR adolescent* OR teen* OR minor* OR youth* OR pediat* OR boy* OR girl*) and Treatment (treatment* OR intervention* OR therapy OR psychotherapy OR exposure OR trial OR counselling). No restrictions were be made regarding language.

All titles and abstracts of search results were reviewed and any which did not meet inclusion criteria removed, followed by a full text review of all the remaining publications. All search results were reviewed independently by two researchers (LG and ZT); any differences in opinion were discussed with the project's primary supervisor (RMS).

Quality assessments conducted by Hoppen and Morina (2020) were reviewed and utilised for the present study. The quality of each study was assessed using the eight criteria proposed by Cuijpers et al. (2010; See Appendix C for full quality assessment criteria). Namely, a study was considered to be of high quality if (1) participants meet diagnostic criteria for PTSD; (2) a treatment manual was applied; (3) the therapists who conducted the therapy were trained for the specific therapy; (4) treatment integrity was checked during the study; (5) data were analysed with intention-to-treat analyses; (6) the study had a minimal level of statistical power to find significant effects of the treatment, and included at least 50 patients in the comparison between treatment and control groups; (7) the study reported that randomization was conducted by an independent party; (8)

assessors of outcome were blinded to treatment condition (see Appendix B for quality scores of each study). In line with Hoppen & Morina's (2020) protocol, we decided to label a trial as high quality if it reached a quality sum score of seven or eight. Although quality was assessed independently by two researchers (LG and ZT), it was not possible for the researchers to be blinded to Hoppen & Morina's (2020) ratings, potentially increasing the risk of bias in the quality assessment process.

Coding of publications

For each included publication, in addition to treatment outcome data, data on the trial therapists were extracted, along with any available data regarding the training they received in the trial therapy and the supervision they received throughout the study. Therapist data were then coded and categorised according to professional background and education level of therapist, the amount of training therapists received in the trial intervention and the frequency of supervision provided (see Table 2 for therapist categorisation for each study). Therapists who received some training to provide the trial therapy, but did not appear to have professional healthcare qualifications, were defined as "lay therapists" (Lewin et al., 2010). Due to the variety of professional backgrounds reported as trial therapists, some were categorised together as "other therapists"; these included professionals such as CBT therapists, psychotherapists and child-advocacy service therapists. The data from each study was extracted and coded independently by two researchers (LG and ZT) and any discrepancies reviewed and discussed. Any disagreements regarding data categorisation were discussed with the project's primary supervisor (RMS) for resolution.

Statistical analysis

A Hedge's g effect size for each study was calculated using means and standard deviations of post-intervention PTSD symptoms. When no standard deviation was reported, the standard error was

computed using 95% confidence intervals; similarly, standard deviations were derived from confidence intervals if necessary.

Where studies utilised TF-CBT in two experimental arms, results were pooled. Where studies included both a passive and active control arm (Ertl, 2011; de Roos, 2017), the results from the passive control arm were utilised in the main analysis but further sensitivity analysis were conducted using the active control arm to ensure this did not significantly impact results. When further moderator analyses were conducted according to type of control, both arms were included in each analysis respectively. In one study (Cohen, 2011) standardised mean differences of change scores were reported instead of post treatment data; concerns have been highlighted around pooling this data in analyses (Deeks et al., 2020) therefore, analysis was repeated with this paper removed as a sensitivity analysis to examine whether the inclusion of this study affected the results. Follow up data were not included in our analyses due to post-treatment data being arguably more pertinent to the research question, and due to inconsistencies in timings and availabilities of follow up data reported across included studies.

Statistical heterogeneity was assessed using the Q test and quantified using the I^2 statistic. Random-effects meta-analyses were conducted. Sub-group analyses compared the outcomes of interventions conducted by different types of therapists.

Results

Characteristics of included studies

Figure 1 illustrates the flow of publications through the systematic review. In total, 46 studies were transferred from Hoppen & Morina's (2020) review (see Appendix A for reference list of included studies and Table 1 for characteristics of included studies). A further 76 publications were identified through updated database searches. After examining 115 abstracts, 38 full text publications were

reviewed; of these, 35 titles met inclusion criteria and were included in the meta-analysis. No additional studies were found to meet inclusion criteria since Hoppen & Morina's (2020) review. An active control arm was used in 54.3% (n=19) of included studies.

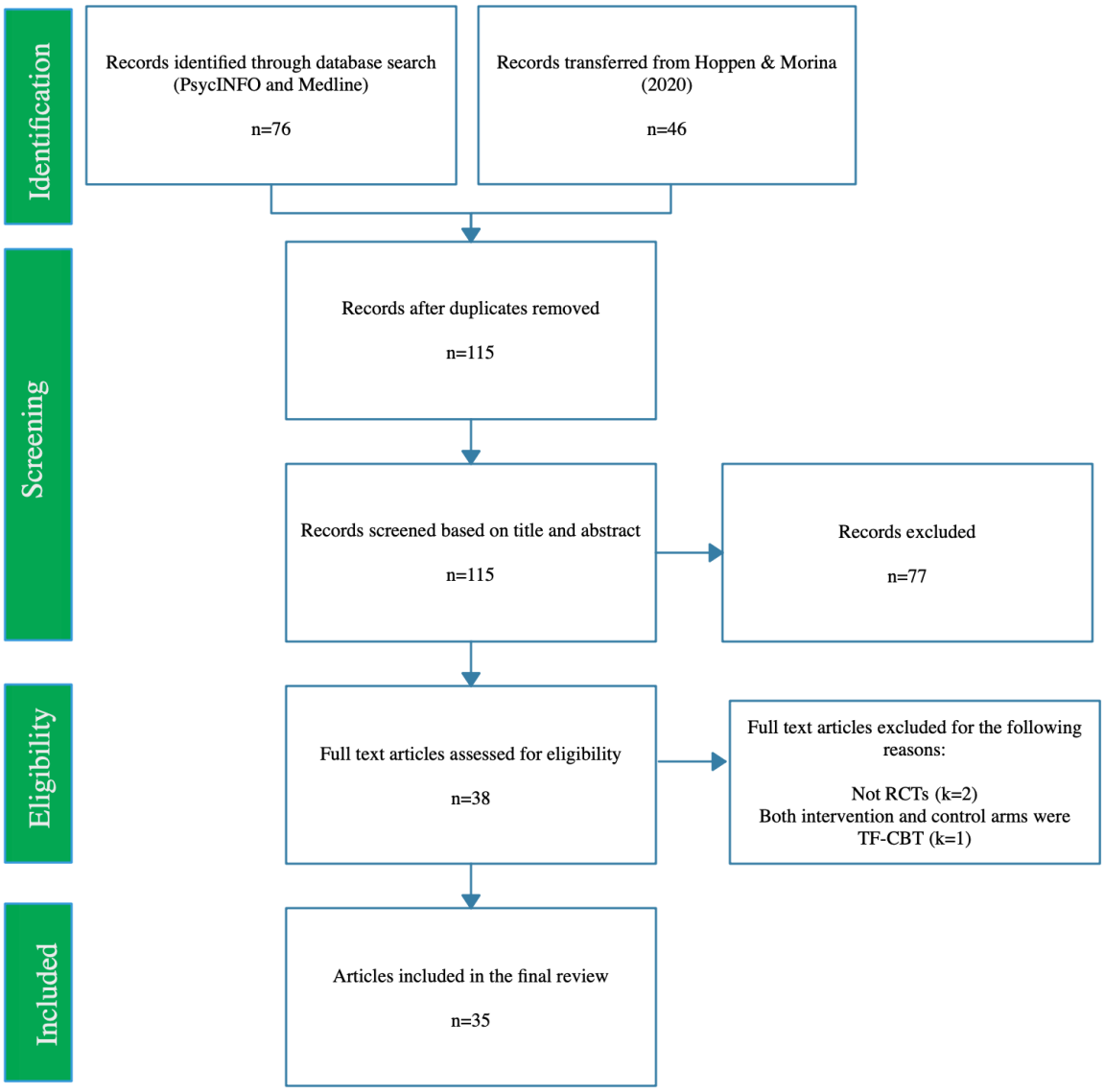

Fig. 1: PRISMA flow diagram

Quality of included studies

As illustrated in Appendix B, overall studies were of moderate quality, with a mean score of 5.8. No studies received a quality score of between zero and two and only three studies received a quality score of three. Fifteen studies were rated as high quality. The remainder of studies had a quality rating of between four and six (n=17).

Table 1: Characteristics of included publications

Publication	Type of intervention (format of delivery)	Control treatment	Control group type	PTSD outcome measure	Country
Ahrens & Rexford (2002)	CPT (group)	WL	PCC	PSS-SR	USA
Auslander et al. (2017)	GAIN (group, PAR-INV)	TAU	ACC	CPSS	USA
Barron et al (2016)	TRT (group)	WL	PCC	CRIES	Palestine
Catani et al. (2009)	KIDNET (individual)	MED	ACC	UPID	Sri Lanka
Celano et al. (2009)	Recovering from abuse program (individual, PAR-INV)	TAU	ACC	CITES-R	USA
Cohen et al. (2004)	TF-CBT	CCT	ACC	K-SADS	USA
Cohen et al. (2005)	TF-CBT (individual, PAR-INV)	SC	ACC	TSCC	USA
Cohen et al. (2011)	TF-CBT	CCT	ACC	K-SADS	USA
Dawson et al. (2018)	TF-CBT (individual, PAR-INV)	SC	ACC	UCLA PTSD-RI	Indonesia
De Roos et al. (2011)	TF-CBT (individual, PAR-INV)	EMDR	ACC	UCLA PTSD-RI	Netherlands
De Roos et al. (2017)	CBWT (individual)	EMDR & WL	ACC & PCC	CRTI	Netherlands
Deblinger et al. (1996)	TF-CBT (individual, child-only, child & parent, parent only)	TAU	ACC	K-SADS	USA

Diehle et al. (2015)	TF-CBT	EMDR	ACC	CAPS-CA	Netherlands
Ertl et al. (2011)	KIDNET (individual)	SC & WL	ACC & PCC	CAPS-CA	Uganda
Foa et al. (2013)	PE (individual)	SC	ACC	CPSS-I	USA
Gilboa-Schechteman et al. (2010)	PE	PDP	ACC	CPSS	Israel
Goldbeck et al. (2016)	TF-CBT (individual, PAR-INV)	WL	PCC	CAPS-CA	Germany
Jensen et al. (2014)	TF-CBT (individual, PAR-INV)	TAU	ACC	CAPS-CA	Norway
King et al. (2000)	TF-CBT (individual, child only, child &			ADIS	
	PAR-INV)	WL	PCC		Australia
McMullen et al. (2013)	TF-CBT (group)			UCLA PTSD-	
		WL	PCC	RI	DR Congo
Meiser-Stedman et al. (2017)	CT (individual)	WL	PCC	CPTSDI	UK
Murray et al. (2015)	TF-CBT (individual)	TAU	ACC	UPID	Zambia
O'Callaghan et al. (2013)	TF-CBT (group, PAR-INV)			UCLA-PTSD-	
		WL	PCC	RI	DR Congo
O'Callaghan et al. (2015)	TF-CBT (group, PAR-INV)	MDT		UCLA-PTSD-	
			ACC	RI	DR Congo
Peltonen & Kangaslampi (2019)	NET (individual)	TAU	ACC	CRIES	Finland
Pityaratstian et al. (2015)	TF-CBT (group)	WL		UCLA-PTSD-	
			PCC	RI	Thailand
Rosner et al. (2019)	D-CPT (individual)	WL	PCC	CAPS-CA	Germany
Rossouw et al. (2018	PE (group)	SC	ACC	CPSS-I	South Africa
Ruf et al. (2010)	KIDNET (individual)	WL	PCC	UPID	Germany

Schauer (2008)	KIDNET (individual)	MED	ACC	CAPS-CA	Sri Lanka
Scheeringa et al. (2011)	CBT (individual, PAR-INV)	WL	PCC	PAPA	USA
Schottelkorb et al. (2012)	TF-CBT	CCPT	ACC	UPID	USA
Shein-Szydlo et al. (2016)	CBT-TSC (individual)	WL	PCC	CPSS	Mexico
Smith et al. (2007)	TF-CBT (individual, PAR-INV)	WL	PCC	CAPS-CA	UK
Stein et al. (2003)	TF-CBT (group)	WL	PCC	CPSS	USA

Note: ADIS = Anxiety Disorders Interview Schedule; CAPS-CA = Clinician Administered PTSD Scale for Children and Adolescents; CBT = Cognitive Behaviour Therapy; CBT- TSC = CBT for trauma in street children; CCPT = Child Centred Play Therapy; CCT = Child Centred Therapy; CITES-R = Children's Impact of Traumatic Events Scales-Revised; CPSS = Child PTSD Symptom Scale; CPSS-I = CPSS Interview version; CPT = Cognitive Processing Therapy; CPTSDI = Child PTSD Inventor; CRIES = Children's Revised Impact of Event Scale; CRTI = Children's Responses to Trauma Inventory; CT = Cognitive Therapy; D-CPT = Developmentally adapted Cognitive Processing Therapy; DR Congo = Democratic Republic of Congo; EMDR = Eye Movement Desensitization and Reprocessing; K-SADS = Schedule for Affective Disorders and Schizophrenia for School-Age Children; KIDNET = Narrative Exposure Therapy for Children; NET = Narrative Exposure Therapy; PAPA = The Preschool Age Psychiatric Assessment; PAR-INV = parent involvement; PE = Prolonged Exposure; PDP = Psychodynamic Psychotherapy; SC = Supportive Counselling; TAU = Treatment as Usual; TF-CBT = Trauma-focused Cognitive Behaviour Therapy; TSCC = Trauma Symptom Checklist for Children; UCLA PTSD-RI = University of California–Los Angeles PTSD Reaction Index; UK = United Kingdom; UPID = The University of California at Los Angeles PTSD Index; USA = United States of America; WL = Waitlist;

Coding of therapists

Regarding therapist profession, 20.6% (n=7) of included studies employed either clinical psychologists or psychiatrists as trial therapists, 23.5% (n=8) counsellors, 11.8% (n=4) social workers 29.4% (n=10) used a variety of therapists from different professional backgrounds, while 14.3% (n=5) studies used other therapist types (e.g., CBT therapists, psychotherapists). For one trial (Cohen et al., 2005), therapist profession was not reported.

Regarding therapist educational level, 20.0% (n=7) of included trials used therapists educated to doctoral level, 14.3% (n=5) used therapists educated to master's level, 5.7% (n=2) used therapists educated to school level, while 25.7% (n=9) included a therapists with a mixture of educational levels; for 34.3% (n=12) therapist educational level was not reported. Lay therapists (i.e. therapists who did not appear to have formal healthcare qualifications) were used in 17.7% (n=6) of studies, while the other 28 trials utilized therapists classified as being professional therapists; in one trial, therapist status could not be ascertained.

Of all included studies, 82.9% (n=29) reported providing specific training in the trial intervention to therapists: of these, 48.3% (n=14) reported providing training which was conducted over 3 days or longer; the remainder reported training sessions of less than 3 days or did not report the amount of training provided (n=15). Clinical supervision for trial therapists was reported in 85.7% (n=30) of studies; of these, 53.3% (n=16) provided supervision on a fortnightly basis or more frequently; the remainder either provided supervision less frequently than fortnightly (e.g., monthly; n=2) or did not report supervision frequency (n=13).

Table 2: Categorisation of trial therapists

Publication	Type of therapist	Therapist education level	CP/Psychiatrist vs other	Qualification: Master's degree vs other	Lay vs professional
Ahrens & Rexford (2002)	Mixed	Doctoral	Mixed	Master's	Professional
Auslander et al. (2017)	Other	NR	NR	NR	Professional
Barron et al. (2016)	Counsellor	NR	Other	NR	Professional
Catani et al. (2009)	Counsellor	NR	Other	Other	Lay
Celano et al. (2009)	Mixed	Mixed	Mixed	Mixed	Professional
Cohen et al. (2004)	Mixed	Mixed	Mixed	Mixed	Professional
Cohen et al. (2005)	NR	NR	NR	NR	NR
Cohen et al. (2011)	Social worker	Master's	Other	Master's	Professional
Dawson et al. (2018)	Counsellor	School	Other	Other	Lay
De Roos et al. (2011)	Mixed	Mixed	Mixed	Master's	Professional
De Roos et al. (2017)	CP/Psychiatrist	Doctoral	CP/Psychiatrist	Master's	Professional
Deblinger et al. (1996)	Other	NR	Other	NR	Professional
Diehle et al. (2015)	Other	NR	Other	NR	Professional
Ertl et al. (2011)	Counsellor	NR	Other	Other	Lay
Foa et al. (2013)	Counsellor	Master's	Other	Master's	Professional
Gilboa-Schechteman et al. (2010)	Mixed	Master's	Other	Master's	Professional

Goldbeck et al. (2016)	Mixed	Mixed	Mixed	Master's	Professional
Jensen et al. (2014)	Mixed	Mixed	Mixed	Mixed	Professional
King et al. (2000)	CP/ Psychiatrist	Doctoral	CP/Psychiatrist	Master's	Professional
McMullen et al. (2013)	Mixed	Mixed	Mixed	NR	Professional
Meiser-Stedman et al. (2017)	CP/Psychiatrist	Doctoral	CP/Psychiatrist	Master's	Professional
Murray et al. (2015)	Counsellor	School	Other	Other	Professional
O'Callaghan et al. (2013)	Social worker	NR	Other	Other	Professional
O'Callaghan et al. (2015)	Mixed	NR	Other	Other	Lay
Peltonen & Kangaslampi (2019)	Mixed	Mixed	Mixed	Mixed	Professional
Pityaratstian et al. (2015)	CP/Psychiatrist	Doctoral	CP/Psychiatrist	Master's	Professional
Rosner et al. (2019)	Other	Mixed	Other	Master's	Professional
Rossouw et al. (2018	Other	NR	Other	Other	Lay
Ruf et al. (2010)	CP/Psychiatrist	Doctoral	CP/Psychiatrist	Master's	Professional
Schauer (2008)	Counsellor	NR	Other	NR	Professional
Scheeringa et al. (2011)	Social worker	Mixed	Other	Other	Professional
Schottelkorb et al. (2012)	Counsellor	Master's	Other	Other	Lay
Shein-Szydlo et al. (2016)	CP/Psychiatrist	Master's	CP/Psychiatrist	Master's	Professional
Smith et al. (2007)	CP/Psychiatrist	Doctoral	CP/Psychiatrist	Master's	Professional
Stein et al. (2003)	Social worker	NR	Other	NR	Professional

Note: CP= clinical psychologist; NR = not reported

Analysis

All studies were included in the meta-analysis (n=35); individual effect sizes for each study can be found in Appendix D. Consistent with Hoppen & Morina (2020), pooling effect sizes suggested that TF-CBT interventions were better than control conditions at reducing PTSD symptoms (g = −0.73, 95% CI -0.96 to -0.50). This was true even when restricting the included studies to active control conditions. There was a large degree of heterogeneity between the studies (I^2 = 86%).

In order to address our primary questions, subgroup and moderator analyses were conducted to investigate the influence of specific therapist factors on treatment outcomes. Thirty-four studies were included in analysis comparing the effect of therapist professional background on treatment outcomes (see Table 1); one study was excluded (Cohen et al., 2005) as no therapist characteristics were reported. All therapist groups yielded significant effects, with the largest effect size (g=-1.22) found for clinical psychologists and psychiatrists; medium sized effects were observed for studies that used a mix of therapist types, social workers and other types of therapist.

Similarly, in further analysis of therapists' educational background, therapists trained to doctoral level appeared to show the largest effects (g=-1.18). Small to medium sized effects were observed for therapists educated to school to master's level or with mixed educational background; however, for masters and school educated therapists, these effects were not significant. This lack of significance may reflect the small numbers of studies that might be categorised in these specific ways.

A significant moderating effect was found when comparing the treatment outcomes of clinical psychologists and psychiatrists versus other professionals (p=0.03), however further inspection revealed that studies employing doctoral-level therapists predominantly utilised a *passive* control arm; this significant effect was no longer apparent once this confound was controlled for (i.e., only studies using a passive control group; see Table 1). Further moderator analyses found no significant

difference between therapist profession or education level (i.e., master's level qualification or above versus other; lay versus professional) and PTSD treatment outcomes, regardless of whether all studies were included or studies were restricted to active or passive control conditions only (see Table 1). However, it is important to note that some comparisons involved very few studies; for example, only one included study employing lay therapists utilised a passive control arm, compared to six utilising an active control.

Table 3: Results on the efficacy of TF-CBT interventions for child and adolescent PTSD

Analysis	k	Hedge's g	95% CI	I^2 (%)	Moderator test coefficient (Q test statistic)	p
All studies	35	-0.73	-0.96, -0.50	86	-	-
By control condition:					10.74	<0.01
ACC	19	-0.43	-0.69, -0.17	80		
PCC	16	-1.08	-1.38, -0.79	80		
By profession:					-	-
CP /Psychiatrist	7	-1.22	-1.71, -0.73	69		
Counsellor	8	-0.39	-0.82, -0.03	78		
Social worker	4	-0.73	-1.33, -0.12	93		
Mixed	10	-0.77	-1.15, -0.38	84		
Other therapist	5	-0.67	-1.22, -0.13	40		
By educational level:					-	-
Doctoral	7	-1.18	-1.71, -0.65	65		
Master's	5	-0.47	-1.05, 0.11	92		
School	2	-0.56	-1.43, 0.31	93		
Mixed	9	-0.66	-1.93, -0.23	80		
CP/Psychiatrist vs other, ALL					4.73	0.03
CP/Psychiatrist	7	-1.21	-1.63, -0.78	69		
Other	18	-0.66	-0.90, -0.42	76		

CP/Psychiatrist vs other, ACC					NA		NA
CP/Psychiatrist	1	0.27	-0.81, 1.35	NA			
Other	13	-0.51	-0.83, -0.20	80			
CP/Psychiatrist vs other, PCC					1.52		0.22
CP/doctoral	7	-1.20	-1.62, -0.79	69			
Other	6	-0.84	-1.24, -0.44	71			
Master's plus vs other, ALL						<0.01	0.98
Master's plus	14	-0.81	-1.19, -0.44	84			
Other	9	-0.81	-1.27, -0.34	85			
Master''s plus vs other, ACC					0.89		0.35
Master's plus	6	-0.24	-0.71, 0.22	67			
Other	9	-0.54	-0.93, -0.15	85			
Maste'rs plus vs other, PCC					0.04		0.83
Masters plus	11	-1.00	-1.36, -0.65	72			
Other	3	-1.08	-1.77, -0.40	86			
Lay vs Professional, ALL					0.83		0.36
Lay	6	-0.53	-1.03, -0.02	85			
Professional	28	-0.78	-1.01, 0.55	82			
Lay vs Professional, ACC					0.04		0.85
Lay	6	-0.46	-0.91, -0.02	86			
Professional	14	-0.41	-0.68, -0.14	72			
Lay vs Professional, PCC					NA		NA

Lay	1	-0.30	-1.48, 0.88	NA
Professional	15	-1.15	-1.46, -0.83	80

Note. ACC = active control condition; CP = clinical psychologist; Master's plus = therapists educated to master's level or above; PCC = passive control condition.

Discussion

This project aimed, firstly, to collate and summarise the data regarding the professional characteristics of therapists who are delivering TF-CBT interventions for children and young people in clinical trials and, secondly, to understand whether trial therapist factors influenced the efficacy of TF-CBT in RCTs.

The review found that across the 35 clinical trials examined, there was large variation in the professional backgrounds of the therapists delivering TF-CBT. Although there was also variation in the amount and type of training and clinical supervision provided for trial therapists, it was noted that the majority of therapists delivering TF-CBT were provided with specific training in the treatment model and received regular clinical case supervision; many of which on at least a fortnightly basis. This finding does not corroborate with reports of supervision and training provision for therapists delivering TF-CBT in routine care. Laksa and colleagues (2013) previously highlighted that there is frequently a disparity in the level of training and supervision provided in RCTs compared with the amount therapists receive in routine care, which could risk reducing the external validity of trial results. The British Association for Behavioural and Cognitive Psychotherapies (BABCP, 2021) recommends that accredited CBT therapists receive at least 90 minutes of clinical supervision per month to cover their caseload, which is significantly less than the amount provided in the majority of trials in the current review, particularly when therapists in routine care are likely to have multiple clients to discuss in supervision. In terms of training, many therapists delivering TF-CBT in routine care have reported experiencing a lack of training in trauma approaches which provide a barrier to them delivering evidence-based care for clients experiencing PTSD (Finch et al., 2020b). Similarly, a survey completed in Canada by Czincz and Romano (2013) found that 78% of trauma therapists working with children had received no training in trauma approaches and 66% reported never receiving clinical supervision. These findings suggest that in order to deliver similar patient outcomes

in routine care that treatments are providing in clinical trials, more must be done to increase supervision frequency and improve training opportunities for therapists.

The results of the current meta-analysis suggested that TF-CBT interventions performed better than control conditions at reducing PTSD symptoms, a finding consistent with numerous previous reviews in this area (e.g. Hoppen & Morina, 2020; John-Baptiste Bastien et al., 2020; Mavranezouli et al., 2019). With respect to our research questions, there was no significant difference between therapist profession or therapist education level on PTSD treatment outcome. In line with conclusions drawn from the previous study in this area (Pfeiffer et al., 2020), this result suggests that therapists from a variety of professional backgrounds are able to deliver TF-CBT effectively. However, this finding must be set within the context of the current research being conducted within an artificial, RCT setting and therefore clinicians usually received a significant level of training and supervision – arguably more than is likely to be received in routine care. Although it is encouraging that a wide range of clinicians can deliver TF-CBT effectively, these findings should be replicated within routine care before generalisations can be made. Nevertheless, the current findings have potentially significant clinical and economic implications for health services. The suggestion that therapists with minimal professional training can provide PTSD treatment outcomes comparable to doctoral level clinicians has potential implications for future service development and cost-saving strategies.

As the present study took into account the vastly different professional backgrounds of the therapists, the current sample is likely to be representative of clinical practice, although levels of training and supervision may differ. Moreover, as a number of the clinical trials included were conducted in non-Western countries, there is also potential for generalisability of these findings across cultural contexts and healthcare systems. It is also hoped that the results of this study may go some way to improve clinician confidence in delivering evidence-based treatments for PTSD in

children, particularly around aspects of treatment such as exposure, which many clinicians report negative beliefs about (e.g. Feeny et al., 2003; Gunter & Whittal, 2010; Zoellner et al., 2011) but are a component of many TF-CBT treatments.

The current review utilised the search strategy of Hoppen & Morina (2020) to investigate RCTs examining the efficacy of psychological treatments for children and young people with PTSD. Alternative methodologies could be considered and would likely reveal alternative perspectives. Utilising a search strategy which incorporated "therapist factors" as a specific search-term could broaden the variety of therapist factors considered further than just the professional factors reported by RCTs. For example, future reviews regarding the effects of gender, age or personality differences would be useful to inform efficient matching of therapist and patient (Johns et al., 2019). It is possible that other therapist factors which could not be captured in the current review contributed to the outcomes; again this highlights the importance of more thorough reporting of clinician factors within clinical trials.

This is the first meta-analysis on the efficacy of TF-CBT interventions for PTSD in children and young people that assessed the potential influence of therapist characteristics on treatment efficacy. The ability of the review to differentiate between passive and active control conditions meant that this potential confound could be reduced, thus revealing that, although a significant effect was found for doctoral-level clinicians, this was no longer present once passive controls had been removed. However, several limitations relate the to the categorisation of therapist factors and how these were operationalised. The variety of professional backgrounds of the therapists used in clinical trials made grouping therapists challenging. Determining the educational level of clinicians involved was also hard to determine with any clarity; for example, some social workers may have obtained a master's level degree and others may not. This became additionally challenging when cultural differences were considered, as different routes to professional qualification are employed in different

countries. In practice, the most common route to qualification for that particular profession in the UK was assumed by the researchers and any uncertainties were considered in consultation with the project's supervisor.

An additional challenge in conducting the review was the lack of consistency in the therapist data reported by trial researchers; this limited the breadth of the review as missing data meant that some comparisons included very few studies. Recent reviews studying therapist effects have highlighted concerns that therapist characteristics are generally neglected in the clinical research process (Fjermestad et al., 2016; Karver et al., 2005). There is currently no clear guidance to researchers on the type of therapist data that should be reported in clinical trials which provides challenges when looking to understand the effects these might have on treatment outcomes. Future research would benefit from comprehensive reporting of therapist characteristics such as professional background, years of clinical experience and educational history as well as a thorough summary of the training provided during the trial and the nature of supervision provided. The consistent reporting of these factors would significantly improve the quality of future research into the influence therapists have on treatment outcomes and allow for useful clinical recommendations to be made as a result.

In conclusion, the results of this review support previous findings that TF-CBT is an effective psychological treatment for PTSD in children and young people and suggests that a variety of therapists with varied educational and professional backgrounds are able produce positive results when delivering this treatment for the current population within an RCT setting. However, limitations regarding the comprehensiveness of data availability necessitate the need for further research seeking to understand the effect that therapist factors may have on treatment outcomes for young people experiencing PTSD.

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Chapter Two: Bridging Chapter

The previous chapter suggested that, not only is trauma focussed-CBT (TF-CBT) an effective treatment for children and young people with post-traumatic stress disorder (PTSD), but it can be delivered successfully by a wide range of therapists from a variety of professional backgrounds within the context of a randomised controlled trial. The chapter also summarised the amount of training and supervision which is provided to therapists in clinical trials before they deliver trial therapies to children and young people. However, there is evidence to suggest that, despite clinical guidelines advocating evidence-informed practice, there is frequently a gap between research protocol and clinical practice (Hoagwood & Olin, 2002; Ruzek & Rosen, 2009). A survey by Finch and colleagues (2020b) indicated that UK clinicians were reporting a significant lack of training and supervision related to trauma work which impacted on their confidence in delivering evidence-based treatments. This finding has been echoed in previous surveys, for example, in a sample of Canadian psychologists working with sexually abused young people, only 5% had received training in TF-CBT despite this being an evidence-based treatment for this population (Czincz & Romano, 2013). It therefore feels important that further investigations are undertaken to understand the experiences of clinicians delivering trauma-focussed treatments within routine care to support insight into potential barriers to evidence-based practice.

Furthermore, with a growing body of evidence supporting the use of TF-CBT interventions, a number of treatment variations are being trialled which employ cognitive and behavioural mechanisms. One example of this is cognitive therapy for PTSD (CT-PTSD) which is a structured, manualised psychological treatment for PTSD (Smith et al., 2009) based on mechanisms implicated in the cognitive model of PTSD (Ehlers & Clark, 2000). CT-PTSD has already been shown to be efficacious for young people who have experienced single-event trauma (Meiser-Stedman et al., 2017; Smith et al., 2007) and is now being trialled with young people who have experienced multiple traumatic experiences.

As well as gathering efficacy data on emerging TF-CBT treatment, it is also important that treatment acceptability is monitored. Treatment acceptability has been defined as the degree to which an individual perceives a treatment procedure to be fair, reasonable, appropriate and unintrusive for a given clinical problem (Kazdin, 1980). A 2006 survey into the acceptability of psychological treatments for PTSD revealed that respondents rated cognitive therapy, exposure and psycho-education to be the preferred aspects of treatment (Tarrier et al., 2006). However, these findings do not correlate with some of the literature around trauma therapists' views of TF-CBT treatments. For example, despite good evidence to support the efficacy and patient acceptability of exposure-based treatments, there appears to be a commonly held view amongst some professionals that these methods can be potentially harmful or unacceptable to patients (Kilpatrick & Best, 1984; Pitman et al., 1991; Scott & Stradling, 1997). As "clinician confidence" and "fears around client distress" have both been noted as barriers for patients receiving evidence informed treatments (Finch et al., 2020a), it is important that, when building an evidence base, the acceptability of treatments to clinicians are explored, along with that of patients, to build insight into any potential barriers for delivery within routine care.

Building an understanding of the experiences of the therapists delivering psychological therapies for PTSD is also important from a wellbeing perspective. It is now widely recognised that indirect exposure to trauma can lead to significant emotional and behavioural changes (Bride et al., 2007) which may be a contributing factor as to why trauma therapists have been shown to be at increased risk of secondary trauma and burnout (Herman, 1992; Hesse, 2002). Indeed, the emotional burden of trauma work on the therapist has been noted as a barrier to clinicians delivering evidence-based PTSD interventions (Finch et al., 2020a).

The study described in the following chapter was designed to understand the views of NHS clinicians who are delivering CT-PTSD for children and young people in routine care, as part of the DECRYPT (Delivery of Cognitive Therapy for Young People After Trauma) trial. The study aimed to develop a rich understanding of what it was like to deliver CT-PTSD to children and young people, as well as a wider understanding of the therapists' experiences of working within the NHS and receiving trauma informed clinical supervision and training.

Chapter Three: Empirical Paper

Prepared for submission to European Journal of Psychotraumatology

Clinicians' experiences of delivering Cognitive Therapy for PTSD with children and young people

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Abstract

Background & Objectives

There is growing evidence supporting the use of trauma-focussed cognitive behavioural therapies (TF-CBT) for children and young people who have experienced post-traumatic stress disorder (PTSD). As the research highlights that clinicians are critical agents in ensuring that best practice is adopted within healthcare services, it is important that acceptability of trauma-therapies to clinicians is understood. This qualitative project looks to understand the experiences of therapists delivering trauma-focussed treatments for young people within routine NHS care. This project was conducted as part of the DECRYPT trial (Delivery of Cognitive Therapy for Young People after Trauma), a randomised controlled trial (RCT) looking to evaluate the effectiveness of Cognitive Therapy for Post-Traumatic Stress Disorder (CT-PTSD) with children and young people.

Method

Ten therapists who had delivered CT-PTSD for at least one young person within Child and Adolescent Mental Health services (CAMHs) as part of the DECRYPT trial were interviewed. Data from the interviews was transcribed and analysed using thematic analysis.

Results

Participants' responses were summarised through four key topic domains: "the experience of being a trauma therapist", "CT-PTSD treatment", "supporting services to deliver CT-PTSD in the future" and "involvement in research".

Conclusions

Delivering trauma therapies for children and young people within NHS settings can feel challenging for clinicians but improved access to training and supervision may support them to feel more confident. The majority of clinicians found CT-PTSD to be an acceptable and effective treatment to deliver within mainstream care.

Keywords: PTSD, children and adolescents, cognitive therapy for PTSD, qualitative, trauma therapists

Introduction

Background and Rationale

More than two- thirds of children have experienced at least one traumatic event by the time they reach 16 years old (Copeland et al., 2007); of these children, studies suggest that 16% will go on to develop Post-Traumatic Stress Disorder (PTSD; Alisic et al., 2014) and this figure can rise to 74% if young people have experienced direct interpersonal trauma such as sexual assault (Lewis et al., 2019). PTSD is characterised by pervasive reliving of traumatic events through flashbacks and nightmares, as well as hypervigilance to threat and avoidance of any reminders of the traumatic event (American Psychiatric Association, 2013).

Despite the fact that trauma-exposed young people have been found to be twice as likely to develop mental health conditions such as depression, substance misuse and suicide, surveys suggest that only one in five young people with PTSD in the UK has accessed support from a mental health professional (Lewis et al., 2019). These findings indicate that there is a significant demand for effective therapeutic service provisions for young people who have experienced trauma. NICE guidelines (2018) recommend that the primary provision for trauma-exposed young people is psychological therapy, in particular trauma-focussed cognitive behavioural therapy (TF-CBT). Empirical support for TF-CBT in adult populations is substantial and the evidence-base for its use with young people is rapidly gaining momentum, however the literature suggests that despite this, there appears to be an evidence-practice gap in the delivery of trauma-informed therapies (Becker et al., 2004; Allen et al., 2011; Czincz & Romano, 2013).

When exploring the barriers to providing evidence-based treatments for PTSD, it becomes evident that clinicians are critical agents in ensuring that best practice is adopted (Adams et al., 2016). A

recent survey found that NHS clinicians are reporting a lack of confidence in treating trauma in young people due to insufficient training, supervision and experience (Finch et al., 2020b).

The literature has also highlighted clinician concerns around acceptability of trauma therapies which could be providing an additional barrier towards its implementation in routine care. Feeny and colleagues (2003) argued that clinicians' reluctance to implement aspects of TF-CBT such as exposure techniques, was due a number of commonly held treatment beliefs such as interventions being too rigid to formulate around clients' needs and anxieties around clients' symptoms worsening through therapy. However, a qualitative study conducted in Zambia concluded that child counsellors delivering TF-CBT found the treatment to be positive to facilitate (Murray et al., 2014).

Previous studies have also highlighted the need for further research into the experiences of therapists delivering trauma treatments not only to ensure the best outcomes for patients, but to understand how best to support the wellbeing of the therapists themselves, who have been shown to be at significant risk of secondary trauma and burnout (Herman, 1992; Hesse, 2002).

The current study

The primary objective of this qualitative project was to understand the experiences of clinicians delivering Cognitive Therapy for PTSD (CT-PTSD) with young people, as part of the DECRYPT (Delivery of Cognitive Therapy for Young People After Trauma) study. The DECRYPT study is a UK-based randomised controlled trial (RCT) looking to evaluate whether CT-PTSD is an effective treatment for PTSD for children and young people aged between 8-17 years old presenting in child and adolescent mental health services (CAMHS) compared to treatment-as-usual (TAU; See Appendix I for more information). CT-PTSD is a structured, manualised psychological treatment for PTSD (Smith et al., 2009) based on cognitive mechanisms implicated in the cognitive model of PTSD (Ehlers & Clark, 2000; See Appendix J for more information). CT-PTSD has already been shown to be efficacious for young people who have experienced a single traumatic event (Meiser-Stedman et al., 2017; Smith et

al., 2007) and is now being trialled with young people who have experienced multiple traumatic experiences. In the DECRYPT trial, CT-PTSD was delivered by NHS CAMHS clinicians with varied professional backgrounds and levels of experience working with trauma. The therapists were not required to have previous training in CBT, but all attended a two-day training in CT-PTSD facilitated by the DECRYPT trial Chief Investigator.

The current project aimed to hear the experiences of the clinicians who took part in the DECRYPT trial to further understand the acceptability of CT-PTSD to those delivering the treatment; the perceived feasibility of CT-PTSD as a treatment in CAMHS, as well as exploring the general experiences of clinicians treating trauma in routine practice, which may help to understand how the evidence-practice gap can be reduced and how we can support clinicians more effectively.

Method

Participants

In total, 22 therapists were invited to take part in the study, with a consent rate of 46%. Participants were 10 clinicians working in NHS CAMHS or youth mental health services who participated in the DECRYPT study as CT-PTSD therapists. Clinicians were recruited from four NHS Trusts across England. The eligibility criteria for therapists in the DECRYPT study and additional criteria for the current qualitative study are detailed in Table 4. All eligible DECRYPT clinicians were invited to take part by the primary researcher (LG).

Table 4: Inclusion and exclusion criteria for trial therapists.

DECRYPT Trial therapists must all meet the following criteria:	(1) Clinicians will have an appropriate professional qualification (e.g. as a nurse, occupational therapist, clinical psychologist, social worker, psychiatrist or BABCP-registered cognitive-behavioural therapist)

	(2) Clinicians will have completed training in CT-PTSD, as approved by a member of the trial team
	(3) Be approved by their site Principal Investigator to act a trial therapist
	(4) Receive clinical supervision from a member of the trial team while working with trial participants
	(5) Record all treatment sessions (to help monitor and ensure treatment adherence)
	(6) Allow therapy supervisors to review all therapy session notes and rate adherence to the CT-PTSD model; this would involve audio recording of sessions.
Additional criteria required for participation in the current qualitative study:	(1) Clinicians must be currently working, or have previously worked, as a trial therapist for the DECRYPT Study
	(2) Clinicians must have completed a course of CT-PTSD with at least one clinical case

Procedure

The main trial study was approved by The UK Health Research Authority Cambridge South Research Ethics Committee (16/EE/0233, in July 2016; Appendix M-N)

All clinicians involved in DECRYPT provided verbal consent to being contacted by the research team regarding the opportunity to participate in the present study, clinicians were then invited to take part by email. All clinicians were provided with an information sheet (see Appendix K) and provided informed consent prior to participation (see Appendix L).

Data was collected through semi-structured interviews facilitated by the first author (LG). Due to participant preference and restrictions in place due to the Covid-19 pandemic, all interviews took place over the telephone or video call. Interview guides were designed in collaboration with the DECRYPT trial team with feedback from public and patient involvement (PPI) representatives.

The interview guides covered four main areas of interest which are detailed in Table 5 with example questions provided. Full interview topic guides can be found in Appendix O.

Table 5: Examples of key questions asked during the Clinician interview

Area of interest	Example question
(1) CT-PTSD training and initial thoughts on the therapy model	What are your initial thoughts on the CT-PTSD training you received?
(2) Delivering the therapy	How did you find delivering CT-PTSD as a treatment for PTSD with the children and young people that you worked with?
(3) Clinical supervision	How did you find the supervision you received for you CT-PTSD cases?

(4) Completion of treatment	Have there been any ways in which your work on the DECRYPT trial has changed your own clinical practice or that of the service you work in?

Analysis

All interviews were audio recorded and transcribed verbatim. Data was analysed by the first author (LG) according to Reflexive Thematic Analysis (Braun & Clarke, 2019) using NVIVO version 12 software. Thematic analysis was used due to the exploratory nature of the project, as it does not require a specific theoretical framework but instead allowed for detailed examination of the data (Braun & Clarke, 2006). Data was analysed from an epistemological position of critical realism, assuming that an ultimate reality exists, but it is experienced and understood through lenses such as culture and language. Analysis followed an inductive thematic approach but was structured using research questions. After each interview, the interviewer made comments and reflections in a diary, in order to hold in mind researcher reflexivity and reflect on the interviewer's standpoint and epistemology. These reflective diaries were also used to aid with analysis, which was particularly important given the interviewer's previous link with the DECRYPT study. The reflective diary allowed the researcher to consider the process of carrying out the interviews as well as record the decision-making process during analysis. For example, the reflective diary was useful in recording the researchers' questions around whether she was noticing certain themes more than others due to her own views and biases. This could have made certain themes more prominent and therefore influenced the interpretation of the data. This reflection was useful to highlight areas of analysis which should be considered in collaboration with the project's supervisors to minimise bias.

Braun & Clarke's (2006) six phases of thematic analysis (see Appendix P) was utilised to guide the analysis process. Coding and the emergence of qualitative findings was reviewed by the author's supervisory team to support credibility.

Results

Therapist demographic information

Descriptive statistics are presented in Table 6. Of all eligible clinicians invited to take part in the study, 45.5% agreed to participate. Participating clinicians were mostly female (n=9) and had 3–17 years of clinical experience working with children and young people with an average of 8.7 years. All participants had previous experience of working with PTSD and previous CBT training or clinical experience. Participating clinicians had treated an average of 1.8 DECRYPT cases each. The mean length of qualitative interviews was 44 minutes, with a range of 32.

Table 6: Study Participant information

Index	Sample statistics (n=10)
Gender of clinician, n	
Female	9
Male	1
Professional Background, n	
Clinical Psychologist	5
Occupational Therapist/ CBT Therapist	2
Mental Health Nurse	1
Social Worker/ CBT Therapist	1
Psychiatrist	1

Years Clinical Experience working with children and young people, n	
0-5 years	4
6-10 years	2
10 + years	4
Clinicians with previous CBT training/experience, n	10
Clinicians with previous experience/ training in treating PTSD	10
Number of DECRYPT cases treated, n	
1 case	4
2 cases	4
3 cases	2

Key topic domains

Thematic analysis revealed four key themes relating to the exploratory research question of 'clinicians' experiences of delivering CT-PTSD with children and young people' (see Table 7). The themes are presented below with selective verbatim quotations to illustrate each theme and subtheme; additional quotations for each subtheme can be found in Appendix H.

Table 7: Key topic domains

Clinicians' experiences of delivering CT-PTSD with children and young people	
1	The experience of being a trauma therapist
1:1	The emotional burden of working with trauma

	1:2	The pressures of working within the NHS
2		CT-PTSD treatment
	2:1	The experience of delivering CT-PTSD with children and young people
	2:2	The benefits of training
	2:3	Everybody's clinical supervision needs are different
3		Supporting services to continue delivering CT-PTSD in the future
	3:1	The feasibility of CT-PTSD as a treatment in the NHS
	3:2	How to support implementation
4		Involvement in research
	4:1	The rewards and challenges of research involvement
	4:2	Improved clinician confidence in treating PTSD
	4:3	Impact on services

1. The experience of being a trauma therapist

Participants discussed their experience of delivering psychological treatments for trauma within the context of routine NHS care. They described the emotional experience of working with young people who have experienced trauma, particularly feelings of anxiety, and noted how this work often felt particularly challenging due to the current demand on NHS mental health services.

1:1. The emotional burden of working with trauma

Many of the clinicians interviewed described feeling anxious when working with a young person who has experienced trauma, particularly when there are additional complexities around the young person's presentation. One participant highlighted a gap between the clinical training that clinicians

receive, which often focusses on single-event trauma, and the nature of the cases which therapists see in clinic which are often much more complex.

Therapists alluded to a general sense of feeling under-prepared and under-confident when it comes to treating trauma which can lead to therapists avoiding taking on trauma cases.

> *"I think you can feel very underprepared, and as a clinician, you can feel like, 'oh my God, am I going to open up a big can of worms?' Or, 'I'm going to really destabilise client, the young person, because it means that they'll recall very, very stressful or traumatic events that they've been suppressing…"*– Participant 2

Clinicians also shared how the process of listening to the traumatic events the young person might have experienced can feel tiring and potentially put clinicians at risk of burnout or vicarious traumatisation, particularly when services are so stretched that their own wellbeing and supervision time might be limited.

> *"I do feel like, when I'm thinking with the team about what is it that stops people from doing that trauma work, I do think a big part of it is that people are really scared of having these conversations with people. Because it's such traumatic stuff to listen to and to actually get the detail of a rape or things, it's quite a hard conversation to have. So, that is probably an area people do need support with."* – Participant 9

A number of clinicians reflected on how, when working with trauma, confidence is particularly important for the work to be effective in helping young people and for clinicians to feel empowered not to avoid trauma work.

> *"…because you need to be able to go into the trauma without being scared yourself, so that you can help the child feel confident enough to do what they are scared of doing"* - Participant 6

The responses clinicians gave alluded to a systemic issue around therapists not feeling safe enough to effectively deliver trauma therapies. This appeared to be due to concerns around their own competence in this area and feeling inadequately supported to manage the associated emotional responses it might provoke for them personally.

1:2. The pressures of working within the NHS

Clinicians shared a view that young people struggling with trauma was a very common presentation in CAMHS. However, a number of clinicians expressed concern that due to limited resources, the service provided to young people who have experienced trauma was being compromised in a number of areas. They described long waiting times for treatment and concerns around children being unable to access the services and treatments they need due to inadequate funding.

> *"CAMHS, out of all services I think, is so under resourced …you really cannot provide what is needed or you can't allow the time that is needed, often, to be able to help the children and young people. You're always compromising the work in some way, just because of the amount of people that need to be seen."* – Participant 7

2. CT-PTSD treatment

All clinicians interviewed were asked about their experiences of delivering CT-PTSD with the young people they had worked with, in terms of how straightforward it felt to facilitate with young people

and how useful they felt certain components of the treatment were in supporting their clients. Clinicians also shared their experiences of attending training to deliver the CT-PTSD model and receiving clinical case supervision.

2.1. The experience of delivering CT-PTSD with children and young people

The vast majority of clinicians interviewed shared largely positive experiences of delivering CT-PTSD as a treatment for PTSD for young people.

> *"I thought it* [CT-PTSD] *was brilliant. It was one of those things where I thought, 'oh damn, why hadn't I have thought of it before?' It was so elegant and so simple and so logical, but yes, until it was pointed out, we didn't think about it or think of it. So, yes, it's really good."* – Participant 6

It appeared that the majority of therapists found the structure of the protocol helpful to provide a guide and alleviate the anxiety they might feel around delivering the trauma therapy, but also felt there was enough flexibility to tailor the treatment to the young person they were working with.

"*I think it was really nice because it was really flexible…You can pick and choose which bits you do in which order based on the needs of the client, rather than doing something in a particular, manualised way, which I find really helpful.*" (Participant 8).

Many clinicians highlighted particular aspects of the treatment which they found especially positive or effective for their clients. These were varied and were usually the aspects of treatment which clinicians felt contributed to their clients' improved functioning the most.

> "*Just the practical psycho-education, the grounding skills, the coping with flashbacks and distancing techniques and all of that wonderful stuff that people really find helpful."* – *Participant 7*

Clinicians also noted that parts of the treatment, such as exposure work, improved their confidence in delivering these aspects of trauma-focussed therapy which they might previously have felt anxious about.

There were some mixed opinions regarding the number of sessions recommended for delivering the full treatment model. Clinicians were asked to provide no more than 15 sessions of treatment, which some therapists found to be an adequate amount of time or, in some cases, they did not require this long to see positive outcomes. This appeared to be case- dependent though and some clinicians felt that the level of complexity with some of their clients required more than 15 sessions. It seemed that providing a flexible guide around the number of recommended sessions allowed clinicians to adequately address the complexity around their cases but still encouraged them to remain focussed on the treatment model throughout therapy. Some clinicians mentioned the temptation to deviate from the treatment model based on other difficulties that the young person might bring or to spend lots of time focussing on emotional regulation strategies, rather than remain focussed directly on the trauma therapy and the guide around session numbers helped to alleviate this.

Two clinicians highlighted some of the challenges they had experienced when delivering CT-PSTD with the young people in their care, although these views came in the context of a generally positive view of the model. One clinician expressed that they would have preferred the model to be more manualised. This participant shared that this was partly due to anxieties around delivering the treatment according to the research protocol, but also partly due to feeling apprehensive about conducting trauma therapy, in case they destabilised their client. Another participant raised

questions around how therapists would facilitate this treatment with young people who could not remember their trauma and also shared their feelings that their client may have been more suited to a model which had less of a cognitive focus.

2:2. The benefits of training

All clinicians who delivered CT-PTSD through DECRYPT had attended a two-day training course facilitated by the trial's chief investigator prior to delivering the treatment.

Overall, clinician's views of the CT-PTSD training they received was positive. Most clinicians expressed feeling confident to deliver the therapy with young people after the training was complete. Confidence was highlighted as a key barrier to clinicians feeling empowered to deliver trauma-focussed therapies, but it was noted that that training was reported to "ease anxieties" around this kind of work. However, when asked, most clinicians felt that their previous experience in delivering CBT interventions was beneficial when developing an understanding of CT-PTSD.

> *"Personally, I think without some actual formal background in CBT or having had quite a lot of experience of working within a team that offers that kind of therapy, I think it would've been quite challenging to offer it after doing the training."*- Participant 5

One participant noted how CT-PTSD training could benefit from some time spent reflecting on how delivering trauma therapies may bring up certain emotions or memories in the clinician themselves.

> *"I did find during the treatment as a clinician, just starting to get some nightmares about past things. And I was able to sit with that and think about why…I think that it just happens to a clinician, especially dealing with the young people and the traumas they've gone through. So I think that might be the only thing within future training…it might be useful for the clinician to think abou,t or the training element I suppose to make clear, working with*

people it can sometimes bring up your own experiences" – Participant 3

2:3. Everybody's clinical supervision needs are different

All clinicians were asked about their experiences of receiving clinical supervision for their CT-PTSD case through the DECRYPT trial and many spoke about their experiences of receiving supervision for trauma cases in their usual work.

A number of clinicians reflected on receiving regular supervision through the DECRYPT trial to be a positive experience, particularly compared to their usual practice where supervision was usually provided monthly to most of the clinicians interviewed, therefore more regular supervision was often viewed as a "luxury".

One clinician also highlighted how trauma cases may require more supervision than perhaps other clinical presentation due to the additional support which the therapist may require.

"you run the risk of being, not necessarily traumatised yourself, but it's quite difficult to hear some of these stories. You have to hear about what people have been through, having that more emotional support can be really helpful" - Participant 4

Most clinicians agreed that the amount of supervision required for trauma cases depended on how experienced the individual clinician was and the complexity of the particular case, rather than due to the nature of CT-PTSD treatment delivery.

"*The cases weren't all the same and the practitioners aren't all the same, so, I think it's hard to, probably, generalise that. And, I think, you probably need to offer what the person thinks*

they need based on complexity of client and experience of the person delivering it" – Participant 10

3. Supporting services to continue delivering CT-PTSD in the future

Clinicians reflected on whether they felt CT-PTSD was a feasible treatment to deliver in CAMHS, in terms of its effectiveness, acceptability and practicality for therapists and young people. Many participants also shared their views on ways in which CAMHS might need to be supported to implement CT-PTSD into mainstream care.

3:1. The feasibility of CT-PTSD as a treatment in the NHS

All participants shared a view that, in principle, CT-PTSD would be a feasible treatment to deliver in CAMHS. Clinicians reflected that as well as working practically within services, it was possible that CT-PTSD would be financially beneficial as it encourages clinicians to remain focussed on the treatment model which in turn may reduce the number of sessions required for young people to be treated effectively.

"Yes, I think it's not just helpful but it really feels very essential to provide a treatment like this. There's many aspects of the model that I think work really well for clients who have experienced traumas and multiple traumas. And I hope that people don't shy away from getting in there and processing memories, despite the fact that people may have experienced multiple traumas" – Participant 7

One participant also highlighted how, if left untreated, PTSD can become a chronic condition which could lead to young people requiring considerable support from mental health services on an ongoing basis and therefore supported the timely use of treatments such as CT-PTSD.

> *"I think the repercussions of not providing treatments like this is that you tend to see more of those revolving door clients or the problems persist in different ways or express in different ways. Whether it's through anxiety or depression or more externalising types of behaviours. If you're focussing just on those then you're not getting to the crux of the issue and a treatment like this isn't afraid to get to the crux of the issue."* - Participant 7

3:2. How to support implementation

Clinicians suggested a number of ideas and changes which they felt would support CAMHS to implement CT-PTSD into their everyday practice. A number of clinicians suggested nominating a PTSD "champion" within the service who could support the team in holding trauma in mind and in becoming more trauma informed.

> *"You need someone to champion it because there's so much demand and pressure and everything can become very operational, and I think to keep people thinking clinically about what's valuable and what actually young peoples' families need. You need someone to really hold that stance and view."* – Participant 1

Clinicians also highlighted the importance of DECRYPT providing dissemination of the study results to encourage evidence-based practice. Many clinicians highlighted the challenges in implementing and embedding new treatments such as CT-PTSD due to limited access to resources for clinicians such as training and supervision and high levels of staff turnover. This appeared to feed into clinician's explanations of staff teams feeling under-confident in treating trauma cases. Many clinicians shared

the view that if model-specific supervision and regular training were in place then CT-PTSD would be a helpful treatment to deliver in CAMHS and would also support clinicians to feel more confident in treating the high numbers of young people presenting in CAMHS with PTSD presentations.

> *"I think it is feasible if there was enough robust training combined with robust supervision and oversight over people's cases so they weren't drifting, and that people felt empowered to be able to deliver that."* – Participant 10

4. Involvement in research

All participants were asked about their experiences of contributing to this research trial and whether they'd noticed any changes in their own practice or in the team they were working in, as a result of being involved in DECRYPT.

4:1. The rewards and challenges of research involvement

A number of clinicians reflected on finding it rewarding and a "privilege" to be able to contribute to clinical research. However, some clinicians shared their experiences of feeling like their involvement in research provided an additional pressure to their already significant workload. They expressed feeling that protected work time may have made the experience more manageable for them.

> *"you weren't given any other time, so all the extra paperwork in terms of [trial database], uploading the things, any extra paperwork… that was all on top of doing my job full-time. So it was a great opportunity, but it was also a lot of work on top of what I was already doing*".
> – Participant 2

4:2. improved clinician confidence in treating PTSD

Many clinicians reflected on how their involvement in DECRYPT had improved their confidence and alleviated their anxieties around working with young people with PTSD, particularly using a cognitive-behavioural therapeutic model. Clinicians discussed how having the experience of treating cases using the CT-PTSD model in a supported way gave them the opportunity to experience that clients did not appear to become destabilised or retraumatised by the treatment, but instead, often had positive outcomes.

Clinicians reflected on how their work on DECRYPT has provided encouragement to address trauma with young people directly, whereas they might have avoided these conversations previously.

> *"There's this kind of false narrative that you need to move slowly in order not to upset the patient, which then gives the patient the idea that the trauma is so awful that even the therapist can't approach it. That, I think, was a key message from DECRYPT which I hadn't previously grasped. And since then, I've seen many patients where I have zoomed in and where they have been grateful. Where they've been very surprised also that I'm prepared to actually talk about the trauma, because they've been used to people tiptoeing around it. And particularly for children who've suffered abuse where they've been told, 'don't tell anyone'. If we then also don't ask questions about it, don't speak about it, we are complicit in keeping it secret and colluding with the trauma in a way."* – Participant 6

4:3. Impact on services

Clinicians perceived an apparent disconnect around the high prevalence of trauma cases presenting in CAMHS and the service-level awareness and confidence around addressing trauma. Clinician anxiety around addressing trauma appeared to be mirrored in service-level avoidance and lack of awareness around PTSD. Interestingly, participant responses suggested that services which found it easier to embrace the CT-PTSD model through their work with DECRYPT and supported clinicians learning and implementation of their skills as a CT-PTSD therapist, benefitted from an increased level of awareness and confidence in addressing trauma within their service, compared to teams who found it harder to embed the treatment.

One participant felt that being involved in DECRYPT had contributed to their service receiving an "outstanding" rating by the Care Quality Commission (the independent regulator of health and social care in England; CQC).

> *"The service had a CQC inspection and was rated outstanding… I think it was a combination of things. I think it was about being involved in research, but it also helped boost morale amongst staff, because staff felt more skilled to approach these children with serious trauma. So, they were more positive about the service, and also the feedback from children and families was more positive. So, I think it was a combination of all three things which really led to the outstanding rating being given. I'm pretty sure that had we not had DECRYPT come, we would not have got outstanding"* – Participant 6

However, there appeared to be a mix in terms of how participants felt DECRYPT had been embedded into their clinical team. One participant reflected that they had not noticed any service-level changes as a result of being part of the trial. This participant explained that this may be due partly due to:

"*a tumultuous few years for services, made more chaotic recently by COVID. So, if DECRYPT were seeds, they haven't fallen on fertile soil" (Participant 10).*

This participant, along with others, also reflected that, as results from the trial have not yet been disseminated, this may have had an impact on how much services have felt willing to embrace the approaches advocated by the trial and therefore this could change in due course.

Discussion

This qualitative study aimed to explore clinicians' experiences of delivering CT-PTSD for children and young people within the context of an RCT investigating the efficacy of this treatment within this clinical population. Thematic analysis identified four key topic domains which summarise the clinicians' responses.

As well as service-level contexts in which trauma work was delivered in routine care, clinicians reflected on the personal context to which they were approaching their trauma work. Participants shared a narrative around clinicians feeling chronically under-prepared and anxious when approaching trauma treatment with young people. Although clinicians could recognise the importance of feeling confident when delivering trauma therapy, it felt that a systemic feeling of under-confidence was preventing clinicians and services from delivering trauma-focussed treatments to young people as effectively as they would like to. This apprehension from clinicians around working with trauma-exposed young people has been noted in previous literature (Allen & Johnson, 2012) and a number of specific anxieties, particularly around fears that discussing trauma with young people may lead to "re-traumatisation" have been noted (Feeny et al., 2003; Finch et al., 2020a). These anxieties were echoed in the views shared in the current project, particularly around

aspects of the treatment such as exposure work. Despite a 2006 survey into the acceptability of psychological treatments for PTSD revealing that patients rated exposure to be one of their preferred aspects of trauma treatment (Tarrier et al., 2006), there appears to be a commonly held view amongst professionals that these methods can be potentially harmful or unacceptable to patients (Kilpatrick & Best, 1984; Pitman et al., 1991; Scott & Stradling, 1997). A number of clinicians in the present study reflected on how the experience of delivering CT-PTSD with children and young people alleviated their anxieties around therapy destabilising their clients as they were able to see improved outcomes through an increased focus on the trauma memories, which they may have previously avoided.

Some clinicians noted that their work on DECRYPT improved their confidence in working with young people with PTSD, due to the training and supervision provided, as well as due to the experience of seeing positive outcomes in their clients as a result of the CT-PTSD treatment. It has been previously noted that, although increased training and supervision is a facilitator to evidence-based care for PTSD (Finch et al., 2020a), there is frequently a disparity in the level of training and supervision provided in routine care compared to the level provided in clinical trials (Laksa et al., 2013). This disparity was evidenced by clinician responses in the current project with regular supervision and training being described as a “luxury”. The evidence suggests that this issue is not limited to UK health services, with surveys in Canada reporting that 95% of psychologists working with sexually assaulted children had received no training in TF-CBT (Czincz & Romano, 2013).

Clinicians also gave thorough feedback on CT-PTSD as a treatment for young people. The majority of clinicians interviewed felt that the treatment was comfortable to deliver, tolerated well by the young people they worked with and effective in alleviating trauma symptoms. Almost all clinicians felt that the treatment model was flexible enough to shape to the needs of their client, which is positive as lack of flexibility has been a frequently noted complaint of therapists delivering evidence-

based therapies (Kadzin, 2008; Kendall, 2011; Kendall & Beidas, 2007). These favourable opinions of the treatment echo previous research within both adult populations (e.g. Becker et al., 2004; Ehlers et al., 2013) and child populations (Meiser- Stedman et al., 2017) whereby patients found CT-PTSD to be an acceptable and effective treatment.

With this largely positive view in mind, clinicians gave their thoughts about how services could be supported to implement CT-PTSD within their usual care, such as through increased resourcing of service provision and widespread dissemination of trial results. The literature suggests that even when clinicians hold favourable attitudes towards treatments, there are still a number of barriers to implementation within routine care (Gray et al., 2007) and therefore further exploration into facilitators to implementation of evidence-informed practice is crucial (Aarons et al., 2010). Qualitative methods have been highlighted as particularly helpful way to explore this area (Palinkas et al., 2011; Teddlie & Tashakkori, 2003) so it is hoped that the current project will contribute usefully to the evidence base in this way.

This qualitative study sits within the context of the DECRYPT randomised controlled trial. There is growing discussion around the importance of process evaluation within the design of complex interventions as a way to, “assess fidelity and quality of implementation, clarify causal mechanisms and identify contextual factors associated with variation in outcomes” (Craig et al., 2008). The Complex Interventions Development Framework highlights the importance of conducting qualitative studies alongside RCTs in order to, “capture emerging changes in implementation, experiences of the intervention and unanticipated or complex causal pathways and explain qualitative findings” (Moore et al., 2015). It is hoped that the current qualitative project contributes usefully to the process evaluation of the DECRYPT study in this way.

The current project should be viewed in light of a number of limitations. Firstly, volunteer sampling has limited the conclusions that can be drawn from this project; it may be that clinicians who had more negative views on the treatment felt less inclined to participate. Furthermore, all participating clinicians had prior experience of working with trauma and of using a CBT model; it is not possible to know if this was representative of the population of DECRYPT trial therapists and, if not, how the views of clinicians with no CBT or PTSD experience differed to those in the current sample. The timing of data collection also meant that two NHS Trusts who participated in the DECRYPT study were not represented in this sample so the views cannot be generalised to be representative of all therapists who delivered CT-PTSD within the trial. Similarly, this project did not capture the views of therapists who received CT-PTSD training but who then did not go on to utilise it within their practice. Future qualitative projects would be beneficial to explore the views of these clinicians to gain a clearer understanding of the barriers to delivering the treatment following training. It is also difficult to know the process of how clinicians volunteered/ were selected by their services to become DECRYPT trial therapists and attend CT-PTSD training; it is therefore possible that the therapists trained may have been a particularly motivated group or already favoured CBT model of therapy.

Furthermore, it should be noted that a number of the authors of this paper, including the first author (LG), has had previous or current involvement in the DECRYPT trial. Although considerable efforts were made to reassure participants that their answers were confidential to the current trial team and their honesty was valued, it may be that participants felt reluctant to share more negative opinions. Similarly, findings must be viewed with consideration that the researcher's own biases may have had an impact on interpretation of the data, although attempts were made to limit this through use of a reflective journal.

The findings of this study suggest a number of implications for the clinical setting and areas for further exploration. Firstly, it feels important that clinicians' concerns around deficient resource for effective trauma treatments are addressed. In order to support trauma-exposed young people effectively, it is vital that trauma therapists feel confident in their ability to provide evidence-based treatments through adequate training and supervision and that their own wellbeing is recognised as a priority and unequivocally supported. Previous studies have highlighted the increased risks to the wellbeing of trauma-therapists for many years (Edelwich & Brodsky, 1980; Hermann, 1992; Hesse, 2002), therefore it feels important that therapist wellbeing is prioritised and effective support systems put into place to reduce the emotional impact of this work on clinicians.

This is, to the author's knowledge, the first qualitative study to explore the views of therapists delivering CT-PTSD to children and young people in the UK. However, the results correlate well with a comparable project conducted in Zambia by Murray and colleagues (2014) who interviewed counsellors delivering TF-CBT to children and also reported positive opinions of treatment, including the structure, flexibility and observed client outcomes. Clinician responses in the current project indicate that CT-PTSD appears to be an acceptable treatment to clinicians working in routine NHS care which they felt would be feasible to utilise more widely if the evidence supported its efficacy. It is clear that the views of therapists delivering TF-CBT treatments for children and young people are underrepresented in the literature, despite evidence suggesting that clinician factors can be important barriers and facilitators to evidence-based care; it therefore, it feels important that the views of therapists are explored further as the evidence base for this area grows.

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General Discussion and Critical Evaluation

The aim of this thesis was to understand the role of the therapist in the delivery of trauma-focussed cognitive behavioural therapy (TF-CBT) for children and young people with post-traumatic stress disorder (PTSD). The research aimed to, firstly, understand who was delivering TF-CBT for children and young people in clinical trials and then explore whether the type of therapist delivering the treatment moderated treatment effects. The project also looked to understand the experiences of therapists delivering cognitive therapy for PTSD (CT-PTSD) within routine care, as part of an ongoing clinical trial.

A systematic review synthesised relevant literature exploring the efficacy of TF-CBT for children and young people who have experienced trauma and extracted and analysed the data from 35 studies in total. The results suggested that there are a wide variety of different therapists delivering TF-CBT in clinical trials, with varying professional backgrounds. It was also found that the majority of clinical trials provide their therapists with regular clinical case supervision and specific training for delivering the treatment model. Our analysis found there to be no significant difference in efficacy of treatments delivered by therapists of different professional backgrounds, suggesting that TF-CBT is an intervention which can be successfully delivered by therapists of many different theoretical orientations and types of experience. These findings must, however, be considered in the context of randomised controlled trials, whereby a high level of clinician training and supervision is often present. For this reason, it would not be possible to generalise this finding to clinicians delivering TF-CBT within routine care without further research.

Following the systematic review and meta-analysis, an empirical study aimed to understand the experiences of 10 clinicians who had delivered CT-PTSD to children and young people. Participants views were summarised through four key areas: the experience of being a trauma therapist; delivering CT-PTSD with children and young people; supporting services to continue delivering CT-PTSD in the future and their experiences of being involved in clinical research.

Summary of the findings in the context of the literature

The growing evidence-base supporting TF-CBT for the treatment of PTSD for children and young people has led to it being recommended by the National Institute of Health and Care Excellence (NICE; 2018) as a first-line treatment for this population. The current meta-analysis supports previous findings that TF-CBT is an effective treatment for child and adolescent PTSD; this was true even when restricting the included studies to only active control conditions.

However, despite clear guidelines and increasing emphasis on the development, access to and implementation of evidence-based treatments for this population (NHS England, 2019) there is still a significant evidence-practice gap when it comes to trauma-informed interventions for young people (Ruzek & Rosen, 2009; Reid et al., 2017). Previous research has acknowledged that clinical guidelines alone are ineffective in establishing evidence-based care and, instead, implementation should involve systemic change (Ploeg et al., 2007) and, in particular, frontline clinicians are instrumental in facilitating evidence-based practice (Cook et al., 2017). Therefore, the role that clinicians play in the implementation and outcome of treatments for PTSD in youth are of particular interest.

It has been noted in the literature that clinicians feel increased levels of anxiety in treating children and young people who have experienced trauma, particularly due to feeling a lack of confidence in trauma-informed interventions and worries about “retraumatising” their client (Feeny et al., 2003;

Finch et al., 2020a). This finding was supported in the current qualitative study, where clinicians shared feeling "underprepared" and "underconfident" in treating children with PTSD. Similarly, another barrier highlighted in previous research was trauma therapists reporting a lack of training and supervision for their role (Czincz and Romano, 2013; Finch et al., 2020b). This again was echoed in the current empirical study with clinicians reported training and regular supervision to be a "luxury" in routine care.

In order to address these barriers to evidence-informed care, it is important that research looks to further understand the effect of therapists on treatment efficacy for children and young people with PTSD. Although there has been considerable research conducted investigating therapist effects generally, there has been very few for this population in particular and results are largely mixed. Podell and colleagues (2013) found that more experienced therapists predicted better outcomes for children receiving CBT for anxiety, however clinicians with more anxiety-specific clinical experience tended to produce less optimal outcomes. A previous study exploring therapist effects on TF-CBT outcome for children and young people concluded very little difference in the treatment outcomes of clients with different therapists (Pfeiffer at al., 2020). The current meta-analysis found a similar outcome, that a wide variety of therapists are able to deliver TF-CBT effectively, which, it is hoped, could go some way to alleviate clinicians' anxieties about treating this population.

However, it is important to hold in mind that the large majority of clinical trials included in the current meta-analysis provided treatment-specific training and regular case supervision to their trial therapists – a "luxury" that many trauma therapists in routine care feel they are missing out on, according to the current qualitative paper. Laksa and colleagues (2013) previously highlighted that there is frequently a disparity in the level of training and supervision provided in randomized controlled trials (RCTs) compared with the amount therapists receive in routine care. This should also be considered in light of the differences between training and support offered to therapists of

different professional backgrounds, particularly due to the multidisciplinary nature of clinicians delivering therapy for children and young people within routine care.

The results of the current empirical paper suggest that clinicians found CT-PTSD to be an acceptable treatment to deliver to children and young people who have experienced PTSD. This corroborates acceptability studies completed in both adult and child patient populations (Becker et al., 2004; Ehlers et al., 2013; Meiser-Stedman et al., 2017). Due to the role clinicians play in the implementation of evidence-based treatments within mental health services, it is promising that therapists largely found the current treatment to be an acceptable model to utilise in therapy. Previous studies have highlighted commonly held negative views amongst therapists regarding TF-CBT, particularly around aspects of treatment such as exposure (Kilpatrick & Best, 1984; Pitman et al., 1991; Scott & Stradling, 1997). Furthermore, most clinicians felt that the CT-PTSD model was flexible enough to formulate around their clients' needs, which is also encouraging, as lack of flexibility has been frequently highlighted as a complaint of therapists delivering evidence-based therapies (Kadzin, 2008; Kendall, 2011; Kendall & Beidas, 2007).

Strengths and limitations

The systematic review and meta-analysis included in the current portfolio is the first of its kind to provide a summary of the characteristics of therapists delivering TF-CBT for children and young people in clinical trials and look to understand the link between these characteristics and treatment outcomes. Similarly, the qualitative paper in this portfolio is the first to explore the experiences of therapists delivering CT-PTSD for children and young people within routine NHS services.

The completion of qualitative interviews in the empirical paper has provided rich and meaningful information around the perspectives of clinicians delivering trauma-focussed psychological

interventions with children and young people in NHS care. Care was taken to increase validity and credibility of the research through the completion of a reflective diary, and validity checks on the generation of codes and themes being completed by academic supervisors.

However, the qualitative project should be viewed in light of a number of limitations. Firstly, volunteer sampling has limited the conclusions that can be drawn from this project; it may be that clinicians who had more negative views on the treatment felt less inclined to participate. The sample also did not include clinicians who had no prior experience of CBT or working with trauma, therefore we cannot generalise the responses to include less experienced clinicians. This is regrettable as it makes it difficult to generalise how confident clinicians felt in delivering CT-PTSD from the training alone, as their previous experiences are likely to have affected their perceived confidence; this is important when understanding how much training is needed to deliver CT-PTSD effectively. Similarly, the study did not capture the views of therapists who received CT-PTSD training but who then did not go on to utilise it within their practice. Future qualitative projects would be beneficial to explore the views of these clinicians, to gain a clearer understanding of the barriers to delivering the treatment following training. Furthermore, there is no data available on how clinicians were selected or volunteered from their clinical teams to undertake CT-PTSD training for the DECRYPT trial; it may be that clinicians who were selected or volunteered to undertake training were a particularly motivated group or already favoured cognitive models of therapy. It should also be noted that a number of the authors of this paper, including the first author (LG) had previous or current involvement in the DECRYPT trial. Considerable efforts were made to reassure participants that their answers were confidential to the current trial team but it is possible that performance bias meant participants felt reluctant to share certain opinions. Similarly, findings must be viewed with consideration that the researcher's own biases may have had an impact on interpretation of the data.

The systematic review and meta-analysis were conducted in line with PRISMA guidelines (Shamseer et al., 2015), and the protocol was registered with PROSPERO to ensure the research transparency. The review synthesised the literature relating to TF-CBT interventions for children and young people experiencing PTSD. To ensure inter-rater reliability, a second reviewer was used throughout the review and data extraction process. However, the systematic review was not without limitations. Firstly, the categorisation of therapist factors was to some extent subjective and challenging due to the vastly different professional backgrounds of therapists utilised. Similarly, determining the educational level of clinicians involved was challenging as, in many cases, it was difficult to know the training or qualifications that clinicians may or may not have received as this was not reported in trial data. This became additionally challenging when cultural differences were considered, as different routes to professional qualification are employed in different countries.

Further limitations of the review included the small number of studies which could be included in certain comparisons; this was due to limited therapist data reported by some papers. A number papers did not report clear therapist characteristics such as professional background and few reported comprehensive information regarding the nature and duration of training and supervision provided, meaning this data could not be included in statistical analyses.

Clinical implications

The results from this thesis portfolio provide a number of implications for clinical practice. Firstly, the results of the meta-analysis provide support for the already substantial evidence base for TF-CBT as an effective treatment for PTSD in children and young people. Moreover, this study indicates that TF-CBT can be delivered successfully by a variety of therapists from different theoretical orientations and professional backgrounds. If this finding can be replicated, it has potential economic implications for healthcare services, as analysis did not find that more highly qualified therapists produced significantly different results compared to therapists with minimal training. However, the

review did indicate that the majority of clinical trials in which these positive outcomes are shown, provide specific training to their therapists in delivering the TF-CBT model and provide regular supervision – arguably more than is received in routine healthcare. This suggests that in order to replicate the findings produced in clinical trials for children and young people, it is important that healthcare services take on board the context in which trial therapists are working and look to replicate this as far as possible.

The qualitative study aimed to understand the views of therapists delivering CT-PTSD in routine care. It revealed a number of issues which require further exploration and attention from healthcare providers. For example, clinicians highlighted concerns that limited resourcing could be affecting the quality of care provided to children and young people that are experiencing trauma and that therapists are frequently feeling underconfident in providing effective care for this population. Clinicians also shared largely positive views around CT-PTSD as a treatment for trauma with young people. The treatment appeared to be acceptable to clinicians and most therapists felt it would be feasible to deliver within mainstream care. Clinicians also made helpful suggestions around ways to facilitate evidence-based practice in the NHS, through ideas such as “championing” specific diagnoses within teams and the introduction of model-specific supervision.

Directions for future research

This thesis has looked to highlight the role of the therapist in the delivery of TF-CBT for children and young people. Despite the important role that they play in delivering evidence-based treatments, the literature has raised concerns that therapist characteristics are generally neglected in clinical research (Fjermestad et al., 2016; Karver et al., 2005). It is important that future research focusses more on understanding the effect that therapists have on the treatment they are delivering and also to the effect that being a therapist might be having on their own health and wellbeing.

Future researchers may benefit from clear guidelines around the type of therapist data that should be reported in clinical trials, so that future reviews can deliver comprehensive results around therapist effects. Comprehensive reporting of data such as professional background, years of clinical experience and educational history as well as a thorough summary of the training provided during the trial and the nature of supervision provided would all go some way to support further research in this area.

Efforts to further understand the barriers and facilitators to evidence-based care would benefit from further exploration into clinician factors which might be affecting this; additional qualitative studies would be a useful way of gaining meaningful data in this area. Similarly, widening acceptability studies to include therapists would be useful to ensure evidence-based treatments are well-tolerated by the clinicians delivering them.

Conclusions

Overall, the results of the thesis portfolio indicate that TF-CBT can be effectively delivered for children and young people by a variety of different therapists, with no specific professional background yielding significantly superior treatment outcomes. When looking to understand the experiences of delivering trauma therapies in routine care, therapists shared their views around the pressures of working with PTSD within the context of NHS care; favourable views of CT-PTSD as a treatment; their ideas of how CT-PTSD could be embedded within clinical teams and their experiences of being involved in a research study. These findings highlight the importance of an improved focus on therapist factors in future research endeavours to develop a greater understanding of how we can support therapists and young people who have experienced trauma more effectively.

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Appendices

Appendix A: Reference list of included publications.

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Appendix B: Quality ratings for all included trials (Morina & Hoppen, 2020)

Study	Q1. PTSD diagnosis	Q2. Treatment manual	Q3. Therapist training	Q4. Treatment integrity checks	Q5. ITT analysis	Q6. Statistical power	Q7. Random group allocation	Q8. Blind outcome assessments	Q sum score /8
Ahrens & Rexford (2002)	0	1	1	0	0	0	0	1	3
Auslander et al. (2017)	0	1	1	1	0	0	1	1	5
Barron et al. (2016)	0	1	1	1	1	1	1	1	7
Catani et al. (2009)	0	1	1	1	1	0	1	1	6
Celano et al. (2009)	0	1	1	1	0	0	0	1	4
Cohen et al. (2004)	0	1	1	1	0	1	0	1	5
Cohen et al. (2005)	0	1	0	1	1	1	1	1	6
Cohen et al. (2011)	0	1	1	1	1	1	1	1	7
Dawson et al. (2018)	0	0	1	0	1	1	1	1	5
De Roos et al. (2011)	0	1	1	1	1	0	1	1	6
De Roos et al. (2017)	0	1	1	1	1	1	1	1	7
Deblinger et al. (1996)	0	1	1	1	0	0	0	0	3
Diehle et al. (2015)	0	1	1	1	1	0	1	1	6
Ertl et al. (2011)	1	1	1	1	0	1	0	1	6
Foa et al. (2013)	0	1	1	1	1	1	1	1	7
Gilboa- Schechteman et al. (2010)	1	1	1	1	1	0	1	1	7
Goldbeck et al. (2016)	0	1	1	1	1	1	1	1	7
Jensen et al. (2014)	0	1	1	1	1	1	1	1	7
King et al. (2000)	0	1	1	1	1	0	0	0	4
McMullen et al. (2013)	0	1	1	1	0	0	1	1	5

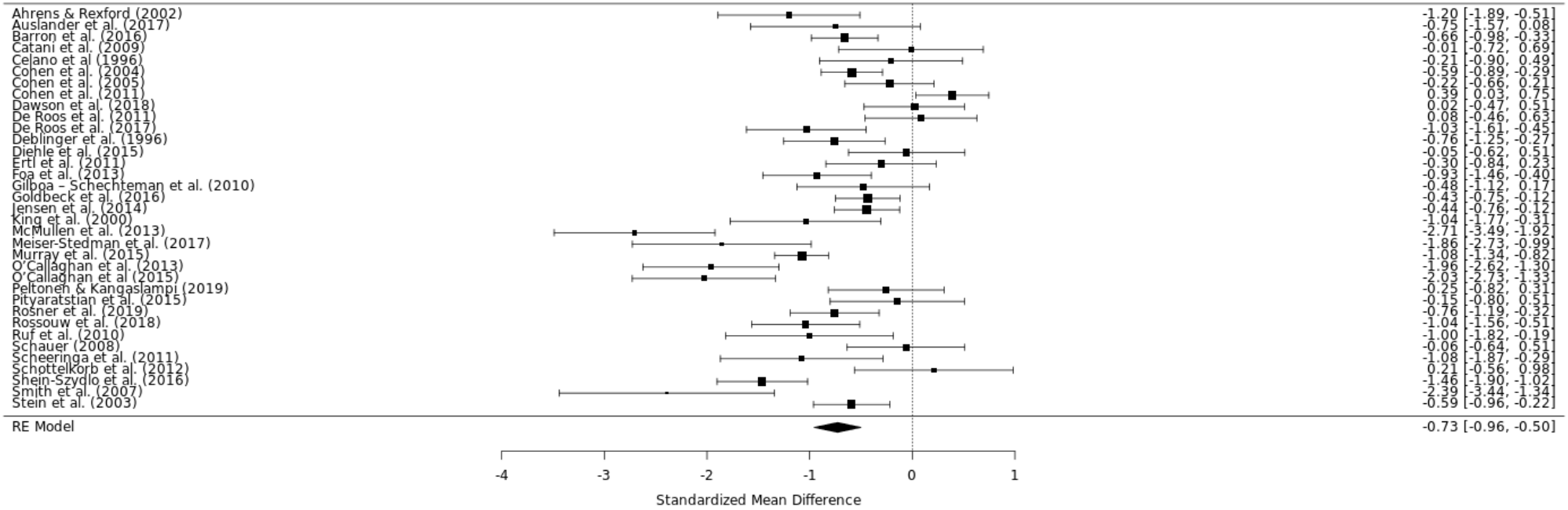
Meiser-Stedman et al. (2017)	1	1	1	1	0	0	0	1	5
Murray et al. (2015)	0	1	1	1	1	1	1	1	7
O'Callaghan et al. (2013)	0	1	1	1	1	1	1	1	7
O'Callaghan et al. (2015)	0	1	1	1	1	1	1	1	7
Peltonen & Kangaslampi (2019)	0	1	1	1	0	0	1	0	4
Pityaratstian et al. (2015)	1	1	1	0	0	0	0	1	4
Rosner et al. (2019)	1	1	1	1	1	1	1	1	8
Rossouw et al. (2018	1	1	1	1	1	1	1	1	8
Ruf et al. (2010)	1	1	1	0	1	0	0	1	5
Schauer (2008)	1	1	1	1	1	0	1	1	7
Scheeringa et al. (2011)	0	1	0	1	0	0	1	0	3
Schottelkorb et al. (2012)	0	1	1	1	0	0	1	0	4
Shein-Szydlo et al. (2016)	1	1	1	1	0	1	1	1	7
Smith et al. (2007)	1	1	1	1	1	0	1	1	7
Stein et al. (2003)	0	1	1	1	0	1	1	1	6

Appendix C: Quality items based on Cuijpers et al. (2010)

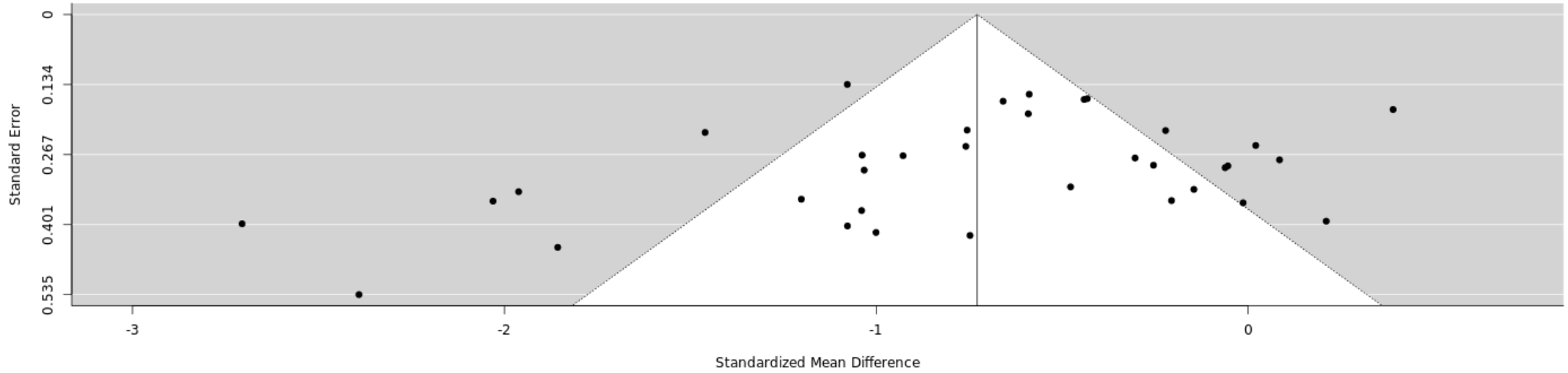
Q1	All participants met diagnostic criteria for PTSD according to DSM or ICD criteria at baseline as assessed with a personal diagnostic interview, such as the SCID	1. Positive 0. Negative / insufficient information
Q2	Use of treatment manual (i.e., published, or specifically designed for the study; in case of multiple experimental conditions all had to be were manual-based)	1. Positive 0. Negative / insufficient information
Q3	Therapists were specifically trained for the given therapy (i.e., particularly in advance to the study or only included trained therapists with substantial prior experience with the given therapy)	1. Positive 0. Negative / insufficient information
Q4	Treatment integrity was checked (i.e., by regular supervision and/or independent, systematic, quantitative analysis of protocol adherence measures)	1. Positive 0. Negative / insufficient information
Q5	Data analysed with intent-to-treat analysis (i.e., all relevant data were reported from ITT analyses)	1. Positive 0. Negative / insufficient information
Q6	Study had a minimal level of statistical power to find effects and included ≥50 participants in the comparison groups ((i.e., n of (smallest) experimental group + n of (smallest) comparison group ≥50))	1. Positive 0. Negative / insufficient information

Q7	Independent and random sequence generation/allocation (i.e., independent person, computer-generated or sealed envelopes)	1. Positive 0. Negative / insufficient information
Q8	Blind outcome assessments (i.e., blinded assessors; if only outcome measure was self-report-based the item was rated as fulfilled)	1. Positive 0. Negative / insufficient information

Appendix D: Forest plot of included studies (random effects model)



Appendix E: Funnel plot of included studies (random effects model)



Appendix F: PRISMA 2009 Checklist

Section/topic	#	Checklist item	Reported on page #
TITLE			
Title	1	Identify the report as a systematic review, meta-analysis, or both.	8
ABSTRACT			
Structured summary	2	Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.	9
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known.	11
Objectives	4	Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).	13
METHODS			
Protocol and registration	5	Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number.	13
Eligibility criteria	6	Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale.	13
Information sources	7	Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.	13
Search	8	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.	13
Study selection	9	State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).	14
Data collection process	10	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.	14

Data items	11	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.	14
Risk of bias in individual studies	12	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.	14
Summary measures	13	State the principal summary measures (e.g., risk ratio, difference in means).	15
Synthesis of results	14	Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., I^2) for each meta-analysis.	15

Section/topic	#	Checklist item	Reported on page #
Risk of bias across studies	15	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).	15
Additional analyses	16	Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.	15
RESULTS			
Study selection	17	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.	16
Study characteristics	18	For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.	18
Risk of bias within studies	19	Present data on risk of bias of each study and, if available, any outcome level assessment (see item 12).	93
Results of individual studies	20	For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group (b) effect estimates and confidence intervals, ideally with a forest plot.	26
Synthesis of results	21	Present results of each meta-analysis done, including confidence intervals and measures of consistency.	26
Risk of bias across studies	22	Present results of any assessment of risk of bias across studies (see Item 15).	17
Additional analysis	23	Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression [see Item 16]).	26
DISCUSSION			

Summary of evidence	24	Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., healthcare providers, users, and policy makers).	29
Limitations	25	Discuss limitations at study and outcome level (e.g., risk of bias), and at review-level (e.g., incomplete retrieval of identified research, reporting bias).	30
Conclusions	26	Provide a general interpretation of the results in the context of other evidence, and implications for future research.	32
FUNDING			
Funding	27	Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review.	N/A

Appendix G: Author guidelines for Journal of Child & Adolescent Mental Health

Author Guidelines

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: 2018: 75/124 (Pediatrics); 109/146 (Psychiatry); 93/142 (Psychiatry, Social Science); 78/130 (Psychology, Clinical).
- 6,239 institutions with access to current content, and a further 7,939 institutions in the developing world
- High international readership - accessed by institutions globally, including North America (25%), Europe (39%) and Asia-Pacific (13%)
- 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 84%
- Acceptance to Early View publication averages 6 weeks
- Simple and efficient online submission – visit http://mc.manuscriptcentral.com/camh_journal
- 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.

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).

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

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. For detailed instructions please go to: **http://mc.manuscriptcentral.com/camh_journal** and c*heck for existing account* if you have submitted to or reviewed for the journal before, or have forgotten your details. If you are new to the journal c*reate a new account.* Help with submitting online can be obtained from the Editorial Office at ACAMH (email: **publications@acamh.org**)

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.

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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 he or she had full access to all the data in the study and takes 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: Please disclose any conflicts of interest of potential relevance to the work reported for each of the authors. If no conflicts of interest exist, please include an explicit declaration of the form: "The author(s) have declared that they have no competing or potential conflicts of interest".

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 5,500 words including tables, figures and 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.

Your Review Article should be no more than 8,000 words excluding tables, figures and references and no more than 10,000 including tables, figures and references.

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.

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: **Gordon.Bates@covwarkpt.nhs.uk**. 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.

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 8 references. If in doubt, please contact the section editor **Rachel.Elvins@mft.nhs.uk**

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Appendix H: Additional illustrative data extracts

Subtheme	Illustrative data extracts
1:1	*"I think, generally, therapists tend to be really scared about working with PTSD, particularly when the clinical training doesn't tend to include people with more than a single-event trauma or where there's complexity."*- Participant 2
	"*I've noticed there's a lot of CBT therapists that start freaking out when someone comes and says they have childhood trauma and they're like, oh no, we can't work with them. They're too complex.*" – Participant 2
	"…particularly when you're doing reliving work on top of just your day- to-day CAMHS firefighting, I think the risks of vicarious traumatisation and burnout and all of that is probably greater." – Participant 7
	"I think generally therapists have all got the experience and competence to deliver work with children and young people about trauma. But it's more about confidence, about the distress you might have to help them tolerate and hearing difficult details sometimes". – Participant 1
1:2	*"Trauma is the main reason why children come to CAMHS. I'm now excluding neurodevelopmental disorders, although those children very often also suffer trauma. But if we just look at the general CAMHS, the vast majority are there because of trauma."* – Participant 6
	"I also think that resources need to be increased dramatically, because NHS England are actually admitting that they're only commissioning help for 30% of children who need it… they're admitting it. That means that 70% of children with mental health problems can't get help because the NHS doesn't have money to pay for it, which is an outrage" - Participant 6
2:1	*"it gives some sense of containment and security, knowing that there is a specific protocol that needs to be followed for both the therapist and the clients."* – Participant 7
	"The cognitive restructuring element of that, to me, seems to be the most helpful part of [the treatment]."– Participant 2
	"My favourite bit was the narratives, and updating the memory… And I've used that with clients who've not been on the trial as well."- Participant 8

	"the length I got to do the PTSD work felt fine and actually it fit really neatly in the amount of time we needed, it didn't feel like there was anything else left to cover." – Participant 4
	"I wonder if it needs more because I feel like with a lot of our young people, we're six sessions in but only really getting started. So, 15 sessions, I feel like we're only just at the beginning. And, I don't know, I wouldn't like to put a number on it but, yes, it feels quite early on actually, I feel like we could probably have 20 or 30 sessions with some of them." – Participant 9
	"*I think both of them had five sessions and they were better…It was miraculous. I don't know if it was the model or the experience of having a therapist. I think for both of them they hadn't had an experience of being listened to by their system before… I discharged them both in the space of six sessions"* – Participant 8
	"I had mixed feelings about that because I was really craving something very manualised, particularly as a research protocol, because my understanding of research therapy is that you don't deviate, and it really is very structured. So what I really wanted was a very strict protocol of just like, on Session One, you do this, this, and this, and what I got was something a bit more flexible." – Participant 2
	"I think looking at research, people are much more likely to develop PTSD or C-PTSD when they can't remember or perhaps they've dissociated. So, I think that was more difficult to get round with the model" - Participant 7
	"There was a less of an, 'okay what's going on and what's going on in your body?' and really guessing and connecting with memories in that way. That was the only thing about the model that I think, for someone like her, that does tend to stay in her head anyway, whether a therapy approach that would be getting her into her body more would be maybe beneficial" -Participant 7
2:2	"*I guess it always feels like a bit of a treat to get training in the NHS, because the resources are so tight*" - Participant 1
	"*As a clinician, you have to fight for training and job planning all the time."* - Participant 2
	"It just felt like something that I was quite comfortable to go out and to deliver" – Participant 5
	"Yes, I guess I felt relatively confident. I guess it wasn't particularly a new way of working for me, so it was more building on what I would already be doing. And I

	guess the advantage of the trial as well was, we had regular supervision to think really carefully about the kind of work we were doing in the case" – Participant 1
	"I think, if I hadn't been in a CBT therapist already, I would've felt much less confident in delivering this intervention". – Participant 2
2:3	*"It's a bit of a luxury in CAMHS to get weekly supervision, so, yes, it was great."* – Participant 4
	"I think weekly's so much better because, as a supervisor, you've got much more oversight over actually what people are doing week to week should they bring the cases. So I think any CBT therapist should have weekly supervision, whether they're working with complexity or not." - Participant 2
	"I would say that people without CBT would also be able to do it, because if I think of my colleagues who are child psychotherapists, for example, who haven't got CBT training, they would definitely be able to deliver it. So, yes, I wouldn't say it's a prerequisite." – Participant 6
2:3	*"I think it depends on the content of the trauma, rather than anything else. So, in terms of the model and the supervision around the model, I wouldn't need continual supervision on the model once I'd done a few cases."* – Participant 8
3:1	*"Yes, I think it is definitely feasible and I think it is essential. And I wouldn't say just nationally, I'd say internationally*". – Participant 6
	"I think with the current resources, the CT-PTSD model would save money because it would make therapists more effective… I would definitely say resources need to be increased, but also that CT-PTSD will save time." - Participant 6.
3:2	*"I think that probably that would come from some kind of post-trial debriefing where perhaps [Chief Investigator] and the team were able to say, this is what the feedback is, and this is what we think is useful for young people and maybe we could be a team who could try and implement that."* – Participant 5
	"In terms of practicalities that might be tricky. Because there's a high turnover of staff, it's nothing to do with the trial, but because there's a high turnover of staff it means that there might not be people trained in the treatment." – Participant 8
	"As long as CAMHS services continue to be under-resourced, I think would be incredibly difficult to offer a treatment like this to all the clients who really need it…It also depends on a lot of the social issues being addressed and that was

	often a problem… You could identify clients that would really potentially benefit from something like this, but they might not even be able to access it or attend sessions regularly or to really engage in the way that you need someone to engage to benefit from this sort of work, without destabilising." – Participant 7
4:1	*"It's quite a different experience to be part of a research trial in CAMHS. That's the only experience I've had of it, so that was quite nice to be a part of. It felt like we're contributing to research in that way. That was a different experience and nice to feel like we were helping out and contributing to a body of research, which again doesn't happen very often."* – Participant 4
4:2	*"Certainly training in this model has given me a lot more confidence in working with those clients who have a preference for, or who would suit, more of the cognitive work for PTSD."*– Participant 7
	"it's given me a bit more confidence to do reliving with these clients and not see it as something very scary and might destabilise the client."– Participant 2
4:3	*"I think our service being part of the trial, I think everyone just became more aware of thinking about trauma when they were formulating the assessment. So, I think there's probably a general shift for people to give and to value that as a way of understanding young people's difficulties more."* Participant 1

Appendix I: Further information about DECRYPT trial processes

The Delivery of Cognitive Therapy for Young People after Trauma (DECRYPT) randomised controlled trial (RCT) will examine the effectiveness of Cognitive Therapy for PTSD for treating PTSD in children and young people in comparison to treatment as usual. The trial is a two-arm, single blind,

superiority RCT comparing CT-PTSD (n=60) to treatment- as-usual (TAU, n=60) in children and young people aged 8-17 years with a diagnosis of PTSD following multiple trauma exposure. The primary outcome is PTSD severity assessed using the Child Revised Impact of Event Scale (8-item version) at post-treatment (i.e., approximately five months post-randomisation). Secondary outcomes include using the Child PTSD Symptom Scale for DSM-5, interviewer version (CPSS-I-5; structured interview, psychometric properties made available by authors Foa et al., 2013) to assess PTSD diagnosis and symptoms, with additional items for measuring dissociation and complex PTSD. Further questionnaires are completed assessing depression, anxiety, overall functioning and parent-related mental health.

Participants will be assessed five times during the study: baseline, mid-treatment (approximately 2.5 months post-randomisation), post-treatment (approximately five months post-randomisation) and at 11- and 29-month post-randomisation follow up assessments. Trained assessors collecting post-treatment and follow-up data are blinded to group allocation. These assessments are undertaken by trained assessors with no other role in the trial. Following allocation to CT-PTSD or TAU, all participants in the study, their care coordinator/ referrer and clinical team (if applicable) are asked not to reveal the group to which the participants were randomised to the trained assessor.

Appendix J: Further information about Cognitive-Therapy for PTSD for children and young people

The intervention CT-PTSD is a structured, fully manualised psychological treatment for children and young people with PTSD (Smith, Perrin, Yule & Clark, 2010). The treatment package has been adapted from Ehlers et al (2003) CT-PTSD for adults, to include age- appropriate techniques for

children and young people. It has been shown to be effective for children and young people experiencing single event trauma (Meiser-Stedman et al., 2017; Smith et al., 2007). Following this a number of adaptations for multiple traumatic experiences were made, which included increasing number of treatment sessions from 10-12, to approximately 15 therapy sessions, in order to allow for more time for trauma processing and stabilising other comorbid conditions such as depression.

The targets of CT-PTSD are to form more coherent, elaborated memories of traumatic experiences, restructure maladaptive appraisals relating to the trauma and its consequences and discourage the use of maladaptive coping strategies (as used by the child or young person, and where appropriate their family also).

CT-PTSD involves several core elements: psychoeducation, with an emphasis on the role of cognitive processes in the onset and maintenance of PTSD; narrative work and imaginal reliving to help develop a coherent trauma narrative; cognitive restructuring (to reframe the meanings and interpretations associated with trauma and its aftermath), and coping management (e.g., addressing maladaptive strategies such as thought suppression, rumination and safety-seeking behaviours). In working with youth exposed to multiple traumatic stressors, more time is spent on producing a timeline of the child's experiences (to help identify the most significant experiences but also to clarify autobiographical memory and address meanings around the onset and resolution of repeated trauma such as abuse or domestic violence) and where necessary, stabilization strategies (e.g., techniques for lifting mood, reducing self-harm, anxiety management, anger control)

The intervention was delivered by NHS CAMHS therapists (of any qualified background, i.e. nurse, psychologist) who completed a two-day training in CT-PTSD by a member of the trial team. The therapy took place either in NHS mental health clinics or at the young person's home. Following completion of CT-PTSD, participants were either discharged from CAMHS or continued with care as usual in CAMHS setting.

Appendix K: Therapist information sheet

-TRUST LOGO-

The DECRYPT Study:
Delivery of Cognitive therapy for Young People after Trauma

We are carrying out the DECRYPT study to improve our treatment of post-traumatic stress disorder (PTSD) for children and teenagers who have been through very scary or upsetting experiences.

You are contributing to the DECRYPT study as a therapist, referrer, or you work in the NHS. We would like to undertake an interview with you about your experience of being involved with this study, or interview you about the study findings.

Your participation is *entirely voluntary*.

What is the purpose of the study?

Children and young people who have PTSD might receive help from Child and Adolescent Mental Health Services (CAMHS) and other NHS services. We are trying to see if we can improve the care that services offer to youth with PTSD.

The DECRYPT study is looking at whether a talking therapy called "cognitive therapy" might be a good treatment for PTSD in children and young people. In order to understand how well it works, it is also important to allow people working in the study or who work in the NHS to explain *in their own words* what it was like to be involved in the study, or what they think about the study findings.

It is very important that we find out what you thought about all aspects of the DECRYPT study. This will enable us to improve the way in which treatment is delivered in the future. We would really value your opinions, ***positive or negative***.

Do I have to take part?

No – it is up to you to decide. If you do want to join in we'll ask you to sign a consent form, a copy of which you can keep with this information sheet.

You are free to withdraw from the study any time you like. You do not have to give us a reason if you choose to withdraw, but if you can give us any information that would help us to improve the study and think about how we offer care to young people with PTSD.

If you don't want to take part in the study or decide to withdraw from the study you will not be treated any differently by any NHS service or your doctor.

What will the interview involve?

We would like to interview you to discuss your experiences of the DECRYPT study. Your interview would be tailored to you and what involvement you had in this study.

The interview will probably take between 30 minutes and one hour to complete, although it may be a little shorter or longer than this depending on how much we have to discuss.

We would like to audio record the interview, for analysis. All recordings will be stored securely and then transcribed, at which point all information relating to your identity or that of your employer will be removed.

Who are conducting these interviews?
The interviews are being conducted by members of our team at the University of East Anglia, as part of the DECRYPT study. The DECRYPT study is funded by the National Institute of Health Research (NIHR).

Who is taking part in these interviews?
We are inviting some of the clinicians involved in the DECRYPT study to complete these interviews. We are also inviting other NHS staff to review and give us their thoughts on the study and its findings.

Confidentiality – who will know we are taking part in this study?
All information collected about you during the research will be kept strictly confidential. The only exception to this is if we believe that someone is in danger or at risk of being harmed, when we might need to seek other help. Information will only be analysed by members of our research team.

The results we obtain may be published in order to help other people working with children who have been in very scary or upsetting events. The results may include ***quotes*** from your comments during the interview – however, you or your employer will **not** be named and you will not be identifiable in these publications, e.g. we will *not* publish your name, where you live, or any other information that might identify you.

Has this research study been approved by an ethics committee?
Yes, this study has been checked by The Cambridge South Research Ethics Committee (16/EE/0233) and they have approved the research.

I have some questions about this study, who do I contact?
You can speak to the person who told you about this study. You can also contact X at the X who is over-seeing this project. His contact details are:

Direct line: X Email: X

What if I am not happy about the research study or wish to make a complaint?
If you are not happy about this research study or wish to make a complaint about it, then please contact the NHS Patient Advisory Liaison Service at -TRUST- (Tel: X email: X) or X at the X (phone X, email X).

REMEMBER:

You don't have to take part in this study
You can leave the study any time you like

Thank you very much for reading this information sheet

Appendix L: Therapist consent form

-TRUST LOGO-

NHS
National Institute for Health Research

University of East Anglia

Site number: _____

Participant ID number: _____

STAFF OR RESEARCHER CONSENT FORM (QUALITATIVE INTERVIEW)

Title of project: **DECRYPT – Delivery of Cognitive Therapy for Young People after Trauma**

Name of Researcher: _____

	Please *INITIAL* box
1. I confirm that I have read an information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.	☐
3. I consent to completing interviews relating to my involvement in the DECRYPT trial, or my reading and understanding of the trial findings.	☐
4. I consent to my interview related to the DECRYPT study being audio recorded.	☐

Name of staff member/researcher	Date	Signature

Name of person taking consent	Date	Signature

Appendix M: Ethical approval for DECRYPT study

Re issue letter 21.10.2016

NHS
Health Research Authority

East of England - Cambridge South Research Ethics Committee
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

18 July 2016

Dr [redacted]
Reader in Clinical Psychology
University of East Anglia
Department of Clinical Psychology,
Elizabeth Fry Building
UEA, Norwich
NR4 7TJ

Dear [redacted]

Study title:	**Cognitive Therapy for the treatment of post-traumatic stress disorder (PTSD) in youth exposed to multiple traumatic stressors: a phase II randomised controlled trial.**
REC reference:	**16/EE/0233**
Protocol number:	**1.0**
IRAS project ID:	**188916**

Thank you for your letter of 5 July 2016, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair and Dr Richard Aldridge.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require

Re issue letter 21.10.2016

further information, or wish to make a request to postpone publication, please contact the REC Manager, Ellen Swainston, nrescommittee.eastofengland-cambridgesouth@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for NHS permission for research is available in the Integrated Research Application System, www.hra.nhs.uk or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

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If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

The Committee has not yet completed any site-specific assessment (SSA) for the non-NHS research site(s) taking part in this study. The favourable opinion does not therefore apply to any non-NHS site at present. We will write to you again as soon as an SSA application(s) has been reviewed. In the meantime no study procedures should be initiated at non-NHS sites.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Covering letter on headed paper [Response to REC, 5th July 2016]		05 July 2016
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Sponsor letter - Insurance & Indemnity]	1	06 May 2016
GP/consultant information sheets or letters [GP notification letter]	1	30 April 2016
IRAS Application Form [IRAS_Form_09052016]		09 May 2016
IRAS Checklist XML [Checklist_05072016]		05 July 2016
Letter from funder [NIHR funding contract]	Final contract	01 April 2016
Other [Statement of Activities]	3	30 April 2016
Other [Schedule of Events]	3	
Participant consent form [Trial, child assent (8-15 years)]	1.1	22 June 2016
Participant consent form [Trial, child/YP consent (16-17 yrs)]	1.1	22 June 2016
Participant consent form [Trial, parent consent (child 8-15 yrs)]	1.1	22 June 2016
Participant consent form [Trial, parent assent (YP 16-17 yrs)]	1.1	22 June 2016
Participant consent form [Qual, staff/commissioner/researcher consent form]	1.1	21 June 2016
Participant consent form [Qualitative sub-study, child assent (8-15 yrs)]	1.1	22 June 2016
Participant consent form [Qual sub-study, 8-15 yrs assent form, WITHDRAWN]	1.0	22 June 2016
Participant consent form [Qualitative sub-study, child/YP consent (16-17 yrs)]	1.1	04 July 2016
Participant consent form [Qual sub-study, child/YP consent (16-17	1.0	22 June 2016

Re issue letter 21.10.2016

yrs), WITHDRAWN]		
Participant consent form [Qualitative sub-study, parent consent]	1.1	04 July 2016
Participant consent form [Qual sub-study, parent consent, WITHDRAWN]	1.0	22 June 2016
Participant information sheet (PIS) [Qualitative sub-study, child PIS, 8-11 years]	1.0	04 May 2016
Participant information sheet (PIS) [Qualitative sub-study, child PIS, 12-15 years]	1.0	04 May 2016
Participant information sheet (PIS) [Trial, child PIS, 8-11 years]	1.1	22 June 2016
Participant information sheet (PIS) [Trial, child PIS, 12-15 years]	1.1	21 June 2016
Participant information sheet (PIS) [Trial, child/YP PIS, 16-17 years]	1.1	21 June 2016
Participant information sheet (PIS) [Trial, parent/carer PIS]	1.1	21 June 2016
Participant information sheet (PIS) [Qual, staff/commissioner/researcher PIS]	1.1	21 June 2016
Participant information sheet (PIS) [Qual, child PIS, 8-11 WITHDRAWN]	1.0	22 June 2016
Participant information sheet (PIS) [Qual, child PIS, 12-15 WITHDRAWN]	1.0	22 June 2016
Participant information sheet (PIS) [Qualitative sub-study, child/YP PIS, 16-17 years]	1.1	04 July 2016
Participant information sheet (PIS) [Qual, child PIS, 16-17yrs WITHDRAWN]	1.0	22 June 2016
Participant information sheet (PIS) [Qualitative sub-study, parent PIS]	1.1	04 July 2016
Participant information sheet (PIS) [Qual sub-study, parent PIS, WITHDRAWN]	1.0	22 June 2016
Referee's report or other scientific critique report [NIHR Fellowship application reviews]		30 July 2015
Research protocol or project proposal [DECRYPT trial protocol]	1	04 May 2016
Summary CV for Chief Investigator (CI) [Richard Meiser-Stedman CV]	04/2016	30 April 2016
Validated questionnaire [Child baseline interview]	1	
Validated questionnaire [Child baseline questionnaires]	1	04 May 2016
Validated questionnaire [Child 2.5 month questionnaires]	1	04 May 2016
Validated questionnaire [Parent baseline questionnaires]	1	04 May 2016
Validated questionnaire [Parent baseline interview]	1.1	20 June 2016
Validated questionnaire [Baseline Child & Adolescent Service Use Schedule (CA-SUS)]	1.1	20 June 2016

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed

Re issue letter 21.10.2016

guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

16/EE/0233	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely

Dr Leslie Gelling
Chair

Email: nrescommittee.eastofengland-cambridgesouth@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: [redacted]

Appendix N: Approval of substantial amendment requesting qualitative project use as an education project

NHS
Health Research Authority

East of England - Cambridge South Research Ethics Committee
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Please note: This is the favourable opinion of the REC only and does not allow the amendment to be implemented at NHS sites in England until the outcome of the HRA assessment has been confirmed.

07 June 2018

Ms Leila Allen
School of Psychology
University of Birmingham
Birmingham
B15 2TT

Dear Ms Allen,

Study title:	**Cognitive Therapy for the treatment of post-traumatic stress disorder (PTSD) in youth exposed to multiple traumatic stressors: a phase II randomised controlled trial.**
REC reference:	**16/EE/0233**
Protocol number:	**1.0**
Amendment number:	**SA3**
Amendment date:	**27 April 2018**
IRAS project ID:	**188916**

The above amendment was reviewed on 18 May 2018 by the Sub-Committee in correspondence.

Ethical opinion

The researchers were contacted via email to reply to queries and provided the following clarifications.

The Sub-Committee noted that as CT-PTSD involves extensive, focused discussion of trauma, it may be that this intervention will involve greater potential for distress (at an early stage) than "treatment as usual", and that while the therapist delivering the CT-PTSD sessions will be trained in how to manage any distress that arises, the student will be conducting the interviews. The Sub-Committee requested to know whether there will be adequate support from the research team should the student require it, i.e., a participant becomes distressed during interview.

The applicant responded with the following:

"In many ways a trainee clinical psychologist will be a better person for undertaking these interviews than a typical research associate. They will have received extensive training in assessing and managing risk, and will have undertaken months of supervised clinical practice in working with complex mental health problems in multiple NHS settings (e.g. child and adolescent, adult, learning disabilities). They will be well acquainted with handling situations that evoke strong emotion for themselves as well as their clients/participants. The selection and training for trainee clinical psychologists involves close attention to reflection on handling the stress associated with clinical work in mental health settings.

In addition to being more confident in managing any distress that arises, the chief investigator will provide additional training for any trainee clinical psychologists on how to handle difficult interviews. This training will address how to work with distressed young people and their caregivers. Moreover, the chief investigator will be available at all times to discuss a case with the trainee clinical psychologist, both in terms of considering how to handle any risk issues that arise (e.g. a deterioration in mental health, a child protection concern) and the impact on the trainee clinical psychologist themselves. The chief investigator's mobile phone number will be available for the trainee to contact them.

I think it is important to add that the content of these qualitative interviews will pertain to the participant's experience of undergoing CT-PTSD, and will not directly address the content of these sessions, e.g. what trauma was actually addressed in the sessions will not be the focus of these interviews."

The members of the Sub-Committee were satisfied with the response provided by the applicant and were content to issue a Favourable Opinion for the Amendment.

Approved documents

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*
Covering letter on headed paper		15 May 2018
Notice of Substantial Amendment (non-CTIMP)	SA3	27 April 2018
Other [Re-submitted IRAS Form]		
Participant consent form [DECRYPT (qual withdrawn) child assent (8-15 yrs) form - Tracked Changes]	3.0	14 May 2018
Participant consent form [DECRYPT (qual withdrawn) child consent (16+ yrs) form - Tracked Changes]	3.0	14 May 2018
Participant consent form [DECRYPT (qual withdrawn) parent consent form - Tracked Changes]	3.0	14 May 2018
Participant consent form [DECRYPT (qual) child assent (8-15 yrs) form - Tracked Changes]	3.0	14 May 2018
Participant consent form [DECRYPT (qual) child consent (16+ yrs) form - Tracked Changes]	3.0	14 May 2018
Participant consent form [DECRYPT (qual) parent consent form - Tracked Changes]	3.0	14 May 2018
Participant information sheet (PIS) [DECRYPT (qual withdrawn) child info sheet 8-11 - Tracked Changes]	3.0	14 May 2018
Participant information sheet (PIS) [DECRYPT (qual withdrawn) child info sheet 12-15 - Tracked Changes]	3.0	14 May 2018
Participant information sheet (PIS) [DECRYPT (qual withdrawn) child info sheet 16-17 - Tracked Changes]	3.0	14 May 2018
Participant information sheet (PIS) [DECRYPT (qual withdrawn) parent info sheet - Tracked Changes]	3.0	14 May 2018
Participant information sheet (PIS) [DECRYPT (qual) child info sheet 8-11 - Tracked Changes]	3.0	14 May 2018

Participant information sheet (PIS) [DECRYPT (qual) child info sheet 12-15 - Tracked Changes]	3.0	14 May 2018
Participant information sheet (PIS) [DECRYPT (qual) child info sheet 16-17 - Tracked Changes]	3.0	14 May 2018
Participant information sheet (PIS) [DECRYPT (qual) parent info sheet - Tracked Changes]	3.0	14 May 2018
Summary CV for student		
Summary CV for supervisor (student research)		
Summary CV for supervisor (student research)		
Summary CV for supervisor (student research)		

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

Working with NHS Care Organisations

Sponsors should ensure that they notify the R&D office for the relevant NHS care organisation of this amendment in line with the terms detailed in the categorisation email issued by the lead nation for the study.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our Research Ethics Committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

16/EE/0233:	**Please quote this number on all correspondence**

Yours sincerely,

P. P.

Dr Leslie Gelling
Chair

E-mail: nrescommittee.eastofengland-cambridgesouth@nhs.net

Enclosures: *List of names and professions of members who took part in the review*

Copy to: [redacted]

Appendix O: Qualitative interview topic guide

CT-PTSD Therapist Qualitative Interview

Therapist's initials and NHS Trust: _____

Today's date: _____

Interviewer: _____

Thank you for agreeing to talk to me today – [introduce yourself]

In this part of DECRYPT we are interested in finding out what it was like to take part in the study as a CAMHS clinician and, in particular, what it was like to deliver Cognitive Therapy for PTSD with children and young people. We want to capture your experiences in your own words which is why we are completing this interview.

I would be interested to hear your views (positive or negative) about your experiences. Please do be honest about your experiences, the recordings will be stored anonymously and will not be accessible to the current trial team. Quotations and themes from our discussion may be used in a follow up report but you will not be identified or linked to your views in any way.

I will need to record this interview, for analysis. The recording will be stored securely and then transcribed, at which point all identifying features will be removed. I am the only person that will listen to the tape. Would this be okay?

The whole interview should take no longer than an hour. There will be four parts to this interview. Firstly, I'd like to ask some basic demographic questions about you and your professional background. Then I'll ask about your initial impressions of the CT-PTSD treatment and training, your experiences of delivering the training with young people and finally your reflections on using CT-PTSD going forward. Does that sound okay? Do you have any questions before we begin?

Demographics

Male/Female (circle as appropriate)

1. How many DECRYPT CT-PTSD cases have you worked with in total?

2. What is your main professional background? E.g. Clinical Psychologist, Art therapist etc

3. How long in total have you been working clinically with children and young people?

4. Prior to your DECRYPT CT-PTSD training, had you received any specific training on treating PTSD or trauma?

    If yes - What training have you had? How much experience do you have of working with PTSD?

5. Prior to your DECRYPT CT-PTSD training, did you have any experience/training in CBT?

    If yes- What training have you had? How much experience do you have of using CBT?

Training/ initial thoughts on model

1. **What are your thoughts on the CT-PTSD training you received?**

Possible follow up questions: *How confident did you feel in delivering CT-PTSD after the 2 day training? What could have made you feel more confident/prepared? Are there any improvements which could be made to the training?*

2. **What were your initial thoughts about the CT-PTSD model after the training?**

Possible follow up questions: *How well did the CT-PTSD treatment protocol fit with your prior knowledge/experience/training in CBT? What impact do you think your professional background had on your attitudes towards the therapy? Did you have any initial anxiety/apprehensions around delivering any aspects of the treatment according to the protocol before therapy began? For example, imaginal reliving exercises? If yes - how did you manage these? Do you think this affected how you delivered the therapy? Did you follow the treatment protocol closely or make changes based on your clinical judgement?*

Delivering the therapy

3. **How did you find delivering CT-PTSD as a treatment for PTSD with the children/ young people that you worked with?**

Possible follow up questions: *How did you find formulating and adapting the CT-PTSD model to your client? Did the model make sense to you? Did you feel it was comprehensive enough? Which aspects of the treatment do you think were most helpful for your client? Which aspects of the treatment do you think were least helpful for your client? Were there any parts of the treatment which you experienced as difficult or uncomfortable in any way? How did you find the number of sessions recommended for use with your client? Did it feel enough time to meet therapy goals or did you feel you needed longer?*

Supervision

4. **How did you find the supervision you received for your CT-PTSD cases?**

Possible follow up questions: *How helpful/necessary did it feel to receive weekly supervision for these cases? Did you feel you required more supervision for your CT-PTSD cases than you might for other clients you treat?*

Completion of treatment

5. **Have there been any ways that in which your work on the trial has changed your own clinical practice or that of the service you work in?**

Possible follow up questions: *Does the service you work in routinely offer a CBT treatment for trauma? If yes - how does your usual CBT treatment compare to CT-PTSD? If no - what prevents you/ your service offering a CBT treatment? Do you think CT-PTSD is a feasible treatment to continue offering within your service? What would help you/ your service to continue offering CT-PTSD in the future?*

6. **Is there anything more you'd like to add to add, either about the things we've talked about, or about anything else that you think is relevant to the DECRYPT trial / treatment of children and young people following traumatic events?**

Thank you for sharing your views with me today.

Appendix P: Braun & Clarke's (2006) six phases of thematic analysis

Table 1: Phases of Thematic Analysis

Phase	Description of the process
1. Familiarising yourself with your data:	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes:	Checking in the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells; generating clear definitions and names for each theme.
6. Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

Appendix Q: Author guidelines for the European Journal of Psychotraumatology

About the journal

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Please note that this journal only publishes manuscripts in English. However, we encourage authors to also submit their manuscript in their local language, which will then be included as supplementary material.

This journal accepts the following article types: Original basic & clinical research articles, Review articles, Short Communications, Case Reports, Study Protocols, Clinical Practice papers, Inaugural Lectures, Letters to the Editor, Book Reviews, Editorials, Conference Abstracts, Registered Reports.

In some cases the word limit can be exceeded as we are an online journal, but in principle this should be avoided.

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The standard APC is €1,450/$1,640/£1,260/AUD 2,190 plus VAT, or other local taxes where applicable in your country. The APC for Short Communications and Case Reports is €950/$1,075/£825/AUD 1,435 plus VAT, or other local taxes where applicable in your country.

Members of the European Society for Traumatic Stress Studies (ESTSS) are entitled to 47% discount on the APC as long as the corresponding author's membership is in force at the time of submission of the manuscript. For society members the standard APC is €768.50 plus VAT, or other local taxes where applicable in your country. The APC for society members for Short Communications and Case Reports is €503.50 plus VAT, or other local taxes where applicable in your country. Please contact the ESTSS secretariat for details on how to retrieve the discount code, which must be presented on submission (secretariat@estss.org).

There is no APC for **Letters to the Editor, Book Reviews or Editorials**. The APC for **Conference Abstracts** will be supplied on request.

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Preparing your paper

Article types and word limits

Please note, the final word count includes the abstract and reference section at the end of the paper, but is excl. tables/figures.

In some cases, for longer article, the word limit can be exceeded as we are an online journal, but in principle this should be avoided.

Supplementary material, like large tables, data sets, protocols, videos, questionnaires, non-English versions of the article can be uploaded as supplementary material (free of charge) and will thus also be available online.

- **Original basic & clinical research articles** that consolidate and expand the theoretical and professional basis of the field of traumatic stress (max preferably < 6000 words incl. abstract and references, excl. tables/figures)
- **Review articles** including meta-analyses (max preferably < 6000 words incl. abstract and references, excl. figures/tables)
- **Short Communications** presenting new ideas or early-stage promising research (max 3000 words, incl. abstract and references, excl. tables/figures)
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- **Letters to the Editor** that comment on published articles or research letters. The latter should have the same structure as a research article but are short and concise (max 1000 words).
- **Book Reviews (**max 1000 words including references)
- **Editorials** upon invitation only (max 3000 words incl. abstract and references, excl. tables/figures)
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- **Registered Reports** differ from conventional empirical articles by performing part of the review process before the researchers collect and analyse data. Unlike more conventional process where a full report of empirical research is submitted for peer review, RRs can be considered as proposals for empirical research, which are evaluated on their merit prior to the data being collected. For information on how to prepare Registered Reports (RR) submissions please see here.

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2. A structured **abstract** of no more than 300 words. A structured abstract should cover (in the following order): Background, Objective, Method, Results,

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3. If you are a Chinese or Spanish speaking author please include a **translated abstract** below the English language version.
4. You can opt to include a **video abstract** with your article. Find out how these can help your work reach a wider audience, and what to think about when filming.
5. 5-10 **keywords**. Read making your article more discoverable, including information on choosing a title and search engine optimization.
6. **Funding details**. Please supply all details required by your funding and grant-awarding bodies as follows:
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