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REVIEW ARTICLE

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# Facilitators and barriers to "Positive Outcomes" from cognitive-behavioral therapy, according to young people: A thematic synthesis

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## Abstract

**Objective:** This qualitative review sought to explore how young people (YP) conceptualize positive outcomes from cognitive-behavioral therapy (CBT) and what YP perceive to be the facilitators and barriers to positive outcomes.

**Methods:** A systematic literature search was conducted in June 2021 using six online databases. Studies were included if qualitative data were collected from participants who were aged up to 25, had internalizing mental health difficulties, and had received in-person CBT from trained practitioners.

**Results:** Nineteen studies were included. The Gough Weight of Evidence framework was used to assess methodological and topical quality and relevance. A thematic synthesis identified 34 conceptualizations of positive outcomes, 57 facilitators, and 49 barriers. Descriptive and analytical themes were identified. In line with the review's pragmatic perspective, the latter were worded as practice recommendations: acknowledge YP's perspectives on outcomes, teach tangible CBT techniques, balance autonomy and support, frame CBT as "upskilling," explore nuanced barriers to engagement, and consider the power of group dynamics.

**Conclusions:** This review established the range of YP's views about positive outcomes from CBT, as well as facilitators and barriers to achieving these. Findings should prompt CBT practitioners to reflect and consider how their practice might be shaped through reports from YP as experts by experience.

**KEYWORDS**
barriers, cognitive-behavioral therapy, facilitators, positive outcomes, thematic synthesis, young people

# 1 | INTRODUCTION

## 1.1 | Quantitative research on cognitive behavioral therapy (CBT)

A vast amount of quantitative literature exists examining whether CBT is effective. A meta-review identified 494 reviews, representing 221,128 participants, concluding there is consistent evidence that CBT is beneficial across conditions, populations, and contexts (Fordham et al., 2021; Hofmann et al., 2012). The majority of reviews (76.5%) were conducted with adult populations, showing research on CBT for young people (YP) is less extensive. Nonetheless, CBT is considered the first-line treatment for YP with anxiety and depression (Connolly & Bernstein, 2007). Furthermore, early intervention is important for reducing the long-term impacts of mental health difficulties on individuals and society at large (Frederickson & Cline, 2015). A meta-analysis evaluated individual CBT for YP with anxiety (Sigurvinsdóttir et al., 2020). The authors calculated odds ratios (OR) comparing participants with favorable and unfavorable outcomes. There was a medium effect size (OR 2.55, 95% CI [1.32, 4.93]) across six studies comparing CBT with attention control groups who had nontherapeutic contact with psychotherapists, controlling for participants' expectations of change (Wampold et al., 2005). Such evidence has led to consensus on the value of CBT for supporting YP's mental health.

While CBT is effective for many people, it does not help everybody. One review of 87 studies suggested 49.5% of adults receiving CBT for anxiety had positive responses post-therapy, rising to 53.6% at follow-up (Loerinc et al., 2015). A meta-analysis of 48 studies of YP in mental health care reviewed dropout rates, defined as ending therapy without the mutual agreement of client and practitioner (de Haan et al., 2013). In efficacy studies, the average dropout rate was 28.4% while, in effectiveness studies, the average rate was 50% and ranged up to 72%.

This leads to the research question of why CBT is effective, and the practice question of which CBT elements should be implemented and how this should be done to maximize positive outcomes. One research strand examines process variables (mechanisms of change), shifting the focus of measurement from *outside* the therapy room (questionnaires about mental health symptomatology) to *inside* the therapy room (observations of interactions between practitioner and person receiving therapy) (Orlinsky & Howard, 1986). Key process variables include therapeutic alliance, practitioner competence, and adherence to CBT principles (Rapley & Loades, 2019). A review of alliance-outcome relationships for YP (aged 12–19) receiving CBT found a moderate correlation of $r = .34$, 95% CI [0.21, 0.37], accounting for 8%–12% of variability in treatment outcome (Murphy & Hutton, 2018). These results are comparable to those found in adult populations and suggest a strong alliance facilitates positive CBT outcomes. Unexpectedly, the review found that the quality of therapeutic alliance was affected equally by YP and practitioner characteristics, unlike adult studies, which find that practitioner differences primarily affect alliance. This suggests there may be methodological limitations to alliance measures for YP and that more nuanced means of data collection may be necessary to enhance understanding.

## 1.2 | Qualitative research on CBT

Such nuance may be provided by qualitative research, which aims for diversity, individuality, contextualization of findings, and identification of themes (Braun & Clarke, 2013). Qualitative methods offer several potential advantages.

First, the fact that randomized controlled trials (RCTs) maximize internal validity means they have reduced external validity, often not closely resembling practice conditions. This is referred to as the "implementation gap" (Britten, 2010). In contrast, interviews can be held with people who have direct experience with community mental health services.

Second, qualitative methods can explore CBT effectiveness from the perspectives of those receiving treatment rather than those delivering it. Standardized questionnaires are constructed by researchers based on theoretical understandings of psychological constructs, but they may be reductive in terms of defining "positive outcomes" as reductions in symptomatology. A review found that over 90% of quantitative studies of CBT with YP reported on "mood and affect" as an outcome, but fewer than 5% of studies reported on any other outcomes including resilience, family functioning, and friendships (Krause et al., 2019, 2020). This narrow definition of "outcome" may not be meaningful to those receiving CBT, who commonly report a greater variety of outcomes.

Third, through their focus on group outcomes, RCTs aim to generalize results to larger populations. However, this comes at the expense of nuance, since RCTs provide limited scope for analysing individual participants' responses to CBT. Qualitative methods provide an equal platform to participants whatever their experience of CBT, facilitating exploration of diversity and factors that researchers may not consider.

## 1.3 | Qualitative research with YP

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

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

A third review looked at YP's experiences with trauma-focussed CBT, identifying three superordinate themes across eight studies: engagement, experience of treatment components, and therapeutic outcomes (Neelakantan et al., 2019). Similar to Lynch et al. (2020), participants identified empathy and feeling listened to as key practitioner characteristics. Importantly, a poor alliance was associated with negative outcomes. The fact

that the same process variable (therapeutic alliance) is associated with positive views in its strong form and negative views in its weak form suggests it plays a crucial role from YP's perspectives. Several other treatment barriers were identified, such as lack of resources for participation and confidentiality issues within the group format. Positive outcomes were elaborated, such as improved coping strategies, reduced symptomatology, and better social relationships.

### 1.4 | The current review

This review explores the perspectives of YP with experience receiving CBT. The aims are to extend prevailing research trends (in which standardized measures and practitioners' voices dominate), to foreground the views of a less empowered population (young recipients of CBT), and to prompt practitioners and researchers to reflect on their practice. YP are defined as up to age 25, in line with recent explorations of the expanded social and physical growth associated with adolescence (Sawyer et al., 2018).

This review expands upon existing qualitative reviews by broadening the inclusion criteria to include YP who have experienced the most common and best-evidenced forms of CBT (in-person therapy for anxiety and depression); expanding the focus on "positive outcomes" to better understand how YP conceptualize whether CBT has been helpful; and elaborating findings about barriers and facilitators to positive outcomes from CBT to include a broader range of factors relating to the therapeutic process.

There are three review questions (RQs):

1. How do YP experiencing anxiety and depression conceptualize "positive outcomes" from CBT?
2. What are the facilitators and barriers to "positive outcomes" from CBT, according to YP experiencing anxiety and depression?
3. Based on the findings of RQs 1 and 2, what are the recommendations for CBT practitioners?

## 2 | METHODS

### 2.1 | Literature search

Data collection and analysis were conducted solely by the first author. A systematic literature search was conducted from 24 to 25 June 2021 using six online databases: Web of Science, Educational Resources Information Center (ERIC), CINAHL Plus, British Education Index, PsycINFO, and Child Development and Adolescent Studies. Search terms are listed in Table 1. The SPIDER formulation (Sample, Phenomenon of Interest, Design, Evaluation, Research type) was used to organize search terms (Cooke et al., 2012). A scoping literature search was conducted using Google Scholar. Citation and ancestral searches were conducted on articles included in the review. Inclusion criteria are listed in Table 2.

### 2.2 | Quality appraisal

Included studies were critically appraised using the Weight of Evidence (WoE) framework (Gough, 2007). Dimensions considered were methodological quality (WoE A), methodological relevance (WoE B), and topic relevance (WoE C). WoE A was a generic judgment of research design quality including findings, design, sample, data collection, analysis, reporting, reflexivity and neutrality, ethics, and auditability. A published coding protocol was used (Spencer et al., 2003). WoE B and C were judgments relating to the RQs, using author-developed coding

**TABLE 1** Terms used in the literature searches.

| SPIDER | Search terms |
|---|---|
| S—Sample | child* or teen* or juvenile* or minor* or kid* or youth* or young* or adolescen* or parent* or mother* or father* or carer* or guardian*<br>AND<br>anxi* or "selective mut*" or phobia or ptsd or "post-traumatic stress disorder" or "social phobia" or ocd or "obsessive compulsive" or "panic disorder" or "panic attack*" or SAD or GAD or agoraphobia or separation or depress* or "low mood" or internali* or "mood disorder" or bipolar<br>AND |
| PI—Phenomenon of interest | cbt or "cognitive behavi*" or "cognitive therapy"<br>AND |
| D—Design | questionnaire* or survey* or interview* or "focus group*" or "case stud*" or observ* or "thematic analy*" or "content analy*" or ethnog* or "interpretative phenomenological analysis" or ipa or "field stud*" or "lived experience*" or "narrative analy*" or "discourse analy*" or "grounded theor*"<br>AND |
| E—Evaluation | view* or experienc* or opinion* or attitude* or perce* or belie* or feel* or know* or understand* or thought* or theme* or facilitat* or barrier* or positive* or negative* or relapse<br>AND |
| R—Research type | Qualitati* or multimethod* or mixed-method* or "mixed meth*" or "multi meth*" |

**TABLE 2** Criteria for inclusion in the review.

| | Criterion | Inclusion |
|---|---|---|
| 1 | Type of publication | The article is published in a peer-reviewed journal |
| 2 | Language of publication | The article is written in English |
| 3 | Date of publication | The article is published on or before June 25, 2021 |
| 4 | Primary data | The article consists of original research |
| 5 | Intervention | Participants received CBT |
| 6 | Intervention delivery | CBT is delivered in-person by trained therapists |
| 7 | Participants | Participants are aged up to 25 |
| 8 | Mental health difficulties | Participants had internalizing mental health difficulties |
| 9 | Outcome data | There is qualitative data, including themes (potentially including views expressed by parents/carers but not views expressed by practitioners) |
| 10 | Trauma-focussed approach | The intervention is not trauma-focussed |

Abbreviation: CBT, cognitive-behavioural therapy.

protocols. WoE B addressed sampling, data collection, analytical procedures, and evidence for practice. WoE C addressed intervention, mental health difficulties, interview content, theoretical approach to data analysis, and data reported. WoE D was the average of WoE A, B, and C. See Supporting Information S1: Appendices A and B for further details of the quality appraisal.

## 2.3 | Thematic synthesis

A thematic synthesis was conducted (Thomas & Harden, 2008). This synthesis method was chosen for its rigor in providing clear links between primary data and analytical conclusions. A summary of the process is provided in Figure 1. The first stage of analysis involved line-by-line, explorative coding using NVivo 2020. A complete coding approach was taken, where the same data could be coded in multiple ways (Braun & Clarke, 2013). Codes were researcher-derived, rather than data-derived, going beyond participants' language and beginning the process of data interpretation (Braun & Clarke, 2013). The second stage of analysis involved defining descriptive themes. The intention was to remain interpretively close to primary studies. RQs 1 and 2 were considered separately. A theme was defined if it captured a meaningful pattern across multiple codes (Braun & Clarke, 2013). The third stage of analysis involved defining analytical themes to answer RQ3. The intention was to generate new interpretive insight. Descriptive themes were considered jointly when the researcher was defining analytical themes. Given the intention to provide insight for CBT practitioners, the researcher drew out practice recommendations. The process of deriving analytical themes from descriptive themes was not standardized but based on the researcher's interpretation of what would be most helpful for CBT practitioners. It was not the case that each analytical theme had a certain number of descriptive themes or codes that supported it, although analytical themes were all well supported by the data.

## 2.4 | Reflection

The researchers took a constructionist epistemological position. This holds that meaning is created by people's interactions with their surroundings (Moon & Blackman, 2014). This position applied to participants, who offered views about CBT, and the researchers, who analyzed and interpreted data. While elements of an external reality exist, their meaning is determined by individuals' experiences, beliefs, and cultural background. The researchers took a pragmatist theoretical position. This holds that knowledge is important so far as it is useful and practical for human endeavor (Barker et al., 2016). Pragmatism is compatible with a constructionist epistemology because it is

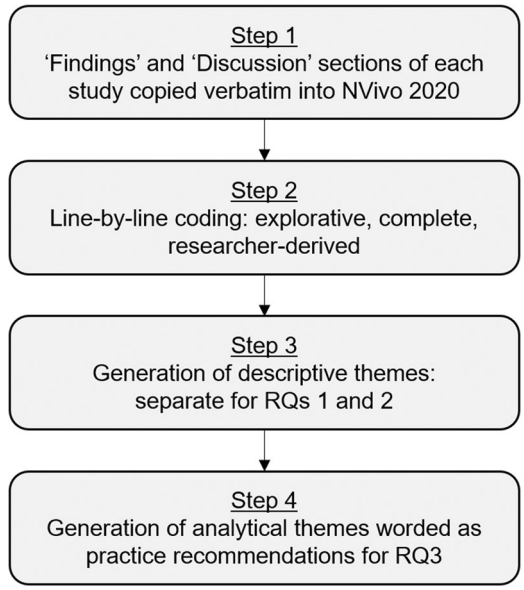


**FIGURE 1** Overview of thematic synthesis.

flexible, allowing for consideration of multiple perspectives, and action-focussed, aiming to shape and prompt reflection on the meanings people assign to external reality (Cornish & Gillespie, 2009). A criticism of pragmatism is that it allows researchers to avoid considering ethical and moral issues, meaning it could be co-opted to justify thoughtless or damaging endeavors. As with all research, the use of ethical codes is vital to ensure researchers privilege participants' well-being above the utility of outcomes (British Psychological Society, 2012).

The researchers' experiences and perspectives influenced data analysis; other researchers may have reached different conclusions based on the same data (Kvale, 1994). The primary researcher had three and a half days' CBT training. Measures were taken to enhance credibility (ensuring research addresses its intended aims) and trustworthiness (ensuring research is documented systematically) (Bazeley, 2013). The researcher kept diary notes on developing thinking and reasoning behind decision-making, which informed the writing up process. The researcher engaged in self-reflection while conducting thematic synthesis; refining, revising, and checking codes and themes against original research. The researcher acted reflexively through bracketing; keeping personal opinions, assumptions, and experiences separate from those expressed by YP (Fischer, 2009). This was to avoid altering the meaning and context of participants' language and to ensure themes accurately and comprehensively reflected the data.

## 3 | RESULTS

Database searches yielded 619 results. Following removal of 152 duplicates, 467 articles underwent title and abstract screening; 394 articles were excluded. Eighty-two articles were screened at full text, including nine added through ancestral and citation searching. Sixty-three studies were excluded, leaving 19 studies eligible for review. A flow diagram of article selection is provided in Figure 2.

### 3.1 | Mapping the field

Details of participants and procedures in the included studies are provided in Table 3. A key of acronyms is provided at the base of the table. In total, 762 participants contributed data to the reviewed studies. Of these, 668 were YP, ranging from age 6 to 25 years old. The rest were parents or carers. Interviews were conducted with 304 YP while 364 filled out forms. From available data, biological sex representation was roughly equal with 55% female participants (161/293). Eleven studies took place in England and one took place in Norway, Sweden, Denmark, Germany, Australia, India, South Africa, and the United States. Regarding data analysis, eight studies employed thematic analysis (Braun & Clarke, 2006), six studies employed interpretative phenomenological analysis (Smith et al., 2009), one study employed the framework method (Gale et al., 2013), three studies employed deductive qualitative content analysis (Elo & Kyngäs, 2008), and one study employed ideal type analysis (Weber, 1949).

### 3.2 | Quality appraisal

A summary of WoE ratings is provided in Table 4. Further details can be found in the Supporting Information.

#### 3.2.1 | Sampling strategy

Seven studies were given a low WoE B rating because researchers involved in delivering interventions selected participants to evaluate the intervention. This created a potentially coercive power dynamic for two reasons. First,

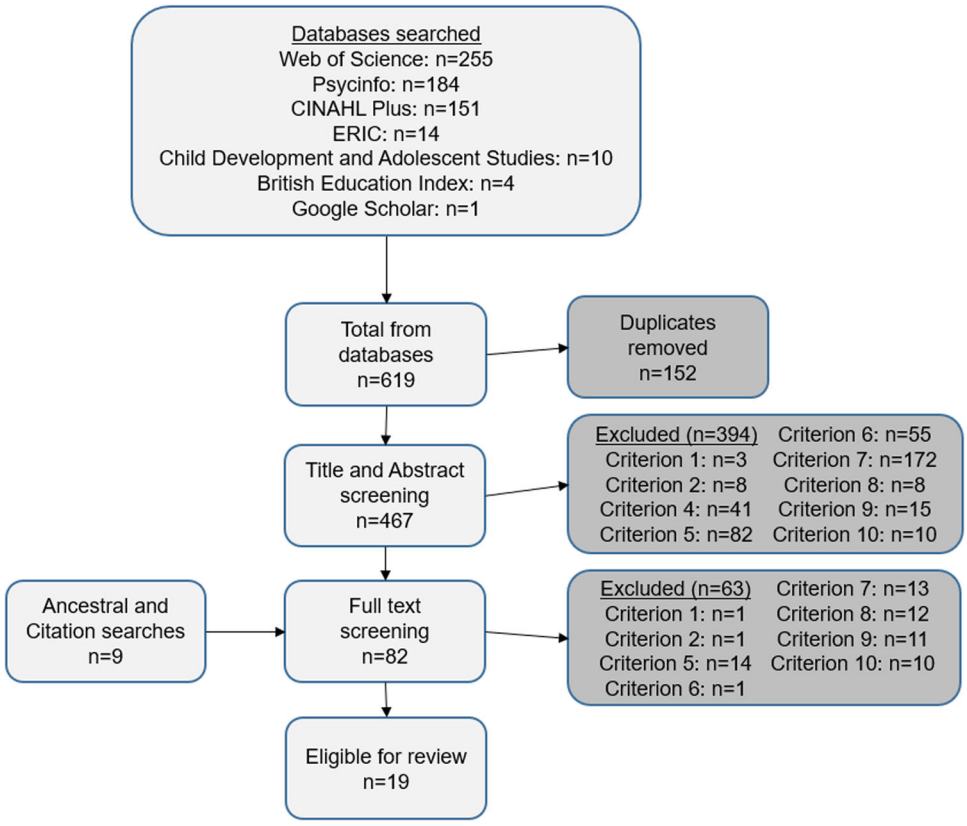


**FIGURE 2** Flow diagram of literature search and article screening.

researchers could shape interview agendas to place their intervention in a positive light; second, participants may have felt unable to provide honest responses due to effects of courtesy bias (Simmons & Elias, 1994). Six studies were given a high rating because researchers were not involved in participants' therapy and did not intend to evaluate specific interventions, so participants would likely not have felt researchers had an agenda (Anyan, 2013).

### 3.2.2 | Data collection

Eighteen studies used semistructured interviews (SSIs). Loucas et al. (2020) also used open-ended questionnaires while Claus et al. (2019) also used a focus group. Howells et al. (2020) were the only researchers not to use SSIs, employing anonymous feedback forms instead. This method led to a low WoE B rating because it was unlikely to facilitate rich data collection and did not allow for reactive follow-up questions (Barker et al., 2016).

### 3.2.3 | Interview content

Six studies were given high ratings because they contained open and nonleading questions with scope for follow-up questions, likely leading to the richest and most honest responses. Four studies were given low ratings because interviews were aimed at evaluating specific interventions and contained loaded questions such as "what was good

**TABLE 3** Key information about participants and procedures.

| Study and location | Intervention | Aims and context | Participants | Method | Key themes (From *n* participants) |
|---|---|---|---|---|---|
| Myburgh, Muris, et al. (2021) South Africa (Western Cape) | I am BRAVE (Myburgh, Loxton, et al., 2021)—Brief, manualised group CBT based on Coping Cat (Kendall & Hedtke, 2006). Eight 45-min sessions | Aimed to evaluate the preliminary effectiveness of the program among vulnerable children within a semirural, disadvantaged farmworker community context | *N* = 21 (10 female).<br>Aged 9–12 ($\bar{x}$ = 10.38, SD = 1.02).<br>Participants all resided in the Western Cape and spoke Afrikaans.<br>Participants had elevated anxiety levels, according to the SCAS.<br>Participants recruited through an NGO offering local services to families experiencing poverty. | Data collection: SSIs conducted in focus groups. Explored learning from intervention, changes in experience of anxiety, and whether intervention components were still used. Conducted 3 months post-treatment.<br>Data analysis: Deductive and inductive content analysis. Theory-based codes were used initially before themes were formulated inductively to contextualize original codes. Some responses quantified.<br>Epistemological position: Pragmatist. Data categorized into a pre-existing matrix but process involved researcher interpretation. | 1. Perceived intervention utility.<br>2. Perceived acquisition of core CBT knowledge.<br>3. Perceived acquisition of core CBT components of change.<br>4. Perceived utility of exposure.<br>5. Generalization of core intervention components of change. |
| Taylor et al. (2021) England (Berkshire and Oxford CAMHS) | Individual CBT tailored for SAD (Leigh & Clark, 2016). Fourteen weekly 1.5-h sessions | Aimed to explore experiences of CBT for SAD delivered in CAMHS | *N* = 12 (6 adolescents (5 female), 6 parents).<br>Adolescents aged 15–18 ($\bar{x}$ = 15.67).<br>Participants had a diagnosis of SAD.<br>No data were provided on ethnicity.<br>Participants sampled from Leigh & Clark (2016). | Data collection: SSIs. Topic guides developed by researchers and two experts-by-experience. Explored participant' understanding of problems, expectations of therapy, hopes for change, and experience of therapy. Conducted post-therapy.<br>Data analysis: IPA. Data from participant groups were coded | 1. Endorsing the treatment.<br>2. Finding therapy to be collaborative and active; challenging but helpful.<br>3. Navigating change in a complex setting. |

**TABLE 3** (Continued)

| Study and location | Intervention | Aims and context | Participants | Method | Key themes (From *n* participants) |
|---|---|---|---|---|---|
| | | | | separately before comparative analysis.<br>Epistemological position: Constructivist/interpretive. | |
| Howells et al. (2020) England (Norfolk) | CBT-based, nondiagnostic group workshops, "Psychology of Emotions" (Howells, 2018). Six sessions. Delivered by PWPs, supervised by CPs. | Aimed to explore the effectiveness of the "Psychology of Emotions" workshops | Sample size cannot be determined. Two hundred and twelve feedback forms were received across six sessions. Three hundred and fifty people attended at least one session, 48 people attended all six ($\bar{x}$ = 1.89, SD = 2.13).<br>Aged 16–25 (for those who attended at least one session, $\bar{x}$ = 19.9, SD = 2.79).<br>No specific inclusion criteria but all participants had emotional difficulties.<br>92.6% of those who recorded ethnicity were White British.<br>Self-selecting sample, based on filling out feedback forms. | Data collection: Anonymous feedback forms provided at the end of each session. Explored likes and dislikes about the intervention.<br>Data analysis: Framework method, from the family of qualitative content analysis (Gale et al., 2013). The justification was to identify descriptive themes in a large data set with a transparent, rigorous method.<br>Epistemological position: Constructivist/interpretive. | *What did you like?*<br>1. Delivery and structure (57).<br>2. Psycho-education (54).<br>3. Positive impact (30).<br>4. Group context (41).<br>5. Facilitators (50).<br>*What could be improved?*<br>1. Group composition (24).<br>2. Session content (20).<br>3. Style of delivery (43). |
| Jones et al. (2020) England | Individual CBT tailored for individuals at risk of bipolar disorder. Up to | Aimed to explore the acceptability of the trial intervention and participants' experiences | *N* = 21. Thirteen (eight female) received CBT. Eight (five female) received TAU. | Data collection: SSIs. Explored trial involvement and experiences of therapy. Conducted post-treatment by service-user | 1. Relevance of study and intervention (acceptability of trial |

(Continues)

**TABLE 3** (Continued)

| Study and location | Intervention | Aims and context | Participants | Method | Key themes (From *n* participants) |
|---|---|---|---|---|---|
| | 26 sessions. Delivered by therapists. | more broadly. Part of an RCT of CBT vs. TAU (undefined). | Aged 17–26 ($\bar{x}$ = 20.86).<br>All participants were at risk of bipolar disorder, through early displays of symptoms.<br>Sixteen participants were White British, three White Other, one Mixed Block Caribbean, and one Mixed White/Black African.<br>Purposively sampled from a larger feasibility trial study. | researchers, with the hope of reducing power imbalances and enabling participants to speak openly.<br>Data analysis: TA. Coding was inductive. Research team had varied experiences including service users (lead researchers), a clinical psychologist, a qualitative methodologist, and a carer who was also a GP.<br>Epistemological position: Constructivist (critical realist). | processes and value of the trial therapy).<br>2. Feeling understood and valued (in assessments and CBT sessions).<br>3. Adaptability and flexibility (of research assistants and therapists). |
| Krause et al. (2020) England (North London) | CBT (up to 20 sessions over 30 weeks), BPI or STPP.<br>Nine, 9, and 16 adolescents respectively received each treatment. | Aimed to systematically map outcomes described by adolescents, parents, and therapists following treatment in the trial study. Compared these to a review of outcomes reported by 92 treatment efficacy and effectiveness studies (Krause et al., 2019). | *N* = 68 (34 adolescents (21 female), 34 parents).<br>Adolescents aged 12–19 ($\bar{x}$ = 16.2, SD = 1.5).<br>Participants had a diagnosis of unipolar Major Depressive Disorder with moderate to severe functional impairment.<br>No data were provided on ethnicity.<br>Purposively sampled from the IMPACT-ME study (Midgley et al., 2014). | Data collection: SSIs. Used "The Experience of Therapy Interview" (Midgley et al., 2011a) to explore current feelings, changes as a result of treatment, experience of therapy, and significant turning points. Conducted immediately post-therapy.<br>Data analysis: Deductive CA. Taxonomy of treatment outcome applied as an a priori coding frame. Justification was to systematically condense a large data set into a conceptual framework. | Outcome domains (% adolescents discussed):<br>1. Symptoms (82%).<br>2. Self-management (71%).<br>3. Functioning (56%).<br>4. Personal growth (68%).<br>5. Relationships (62%).<br>6. Youth wellbeing (27%).<br>7. Parental support and well-being (9%). |

**TABLE 3** (Continued)

| Study and location | Intervention | Aims and context | Participants | Method | Key themes (From *n* participants) |
|---|---|---|---|---|---|
| | | | | Epistemological position: Pragmatist. CA rooted in a positivist paradigm. Participant narratives considered socially constructed. | |
| Loucas et al. (2020) England (Inner London) | CBT-based, group, one-day, manualised "Discover" workshops. Telephone follow-up. Delivered by CPs. | Aimed to explore the feasibility, acceptability and outcomes of Discover. Employed an RCT design with Discover vs. control (TAU). | Overall sample size cannot be determined. Fourteen responded to CSQs, 11 responded to interviews. Seventeen were in the intervention condition, seven in the control condition.<br>Aged 15–18.<br>Participants were on a CAMHS waiting list for specialist treatment, referred for elevated anxiety or depression.<br>Detailed data are provided on ethnicity, summarized as: White British (7), Black (3), and Mixed (7).<br>Self-selecting sample from the intervention condition. | Data collection: SSIs. Explored recruitment/assessment, intervention content, and intervention impact. Conducted immediately post-therapy.<br>Open-ended CSQs.<br>Data analysis: TA.<br>Epistemological position: Not discussed by researchers. | 1. Being acknowledged.<br>2. Valuing the group experience.<br>3. Developing improved ways of coping.<br>4. Improvement suggestions. |
| Wilmots et al. (2020) England (North London) | CBT. Eight to twenty-one sessions attended ($\bar{x}$ = 15.6, SD = 6.11).<br>Delivered by psychologists. | Aimed to explore facilitators and barriers to a positive therapeutic relationship for adolescents with moderate-to-severe depression who had | *N* = 5 (all female).<br>Aged 14–18 ($\bar{x}$ = 16.84, SD = 1.58).<br>Previously diagnosed with depression but had a successful treatment | Data collection: SSIs. Used "The Experience of Therapy Interview" (Midgley et al., 2011a) to explore hopes, difficulties, and expectations of therapy; how they experienced therapeutic | 1. Feeling accepted and understood (5).<br>2. Facilitating change (4).<br>3. Shared decision-making (3). |

(Continues)

**TABLE 3** (Continued)

| Study and location | Intervention | Aims and context | Participants | Method | Key themes (From *n* participants) |
|---|---|---|---|---|---|
| | | good outcomes from CBT | outcome, no longer meeting diagnostic criteria for major depressive disorder on K-SADS (Kaufman et al., 1997).<br>No data were provided on ethnicity.<br>Purposively sampled from the IMPACT-ME study (Midgley et al., 2014). | change; and facilitators and barriers to positive treatment outcomes. Conducted immediately post-therapy.<br>Data analysis: IPA. The justification was to give voice to participants whilst allowing researchers to identify shared experiences across participants.<br>Epistemological position: Constructivist/interpretive. | |
| Claus et al. (2019) Germany | CBT-based, group intervention for children and parents, "Raising Healthy Children." Twelve sessions, 2 h each. Preventative intervention for children of parents with a history of depression. Delivered by trainee psychiatrists, psychologists and doctoral students. | Aimed to explore positives and negatives about the intervention and how participants had transferred learning to their everyday lives | *N* = 40 (22 children, 11 female; 18 adults, 8 female)<br>Aged 9–17 ($\bar{x}$ = 13.09, SD = 2.41).<br>Participants were at-risk for depression, due to at least one of their parents having experienced a depressive episode.<br>No data were provided on ethnicity.<br>Self-selecting sample from 80 total participants involved in the intervention. | Data collection: SSIs and a focus group. Explored what participants had learned from therapy, how the family discussed depression, and facilitators/barriers to successful outcomes. SSIs conducted 4–13 months post-therapy. Focus groups conducted immediately post-therapy.<br>Data analysis: Deductive qualitative CA (Elo & Kyngäs, 2008).<br>Epistemological position: Pragmatist. Data categorized into a pre-existing matrix but process involved researcher interpretation. | 1. General acceptability.<br>2. Motivation for participating.<br>3. Talking about depression.<br>4. Children's knowledge of depression.<br>5. Children's coping with stress.<br>6. Parenting skills.<br>7. Implementation in everyday life.<br>8. Logistics |
| Cunningham et al. (2019) USA (Midwest) | TEACH, a CBT-based intervention tailored for children with lupus. | Aimed to assess feasibility, acceptability, and impact of the intervention | *N* = 18 (17 female).<br>Aged 13–21 ($\bar{x}$ = 16.89, SD = 2.27). | Data collection: SSIs. Explored feasibility, acceptability, content and format of the intervention. | *Domain 1: Feasibility*<br>1. Usability of skills.<br>2. Barriers. |

**TABLE 3** (Continued)

| Study and location | Intervention | Aims and context | Participants | Method | Key themes (From *n* participants) |
|---|---|---|---|---|---|
| | Delivered by psychologists. | | Participants all had childhood-onset lupus and experienced clinical levels of depression.<br>Eleven participants were Caucasian, three African American, two Asian American, one mixed, and one Hispanic/Latino.<br>Convenience sampled from patients at a paediatric rheumatology clinic. | Conducted immediately post-therapy.<br>Data analysis: TA.<br>Epistemological position: Not discussed by researchers. | *Domain 2: Acceptability*<br>1. Program format.<br>2. Therapist characteristics.<br>3. Suggested modifications.<br>*Domain 3: Treatment outcomes*<br>1. Sleep/fatigue<br>2. Mood<br>3. Pain<br>4. Self-management<br>5. Self-efficacy |
| Kandasamy et al. (2019) India (Child and adolescent psychiatry clinic) | CBT manual. Four to eight sessions. Delivered by the first author. | Aimed to explore children's perspectives on their mental health difficulties, their impact on socioacademic functioning, and the treatment process | *N* = 30 (14 female).<br>Aged 6–16<br>Various anxiety disorders, determined by a screener questionnaire and a neuropsychiatric interview.<br>No data were provided on ethnicity.<br>Convenience sampled. | Data collection: SSIs. Explored nature of mental health difficulties and experiences of the treatment process. Conducted at baseline and 12 weeks post-therapy.<br>Data analysis: TA.<br>Epistemological position: Not discussed by researchers. | 1. Achievement.<br>2. Interpersonal difficulties.<br>3. Self-esteem.<br>4. Self-efficacy.These were found across illness experience, illness impact, and treatment impact. |
| O'Keeffe et al. (2019) England (North London) | CBT, BPI or STPP.<br>Nine, 9, and 14 participants respectively received each treatment. All key themes were represented by CBT participants.<br>Unclear who delivered the interventions. | Aimed to explore the reasons why depressed adolescents dropped out of therapy, and to categorize these from a theoretical perspective | *N* = 99. Thirty-two were "dropout cases" (23 female). Sixty-seven completed treatment and were included for statistical comparison (not described below).<br>Aged 11–17 ($\bar{x}$ = 15.84, SD = 1.87). | Data collection: SSIs. Used "The Experience of Therapy Interview" and "Thinking Back About Therapy Interview" (Midgley et al., 2011a, 2011b). Conducted immediately post-therapy and 1 year post-therapy. | 1. Dissatisfied: therapy failed to meet their needs (18, 3 CBT).<br>2. Got-what-they-needed: They felt better before the end of treatment (10, 4 CBT). |

(Continues)

**TABLE 3** (Continued)

| Study and location | Intervention | Aims and context | Participants | Method | Key themes (From *n* participants) |
|---|---|---|---|---|---|
| | | | Clinical levels of depression and anxiety.<br>Fifteen participants were "White British," 16 were "any other ethnic background," and one was unknown.<br>Sampled from the IMPACT-ME study (Midgley et al., 2014). | Data analysis: Ideal type analysis. The justification was to compare cases to form categories, or "ideals," of dropout. Themes were listed and summaries constructed for each case, before cases were systematically compared to form categories.<br>Epistemological position: Constructivist/interpretive. | 3. Troubled: It was not the right time to engage in therapy (4, 2 CBT). |
| Donald et al. (2018) Australia (urban mental health service) | CBT (6–12 sessions, 2 participants).<br>"Eclectic" therapy (12 sessions, 1 participant).<br>Delivered by CPs. | Aimed to explore how clients and therapists perceive therapeutic change and what factors facilitate change | *N* = 3 (2 female).<br>Aged 17–19 ($\bar{x}$ = 17.67, SD = 1.15).<br>One participant had anxiety, one had anxiety and depression, one had trauma.<br>No data were provided on ethnicity.<br>Self-selecting sample. | Data collection: SSIs. Focussed on experiences of therapeutic change, not the nature of mental health. Conducted immediately post-therapy.<br>Data analysis: IPA. The justification was its focus on lived experiences and methodological flexibility.<br>Epistemological position: Constructivist (critical realist). | 1. Facing problems alone (3).<br>2. How the therapeutic space was used (2).<br>3. Change characteristics (2).<br>4. Partial changes (3).<br>5. The role of context in change (2).<br>6. Growing into the new self (3). |
| McKeague et al. (2018) England (inner London) | CBT-based, group, 1-day, manualised "Discover" workshops.<br>Telephone follow-up.<br>Delivered by CPs. | Aimed to explore feasibility and acceptability of the intervention as well as barriers to participation | *N* = 24. Two subsamples: Intervention attenders (15, 12 female) and nonattenders (9, 5 female).<br>Aged 16–19 ($\bar{x}$ = 17.52).<br>Participants wanted to receive help for emotional difficulties and self-referred to the | Data collection: SSIs. For attenders, explored recruitment process, intervention experiences, impact, and feasibility. Conducted 4 months postintervention. For nonattenders, explored barriers to participation. Conducted as soon as possible.<br>Data analysis: TA. Justification was to give voice to participants, | *Experiences of participating*<br>1. Understanding and managing stress.<br>2. Preference for engaging and interactive content.<br>3. Importance of an individualized approach.<br>*Delivery in the school setting*<br>1. Attending a workshop at school |

**TABLE 3** (Continued)

| Study and location | Intervention | Aims and context | Participants | Method | Key themes (From *n* participants) |
|---|---|---|---|---|---|
| | | | intervention. They were not screened for anxiety or depression.<br>Ten participants were Black African, three Black Caribbean, six White British, five other.<br>Attenders were purposively sampled from a larger RCT. Nonattenders were sampled on a rolling basis when they decided not to participate. | exploring commonalities and variations.<br>Epistemological position: Researchers stated analysis was "not conducted from a particular theoretical standpoint." | 2. Group format<br>3. Barriers to attending |
| Clarke et al. (2017) England (South-East) | Group-based, manualised CBT, "Exploring Feelings: CBT to Manage Anxiety" (Attwood, 2004) | Aimed to explore the process of change and maintaining factors of anxiety. Employed an RCT design with intervention vs. control. | $N = 28$ children (all male). $N = 9$ parents.<br>Aged 11–14 ($\bar{x} = 12.75$, SD = 0.78).<br>All participants had autism and high levels of anxiety.<br>Twenty-seven participants were White British, one was Chinese.<br>Convenience sampled from six schools that agreed to participate and identified 37 eligible children, 28 of whose parents gave consent. | Data collection: SSIs. With children, explored emotions, recent difficult events, and coping strategies. With parents, explored autism; children's emotions and behaviors.<br>Data analysis: TA. Themes emerged from the data.<br>Epistemological position: Not discussed by researchers. | *Children's views*<br>1. Thought changes influence behavior (4).<br>2. Learning to process complex emotion (8).<br>3. Pressure to conform to social norms (3).<br>4. Influence of environment and social context on therapeutic engagement (3). |

(Continues)

**TABLE 3** (Continued)

| Study and location | Intervention | Aims and context | Participants | Method | Key themes (From *n* participants) |
|---|---|---|---|---|---|
| Jones et al. (2017) England (London, CAMHS) | Individual CBT (eight participants) or integrative therapy (two). Delivered by CPs, CBT therapists, or CAMHS practitioners. | Aimed to explore adolescents' therapy engagement experiences, facilitators, and barriers | *N* = 10 (seven female, one female–male transgender).<br>Aged 16–18 ($\bar{x}$ = 16.9, SD = 0.74).<br>Mental health needs were not explicitly stated but included clinical levels of anxiety and depression.<br>Four participants were White British, two White European, two Black British, one Latin American, and one British Asian.<br>Convenience sampled. Clinicians identified suitable participants from their caseload and passed on details to the researchers. | Data collection: SSIs. Explored experiences of service; facilitators and barriers to attendance. Researchers consulted other adolescents to ensure appropriateness of schedules.<br>Data analysis: IPA. Themes were developed from data alongside interviewers' notes, through an emergent, iterative process of abstraction, being revised throughout the entire research process.<br>Epistemological position: Constructivist/interpretive. | 1. Engagement begins at help seeking.<br>2. Strength of inner resolve.<br>3. Evolution of the self.<br>4. In the clinic room. |
| Lundkvist-Houndoumadi and Thastum (2017) Denmark (Training and research clinic at Aarhaus University) | Manualised group CBT, 10 weekly 2-h sessions, for youth and parents. 1-h booster 3 months post-treatment. Cool kids (7–12) and chilled adolescents (13–17) manuals, translated into Danish. Delivered by psychologists. | Aimed to examine nonresponse to CBT among youths with anxiety disorders | *N* = 15 children (nine female). At least *N* = 15 parents (families of each child)<br>Aged 10–17 ($\bar{x}$ = 13.5, SD = 2).<br>Participants were identified as nonresponders to the intervention. They all had social anxiety disorder or | Data collection: SSIs. Conducted with youths and their parents to explore experiences of therapy and views on nonresponse. Conducted 3 months post-treatment.<br>Data analysis: IPA. The justification was to understand participants' experiences. Codes | 1. Youths were not involved in therapy work (14).<br>2. Manualised group format posed challenges (10). |

**TABLE 3** (Continued)

| Study and location | Intervention | Aims and context | Participants | Method | Key themes (From *n* participants) |
|---|---|---|---|---|---|
| | | | anxiety with comorbid mood disorders.<br>Participants were of Danish ethnicity.<br>106 youths experienced the intervention; 24 were deemed nonresponders. Of these, 15 were sampled because they had clinical characteristics deemed representative of nonresponders (see above). | were created inductively from the material rather than theory.<br>Epistemological position: Constructivist/interpretive. | |
| Shahnavaz et al. (2015) Sweden (department of paediatric dentistry at Karolinska Institutet) | Individual CBT, 4–15 sessions, for youth and parents. Delivered by CPs. | Aimed to explore how children with dental anxiety and their parents experience CBT | *N* = 12 children (7 female). *N* = 12 parents (7 female).<br>Aged 9–19 ($\bar{x}$ = 13).<br>Participants all fulfilled criteria for specific phobia (blood-injection-injury phobia), relating to dental anxiety.<br>No data were provided on ethnicity.<br>Participants were sampled from a group of 17 children attending the Karolinska Institutet; all those who agreed to participate were included in this study. | Data collection: SSIs. Conducted with children and parents separately to explore thoughts about CBT and perceived outcomes. Conducted 2–14 months post-treatment ($\bar{x}$ = 9).<br>Data analysis: TA. The justification was the generation and understanding of themes within data.<br>Epistemological position: Constructivist/interpretive. | Perspective shift (overarching theme).<br>1. Mastery.<br>2. Safety.<br>3. Reduced fear. |

(Continues)

**TABLE 3** (Continued)

| Study and location | Intervention | Aims and context | Participants | Method | Key themes (From *n* participants) |
|---|---|---|---|---|---|
| Bru et al. (2013) Norway | Group, manualised CBT, similar to the Coping With Depression Course (Cuijpers et al., 2009). Eight sessions and two follow-up sessions | Aimed to explore experience of specific CBT components. Part of a larger RCT evaluating intervention effectiveness. | *N* = 9 (7 female).<br>Aged 17–20 ($\bar{x}$ = 18.4).<br>Participants had subclinical depression or mild to moderate major depressive disorder.<br>No data were provided on ethnicity.<br>Convenience sampled from four courses from the larger RCT. Thirty people were approached, 12 initially consented. | Data collection: SSIs. Explored perceptions of CBT and intervention-specific components. Conducted immediately postintervention or just before the final follow-up session.<br>Data analysis: Theoretical TA, using a priori theory. Initially, categories were deductively imposed before subthemes inductively emerged. The justification was to allow participants' narratives to speak for themselves.<br>Epistemological position: Subjectivist—aimed to allow participants' narratives to speak for themselves and avoid interpretation. | 1. Education about depression.<br>2. Education about relations between thoughts, feelings, and behavior.<br>3. Thought identification.<br>4. Cognitive restructuring.<br>5. Relaxation training.<br>6. Visualization.<br>7. Pleasurable activities.<br>8. Social relationships.<br>9. Homework. |
| Donnellan et al. (2013) England (North-West CAMHS) | Individual CBT. Delivered by CPs. | Aimed to explore how youth perceive and make sense of their experiences of CBT | *N* = 3 (all female).<br>Aged 12–16 ($\bar{x}$ = 15).<br>Two participants had anxiety, one participant had low mood and engaged in self-harm.<br>No data were provided on ethnicity.<br>Purposively sampled by researchers from youth | Data collection: SSIs. Explored content and perceptions of CBT. Before the study, appropriateness of the schedule was assessed with other service users.<br>Data analysis: IPA. Justification was to enable exploration of participants' real-life experiences. | 1. Conceptualizing CBT—impacts on change and progression.<br>2. Process of engagement and its outcomes.<br>3. Developing a therapeutic relationship—A model for real life.<br>4. Structures of therapeutic delivery. |

**TABLE 3** (Continued)

| Study and location | Intervention | Aims and context | Participants | Method | Key themes (From *n* participants) |
|---|---|---|---|---|---|
| | | | attending the CAMHS clinic. | Epistemological position: Constructivist/interpretive. | |

Abbreviations: BPI, brief psychosocial intervention; CA, content analysis; CAMHS, child and adolescent mental health service; CP, clinical psychologist; CSQ, Client Satisfaction Questionnaire; IMPACT-ME, improving mood through psychoanalytic and cognitive-behavioral therapy-my experience; IPA, interpretative phenomenological analysis; K-SADS, kiddie schedule for affective disorders and schizophrenia; NGO, nongovernmental organisation; PWP, psychological well-being practitioner; RCT, randomized controlled trial; SAD, social anxiety disorder; SCAS, Spence Children's Anxiety Scale; SSI, semistructured interview; STPP, short-term psychoanalytic psychotherapy; TA, thematic analysis; TAU, treatment as usual; TEACH, treatment and education approach for childhood-onset lupus.

**TABLE 4** Summary of weight of evidence ratings.

| Study | WoE A: Methodological quality | WoE B: Methodological relevance | WoE C: Topic relevance | WoE D: Overall rating |
|---|---|---|---|---|
| Myburgh, Muris, et al. (2021) | 1.83 | 1.5 | 1.4 | 1.58 |
| | Medium | Low | Low | Medium |
| Taylor et al. (2021) | 2.33 | 2.25 | 3 | 2.53 |
| | Medium | Medium | High | High |
| Howells et al. (2020) | 1.78 | 1.5 | 1.6 | 1.63 |
| | Medium | Low | Medium | Medium |
| Jones et al. (2020) | 2.39 | 2 | 2.2 | 1.63 |
| | Medium | Medium | Medium | Medium |
| Krause et al. (2020) | 2.11 | 1.75 | 2.2 | 2.02 |
| | Medium | Medium | Medium | Medium |
| Loucas et al. (2020) | 2.39 | 1.75 | 1.6 | 1.91 |
| | Medium | Medium | Medium | Medium |
| Wilmots et al. (2020) | 2.67 | 3 | 2.8 | 2.82 |
| | High | High | High | High |
| Claus et al. (2019) | 2.61 | 2.25 | 1.4 | 2.09 |
| | High | Medium | Low | Medium |
| Cunningham et al. (2019) | 2.11 | 1.75 | 2 | 1.95 |
| | Medium | Medium | Medium | Medium |
| Kandasamy et al. (2019) | 1.06 | 1.5 | 2.2 | 1.59 |
| | Low | Low | Medium | Medium |
| O'Keeffe et al. (2019) | 2.72 | 3 | 2.8 | 2.84 |
| | High | High | High | High |
| Donald et al. (2018) | 2.50 | 2.75 | 2.8 | 2.68 |
| | Medium | High | High | High |
| McKeague et al. (2018) | 2.33 | 2.25 | 1.8 | 2.13 |
| | Medium | Medium | Medium | Medium |
| Clarke et al. (2017) | 2.17 | 1.5 | 2.2 | 1.96 |
| | Medium | Low | Medium | Medium |
| Jones et al. (2017) | 2.78 | 2.75 | 2.4 | 2.64 |
| | High | High | Medium | High |
| Lundkvist-Houndoumadi and Thastum (2017) | 2.61 | 2.25 | 2.8 | 2.55 |
| | High | Medium | High | High |
| Shahnavaz et al. (2015) | 2.28 | 2.75 | 2.4 | 2.48 |
| | Medium | High | Medium | Medium |

**TABLE 4** (Continued)

| Study | WoE A: Methodological quality | WoE B: Methodological relevance | WoE C: Topic relevance | WoE D: Overall rating |
|---|---|---|---|---|
| Bru et al. (2013) | 2.72 | 2 | 1.8 | 2.17 |
| | High | Medium | Medium | Medium |
| Donnellan et al. (2013) | 2.78 | 2.5 | 2.6 | 2.63 |
| | High | Medium | High | High |

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

about intervention *x*?" limiting the depth of conversation and possibly making participants feel unable to be honest (Robson, 2002).

### 3.2.4 | Analytical procedures

Seven studies were given low WoE A and B ratings because they reported the accounts of "most" or "many" participants, with little attention paid to diversity of views or context, limiting the richness of data (Braun & Clarke, 2013). Seven studies were given high ratings because they captured diversity of views and included contextual information about participants' lives outside the therapeutic space, lending nuance and depth. This facilitated analysis of systemic facilitators and barriers to positive outcomes, such as resolution of stressful life circumstances and support networks.

### 3.2.5 | Data reported

Five studies were given high WoE C ratings for providing roughly equal discussion of facilitators and barriers to positive outcomes. Negative views of CBT are as valid, and clinically useful, as positive views, so it is helpful for qualitative studies to illustrate breadth of experience (Shedler, 2018).

### 3.2.6 | Theoretical approach to data analysis

Ten studies were given high WoE C ratings because they took an inductive approach, allowing the data to guide thematic development without reference to a priori frameworks (Thomas, 2006). Four studies were given low ratings because they took a deductive approach, basing thematic analysis on a priori frameworks. Three of these were also given low ratings for "sampling," "analytical procedures," and "interview content." This indicated a pattern of low ratings for studies that aimed to evaluate specific interventions, leading to potentially biased sampling, restrictive interviews, a predefined analysis strategy, and decontextualized findings.

## 3.3 | RQ1: How YP conceptualize "positive outcomes" from CBT

Thirty-four conceptualizations of positive outcomes were defined. Findings are summarized in Figure 3 and elaborated in Supporting Information S1: Appendix C. The dotted lines in Figure 3 show conceptual relationships between two themes concerning internal, cognitive/emotional outcomes; and three themes concerning external,

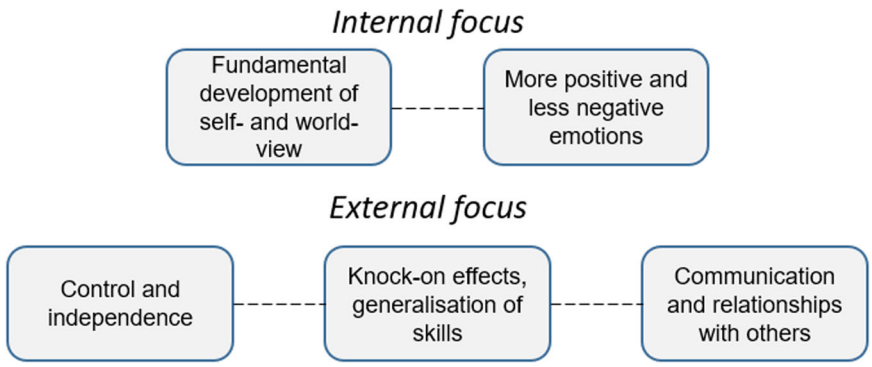


**FIGURE 3** Descriptive thematic map of positive CBT outcomes according to YP. CBT, cognitive-behavioural therapy; YP, young people.

behavioral/social outcomes. Throughout the results and discussion, italicized phrases refer to codes within themes; codes are supported by quotations drawn from reviewed studies.

### 3.3.1 | Internal focus

Two themes related to cognitive and emotional domains. First, "More positive and less negative emotions" covered outcomes that most closely resembled those measured by RCTs. Many experienced *reduced negative emotions*, using language such as "less stressed," "less afraid," and "more relaxed"; few mentioned anxiety or depression directly. Some experienced more positive emotions, "[I'm] a lot happier than what I was before I started" (Cunningham et al., 2019). YP seemed to prefer euphemisms like "less stressed" to clinical terms like "reduced anxiety."

Second, "Fundamental development of self- and world-view" represented cognitive and identity-related outcomes, the most frequently mentioned of which was *perspective shift*. For example, "I understood that much depends on how you look at situations. And I think that has changed a lot about how I view things" (Bru et al., 2013). The starkness of these descriptions contrasts with the interval scales typically used to quantify degrees of symptom reduction. Some participants described *returning to self before mental health issues*, such as "back to the person I was before" (Wilmots et al., 2019). For many, the personalized perspective shift was accompanied by a more academic *greater understanding of emotions and mental health*. Some referenced the CBT model, "becoming aware of how it works; a situation, an interpretation and then a feeling" (Bru et al., 2013). Others referenced the perspective-understanding link, "it gives you a better understanding of what you're going through… as well as… a different way of thinking" (Loucas et al., 2020). Others indicated *normalization of mental health difficulties*, "depression is curable and that people still, you know, are normal" (Claus et al., 2019).

### 3.3.2 | External focus

Three themes related to behavioral and social domains. First, "Control and independence" showed how participants linked cognitive developments with behavioral changes, "You dealt with the fear, got it in perspective; you could control the situation yourself" (Shahnavaz et al., 2015). Such insights suggest maturity, acknowledging that negative emotions still occur but YP are better able to manage them. These are domain-general skills, likely to aid YP across different contexts. The emphasis on independence is salient during adolescence, a developmental period of reduced reliance on adult caregivers and greater risk-taking in exploring a wider social environment (Spear, 2013).

Second, "Knock-on effects, generalization of skills" represented indirect behavioral outcomes, such as *improved educational functioning*, "giving exams without fear" (Kandasamy et al., 2019); *improved financial management*, "being more careful with finances" (Jones et al., 2020); and *being physically more active*, "[I] became in better shape… there was less time to think when I was active" (Bru et al., 2013).

Third, "Communication and relationships with others" represented indirect social outcomes, including *improved social functioning*, "I spend much more time together with other people" (Bru et al., 2013), and *better family system management*, "Some adolescents adjusted their roles within the family system by learning to impose boundaries between their needs and those of family members" (Krause et al., 2020). Several outcomes related specifically to improved communication of emotions such as *better able to open up*, *more open to seeking help*, and *better able to understand and help others*. YP developed empathy and felt empowered to pass on their learning:

> I become more sympathetic as well towards situations because I can understand them more so if anybody else is in that situation, I can be like 'ok, I've been through that', what can I do to help them. (Wilmots et al., 2019)

## 3.4 | RQ2: Facilitators and barriers to "positive outcomes" from CBT

Fifty-seven facilitator and 49 barrier codes were categorized. Findings are summarized in Figure 4 and elaborated in Supporting Information S1: Appendix D. In Figure 4, there are two relationships between person and intervention variables. There is a broader relationship between four themes relating to experiences within the therapeutic space and a single theme relating to experiences outside. All five themes were split into facilitators and barriers.

### 3.4.1 | Intervention content

This theme covered the most frequently mentioned facilitators to positive outcomes. YP value skills they can employ in their everyday lives so they can *see tangible evidence of change* and *be actively involved*, "[A progress chart] was useful cos you could compare… what I'd done each week to see what I was progressing in" (Taylor et al., 2021).

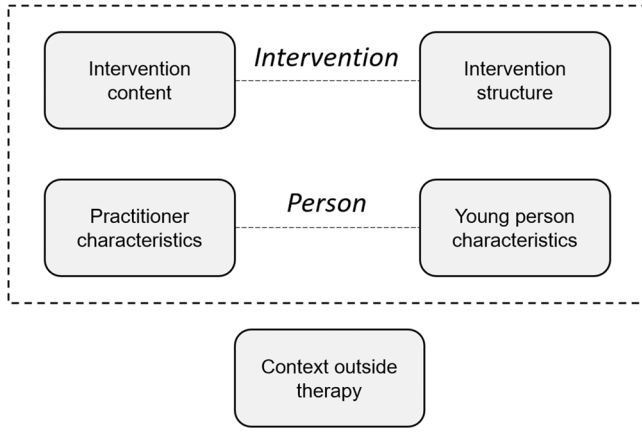


**FIGURE 4** Descriptive thematic map of facilitators and barriers to positive CBT outcomes according to YP, with each theme containing both facilitators and barriers. CBT, cognitive-behavioural therapy; YP, young people.

This suggests a positive reinforcement cycle, where YP are taught useful techniques, employ these techniques, see that they work, and engage more in therapy, "the more she told me about how I can manage my low moods, my anxiety… it made me want to come here more" (Jones et al., 2017).

Regarding specific *CBT techniques*, *cognitive restructuring*, and *psychoeducation* link with *perspective shift* and *greater understanding of emotions and mental health* as key cognitive outcomes. Emotional control techniques, particularly *emotion management* and *relaxation exercises*, were frequently mentioned. Participants rarely mentioned techniques they found unhelpful. Some participants were utilitarian, "Rose and Max spoke about how 'just talking… didn't really solve anything', and expressed the need to be actively working to reduce the impact of symptomology" (Jones et al., 2017).

Many YP experienced *difficulty implementing CBT techniques*, "It's not difficult to find [positive] thoughts, but it's difficult to use them" (Bru et al., 2013) and "If I'm out with friend [*sic*], I probably wouldn't want to do [the coping skills] in front of them" (Cunningham et al., 2019), noting the significance of peer judgment. Supporting evidence is provided by a recent study which explored self-rated facilitators and barriers to youth anxiety recovery 6 years post-treatment (Casline et al., 2022). YP who did not recover were more likely to report difficulties applying CBT techniques in everyday life.

### 3.4.2 | Intervention structure

Regarding group CBT, a common concern was it being *not personalized*, "helping young people that are feeling stressed, the best thing to do would be talk to them about their individual circumstance if they're willing to tell you their personal lives" (McKeague et al., 2018). While the group format can restrict personalization, it can facilitate *sharing experiences* and *engaging with others*, "It made me feel better… to know… there are other people going through the same thing" and "there was other people of my age… with different ways of coping… it helped because I took in how they coped with their stress" (Loucas et al., 2020). Groups provided emotional reassurance and peer learning; meeting peers may have reduced stigma. Furthermore, a valued degree of control may be provided to YP experiencing group CBT through *variety of techniques and activities*, "The fact that they gave us a lot of different approaches… not all of them suited me but there were definitely some that did" (Loucas et al., 2020). Four barrier codes under *group format* were referenced by participants with social anxiety, suggesting the presence of others reinforced their difficulties as they were *unable to open up* and *felt judged*.

Outside group CBT, a key format facilitator was *appropriate pacing*, "being given space to share information at their own pace" (Wilmots et al., 2019). A potential drawback to a slower pace was *insufficient duration of therapy*; YP "wanted more time spent on… information or management techniques" (Howells et al., 2020) while "Families thought that a long process is required for change to occur, and therapy was not long enough for this" (Lundkvist-Houndoumadi & Thastum, 2017). Several YP described effects of the *physical environment*, both as facilitators, "it was quite good doing it in school, 'cause we're all comfortable with our surroundings" (McKeague et al., 2018), and barriers, "[the room was] really small and it felt cramped" (Clarke et al., 2017). Finally, *follow-up communication* after CBT had concluded was greatly appreciated, "it felt like it wasn't just a one-off… it showed that you guys actually care" (Loucas et al., 2020), because it conveyed a sense of being continually held in mind.

### 3.4.3 | Practitioner characteristics

A key facilitator was being given *control over therapy*, "Maddison valued being given the opportunity by her practitioner to exert control over her treatment course, which promoted engagement" (Wilmots et al., 2019) and a practitioner who was *responsive, flexible, personalizing therapy*, "It was [a] more personalized approach. And we could figure out a way… where it wasn't working for me" (Donald et al., 2018). These points around control and

personalization link with the importance of *greater independence* as an outcome, emphasizing that YP value agency and collaboration. Some practitioners were *unresponsive, inflexible, not personalizing therapy*, "He would be like listening, but not listening… like he was tryin' to force me to say something that I din wanna say" (Wilmots et al., 2019). This could come across as *communicating patronizingly*, such as being made to feel "a bit like a child" and "you're talking to me like I'm five" (Jones et al., 2017). In contrast, YP valued practitioners who *communicate nonpatronizingly*, "understand everything from the perspective of young people because in a different age people view things differently and sometimes… an issue might be minor for adults but for young people it's big" (Jones et al., 2017).

While some codes support the value of autonomy, others exhibit the value of adult support including *enabling YP to feel understood* and *being someone for YP to talk to*. For example, "She seemed like a person you could speak to anything about, she had that aura about her" (Jones et al., 2017) and "I felt like [the practitioner] actually understood where I was coming from which was amazing… it's so nice to have someone to listen to that" (Cunningham et al., 2019). Both quotes contain an element of awe, suggesting the practitioner possessed skills which YP could not articulate. Practitioners were appreciated for *authenticity*, "[My practitioner] wanted to help. Not judgmental or anything. You know, like a nice person. So it was a good relationship." (O'Keeffe et al., 2019). Some participants described a process of *scaffolding independence*, "It's like riding a bike, she was kind of like my safety pedals… and I guess they're kind of coming off now and I've got to ride my bike on my own now" (Jones et al., 2020).

While YP depend on a skilled adult listener and desire emotional acceptance, there is also a role for adults in facilitating YP's voices and fostering independence:

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

Notably, this review identified no codes in relation to practitioner confidentiality, despite this being among the most important themes in previous reviews (Freake et al., 2007; Lynch et al., 2020). Confidentiality was mentioned only twice, in relation to concerns that the school setting may limit confidentiality and in the context of personal data collection for a research study.

### 3.4.4 | Young person characteristics

A key facilitator was for YP to *act for their own good, even when it's difficult*, "[I] psyched [myself] up and thought this is going to be a good thing so don't get scared otherwise you won't end up coming" (Jones et al., 2017). While therapy is anxiety-provoking it can bring about gains that make the anxiety worthwhile; accepting this fact was key to engagement. Other YP appeared unable to clear this mental hurdle, *not perceiving therapy as helpful*, "He always has his guards up. According to him, no one can help him… On our way here he told us: 'I told you this will not lead to anything' (Mother)" (Lundkvist-Houndoumadi & Thastum, 2017) and "I don't think I talked that much, I gave quite small answers coz as I say part of me didn't really wanna be there and my heart wasn't really in it, I was rather sceptical" (Donnellan et al., 2013). These quotes suggest different perspectives, the first 'I am un-helpable (the problem is with me)' and the second "therapy isn't helpful (the problem is with therapy)." For some, *negative preconceptions of therapy* fed stigma:

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

### 3.4.5 | Context outside therapy

The resolution of *acutely* stressful life circumstances could render CBT no longer necessary, "the main trigger to his depression was school, and once he finished school, he reported feeling ready to stop therapy" (O'Keeffe et al., 2019). However, *chronically* stressful circumstances, such as "homelessness, history of abuse, and financial and caring responsibilities" could create "lack of stability [that] needed to be addressed before these adolescents would be able to engage in therapy" (O'Keeffe et al., 2019). Even moderately stressful circumstances could create barriers, such as "missing [school] lessons, I thought that was going to add to the stress rather than take it away because just more to juggle" (McKeague et al., 2018).

Some adults highlighted the importance of YP's autonomy in accessing CBT, "they have to make that decision… I don't think it should be forced upon them" (McKeague et al., 2018). However, some YP insightfully recognized that poor wellbeing could cloud decision-making, "at first I was really ill, I felt other people had to make the decisions for me… then as I got… better I was able to make decisions" (Donnellan et al., 2013). Other YP felt "bad about letting people down" (Jones et al., 2017) after figures in their support network prompted their engagement, so accountability could aid motivation.

## 4 | DISCUSSION

### 4.1 | RQ3: Recommendations for CBT practitioners

This review found substantial consensus among participants of different ages, living in different countries, being of roughly equal gender distribution, and undergoing CBT with different practitioners. This suggests the themes are representative of many YP's experiences. The synthesis process has added to the potential generalizability of findings from individual studies. In making recommendations for practice, this review is following the principle of *representational generalization*, whereby qualitative findings can be tentatively extended to populations from which samples are drawn (Lewis et al., 2003). While the concept of generalization is controversial in qualitative research, as it could be seen as incompatible with the emphasis on detail and contextualization (Yin, 2009), the researchers feel there is significant value from the findings in informing evidence-based practice (Larsson, 2009). Analytical themes, worded as practice recommendations, are provided in Figure 5 and form the discussion subheadings. The researcher aimed to balance a comprehensive reflection of the data with a manageable number of recommendations.

#### 4.1.1 | Acknowledge YP's perspectives on outcomes

YP experience a broad range of positive outcomes from CBT across cognitive, emotional, behavioral, and social realms. This contrasts with the standardized, reductive measures typically used in research and practice. The variety reflects the findings of Neelakantan et al. (2019) and Krause et al. (2020).

CBT contributes indirectly to health-related outcomes, social skills, and life skills. This may occur through cognitive development or reduction in emotional distress, which remove barriers that were holding YP back. Some YP feel they can actively help and educate others, spreading benefits beyond those experiencing CBT. Based on how primary studies reported findings, it was unclear whether the same participants articulated both specific and general positive outcomes, and whether these linked to participants' goals at the start of therapy.

Practitioners may be reluctant or struggle to measure additional outcomes as they may require additional administrative efforts, may be subjective to individuals, and YP may not be aware of indirect outcomes until therapy

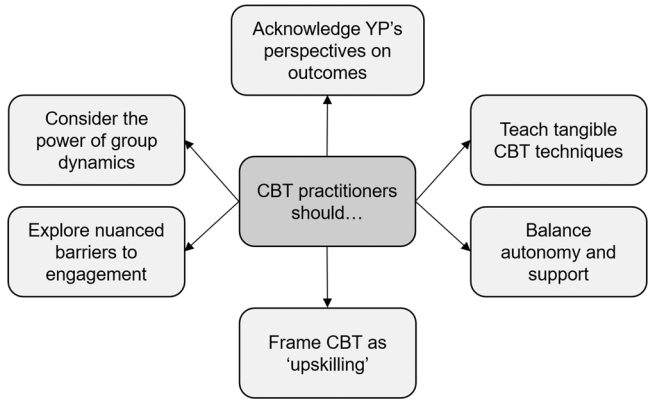


**FIGURE 5** Analytical thematic map of practice recommendations. CBT, cognitive-behavioural therapy; YP, young people.

is completed (James et al., 2015). However, practitioners and researchers should acknowledge that YP may not share their conceptualizations of "positive outcomes," particularly regarding the language used and the variety.

### 4.1.2 | Teach tangible CBT techniques

This sits somewhat counter to research findings that the quality of the therapeutic relationship is a better predictor of outcomes than therapeutic techniques (Lambert & Ogles, 2004; Orlinsky et al., 2004). The well-known "Intervention Pie Chart" suggests "technique and model factors" account for around half the variance in therapeutic change compared with "the therapeutic relationship" (Lambert, 1992). The prominent focus on techniques found by this review may partly have a developmental explanation, since adolescents are typically more sensitive than adults to immediate rewards, such as could be provided by implementing a technique (Spear, 2013). A quantitative study comparing YP who recovered from anxiety with those who did not found the three most helpful facilitators were tangible techniques: relaxation, problem-solving, and changing unhelpful thoughts (Casline et al., 2022). Nonetheless, practitioners should be mindful of complicating factors that only exist outside the therapeutic space and work with YP to problem-solve implementation difficulties, such as peer pressure or embarrassment. This qualitative review cannot assign causality to factors identified; therapeutic techniques may be prominent in YP's minds but not necessarily the most important factor for bringing about change.

### 4.1.3 | Balance autonomy and support

YP articulated conflicting desires between adult support and autonomy. This mirrors adolescence as a transition from adult dependence towards independence (McElhaney et al., 2009). While YP do not wish to be patronized they also have "issues" which are more salient for YP than they would be for adults. Practitioners should respect YP's maturity and avoid patronizing them while ensuring they take seriously issues which may seem trivial to adults.

One method of achieving this involves giving YP control over engagement in and pace of sessions, a factor previously identified by participants engaging in face-to-face, telephone, and text-message-based counseling, showing its ubiquity across therapeutic modalities (Gibson et al., 2016). A second method involves collaboration, such as using Socratic questioning to guide YP to explore their thoughts and reach their own conclusions, rather than taking an expert role and withholding control (Okamoto & Kazantzis, 2021; Padesky, 1993). Quantitative

process research supports the importance of collaboration, with Podell et al. (2013) finding a small significant correlation ($r = -.16$, $p < .05$) between practitioner style (collaborative and empathic) and self-reported anxiety. A third method involves flexibility and adaptability. Chu and Kendall (2009) found practitioner flexibility (adapting treatment to YP's needs and interests) correlated significantly ($r = .25$, $p = .05$) with YP's engagement in later CBT sessions, which in turn predicted improvements in anxiety symptoms post-treatment. The most common reason for flexibility was changing activities to match YP's *interests*; changing activities to match YP's *suggestions* was less common. The importance of therapists being genuine and flexible aligns with the findings of a recent systematic synthesis of young people's experiences developing therapeutic alliance (Dimic et al., 2023).

### 4.1.4 | Frame CBT as "upskilling"

The balance between autonomy and support is informed by Vygotsky's zone of proximal development and its pedagogical counterpart, scaffolding (Bruner, 1985; Vygotsky, 1962). Practitioners should ensure YP feel heard but not patronized, while promoting autonomy and independence so YP are better able to cope in everyday life. "Being listened to" was a prominent theme in a qualitative review of adolescents' opinions of what makes a good medical professional, suggesting it is important to YP when discussing their physical, as well as mental, health (Freake et al., 2007).

This rounded, pedagogical view of CBT fits with how many participants discussed positive CBT outcomes consisting of interwoven cognitive, behavioral, and emotional elements. With a change in perspective and greater self-understanding comes an increased ability to regulate emotions and control behavioral responses when difficult situations arise. Viewed like this, CBT should be presented by practitioners as a practical process of upskilling people to solve problems independently rather than a treatment solely addressing emotional symptomatology. Such a presentation would likely reduce stigma, a common concern also reported by YP in other qualitative reviews, such as reluctance to share personal information and struggling to accept they might benefit from help (Lynch et al., 2020; McCashin et al., 2019). A mixed-methods review of adolescent mental health help-seeking identified public and personal stigma as the most common attitudinal barriers, reported in 9/13 studies (Barrow & Thomas, 2022).

### 4.1.5 | Explore nuanced barriers to engagement

In line with the findings of Murphy and Hutton (2018), successful therapeutic outcomes hinged on YP as well as practitioner characteristics. YP identified considerably more practitioner characteristics as facilitators compared to YP characteristics. It may be that YP see the locus of change in CBT having more to do with a skilled practitioner than action on their own part. There were 18 barrier codes identified in relation to YP characteristics, many of which were mentioned infrequently, suggesting it may be hard to predict why YP are not engaging or making progress. Research suggests up to two thirds of people may feel ambivalent about change before engaging in CBT (Westra & Dozois, 2006). This figure may be higher among YP since they do not typically refer themselves for support (Stallard, 2021). Given the central importance of YP feeling understood and heard, it is imperative for practitioners to clarify why YP are reluctant to engage, to ensure YP's concerns are addressed appropriately and they are not led to feel misunderstood and further disengage.

Given that personalization was identified in this review as a facilitator for positive outcomes, understanding YP's idiosyncratic views is a key responsibility for practitioners; it would be inadvisable to dismiss a view because it seemed atypical. The therapeutic skill of personalizing delivery extends to the time and effort required to understand why YP are not making progress, since reasons are unlikely to be predictable based on general experience and the dangers of misunderstanding reasons are stark. Dwelling on reasons for disengagement might feel counter-productive but could support YP to feel heard and understood, which is a significant factor in facilitating progress.

### 4.1.6 | Consider the power of group dynamics

The group format presents a practical dilemma: some YP feel it provides insufficient personalization while others appreciate the opportunity to share ideas and experiences with peers. Within groups, it may be easier for YP to learn about a range of techniques (from practitioners and peers) and choose what works best for them, rather than feeling pressure to try what an adult is recommending in a one-on-one setting. Addressing this dilemma could involve organizing small group sizes or asking YP in groups whether they feel the need for more personalized support before offering individual CBT. Practitioners should consider whether the nature of YP's difficulties, such as social anxiety, could impede engagement in group CBT.

## 4.2 | Limitations

In conveying diversity in response to the RQs, the researcher was unable to elaborate all codes. It would be difficult to address this nonreductively; if broader codes had been defined, diversity would have been less apparent. This speaks to the issue of data saturation in qualitative research (Saunders et al., 2018). From a utilitarian perspective, this review's purpose was primarily to inform practice, which meant distilling complexity into practical recommendations.

The age range of 0–25 was large and might have glossed over variation in views among YP of different ages. While the age range was chosen to make the most of the limited research in this area, future research might make productive comparisons of subgroups within this large range.

A single researcher conducted all data analysis; involving YP or CBT practitioners would have strengthened the reliability and credibility of recommendations.

## 4.3 | Future research

Studies evaluating specific interventions received lower WoE scores. Future research should carefully consider the implications of power dynamics in such designs. Interviewers should not have prior involvement in interventions, interview schedules should not pose leading questions, and researchers should not employ a priori evaluative frameworks that over-simplify participants' experiences into positives and negatives. This would provide more robust evidence and honest feedback, aiding future intervention design decisions.

Studies exploring how YP conceptualize positive outcomes to CBT should explore whether the same participants identify specific outcomes (e.g., meeting up more with friends) and general outcomes (e.g., perspective shift). Some YP may only identify specific outcomes and practitioners might support them to see how CBT could inform their lives more broadly. It would be helpful to explore whether positive outcomes link with goals set at the beginning of therapy or whether the process of CBT leads to unexpected outcomes. Participants could be interviewed before, during, and after therapy to explore the process of change.

Some codes had relatively thin data; future research could explore whether this is because they are not important to YP, whether they are taken for granted, or some other reason. Greater attention could be paid to facilitators and barriers in the systemic context, since this is theoretically of great importance (Bronfenbrenner, 1979) but was infrequently mentioned by participants. Future research could explore whether clinical language in pre-/post-measures is uncomfortable and whether YP would prefer psychological measures to better reflect their own conceptualizations of mental health difficulties. A future qualitative review could explore what *practitioners* consider to be facilitators and barriers to positive CBT outcomes.

## 5 | CONCLUSION

This thematic synthesis explored how YP with anxiety and depression conceptualize "positive outcomes" from CBT (RQ1) and what they consider to be facilitators and barriers to such outcomes (RQ2). Based on these findings, recommendations were made for CBT practitioners (RQ3). As anticipated, a broader variety of direct and indirect outcomes were identified as meaningful by YP compared with the typical standardized but reductive outcomes reported in RCTs (Krause et al., 2019, 2020). This included outcomes relating to emotions, self-understanding, independence, developing life skills, and relationships. Facilitators and barriers were identified relating to practitioner and YP characteristics, intervention content and structure, and the context outside therapy. This review did not assess the relative importance of factors in contributing to positive outcomes, although data were provided on the prevalence of codes and themes to suggest what might be transferable to other contexts. Overall, this review foregrounded the perspectives of YP with experience receiving CBT to extend prevailing research trends, in which standardized measures and practitioners' voices dominate. It is hoped that practitioners and researchers will reflect on their practice in light of views expressed by YP as experts by experience.

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### CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

### DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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### PEER REVIEW

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## SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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