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Supporting socially anxious children and adolescents: challenges and possibilities

Louise Sawyerr

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Declaration

This work is being submitted for the award of Doctorate of Applied Educational Psychology. This piece contains no material that has been accepted for the award of any other university module or degree. To the best of my knowledge this work contains no material previously published or written by another person except where due reference is made.

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Louise

Supporting socially anxious children and adolescents: challenges and possibilities

Overarching abstract

This thesis starts with a quantitative investigation into the effectiveness of Cognitive Behaviour Therapy (CBT) school-based interventions on children and adolescents' levels of social anxiety. The findings of this systematic review of the literature indicated that CBT interventions might effect a positive reduction in adolescents' social anxiety on an immediate, post-test intervention basis. However, not enough evidence currently exists to suggest that CBT is effective on a longer-term basis due to studies' lack of follow-up data and low/medium methodological quality (based on studies' Weight of Evidence judgments).

This thesis includes a bridging document. This document makes a link between the systematic review of the literature and the empirical research study. The bridging document aims to make explicit how I came to shift my research focus from a quantitative systematic review of the literature on CBT towards a small-scale, qualitative exploration into the perceptions of three parents. Parents were invited to reflect upon anxious adolescents' transitions from compulsory school education into the adult world.

The empirical research study details the rationale, design and findings from a small scale study which involved interviewing parents. The interviews were analysed using Interpretative Phenomenological Analysis (IPA). Three superordinate themes emerged which focussed on: parents' perceptions of service delivery for anxious adolescents, anxious adolescents' ability to cope in social situations, and the potential for anxious adolescents to make a fresh start as they transition into adulthood. This empirical work contributes to research into parental perceptions and social anxiety, and the practical implications for Educational Psychology practice are also considered.

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A systematic review into Cognitive Behavioural Therapy (CBT) school-based interventions with children and adolescents aged 8-18 years old with social anxiety

Abstract

Social anxiety is commonly linked with poor school attendance and low educational attainment. Anxious individuals tend to have low self-esteem and confidence and will avoid interactions with others. A number of self-report, teacher and parent questionnaires have been devised to assess social anxiety. Cognitive Behavioural Therapy (CBT) is most widely used to treat social anxiety. This paper systematically reviewed nine published studies which looked at the relationship between school-based CBT interventions and measures of children and adolescents' social anxiety. The results indicated that CBT interventions might effect a positive reduction in social anxiety on a short term, post-intervention basis. Research has been conducted in to the effectiveness of CBT interventions on individual's levels of social anxiety on a longer-term basis. However, not enough evidence currently exists to suggest that CBT is effective on a longer-term basis due to studies' lack of follow-up data and low/medium methodological quality (based on studies' Weight of Evidence judgments).

Recommendations for further research include ascertaining the more detailed benefits of group vs. individual CBT interventions. Future research may extend beyond a focus on symptom reduction to explore an individual's sense of self and experiences of dealing with social anxiety. It may also investigate parents or teachers perceptions about possible barriers and the opportunities anxious children and adolescents may encounter in the future.

A systematic review into Cognitive Behavioural Therapy (CBT) school-based interventions with children and adolescents aged 8-18 years old with social anxiety

11: Introduction

This review examines the evidence generated by multiple investigations into Cognitive Behavioural Therapy (CBT) interventions for children and adolescents with social anxiety. For clarity, social anxiety within this piece of work is defined as:

> `… a persistent, unrealistically intense fear of social situations that might involve being scrutinised by, or even just exposed to unfamiliar people. Individuals with social anxiety disorder usually try to avoid situations in which they might be evaluated, show signs of anxiety or behave in embarrassing ways. The most common fears include public speaking, speaking up in meetings or classes, meeting new people, and talking to people in authority.''
>
> (Kring & Johnson, 2013, p177)

Chen, Rubin, & Li (1995) have argued that the way in which social anxiety has been construed varies across cultures. Behaviours perceived to be normal in some western cultures may not be acceptable in other cultures, or the reverse. Children and adolescents labelled socially anxious within a western context may be considered perfectly normal within another culture. However, although I am aware that this definition may come under scrutiny, I have chosen to use Kring et al's (2013) definition. In my view, it takes into consideration appropriate contextual and situational factors which often intensify anxious individuals' worries. These factors include adolescents' difficulties in meeting new people and speaking up in class. In making a choice to use this definition, I accepted a critical realist position whereby there exists an independent reality of ourselves (Scott, 2005, 2007). Hence, I understand that there are objects in the world, including social objects, which can be known (Scott, 2005, 2007; Shipway, 2010).

<u>Social anxiety: diagnostic criteria</u>

While general definitions of social anxiety may be useful, there are specific criteria for the diagnosis of social anxiety in clinical settings. A number of anxiety scales have been used to assess children and adolescents' social anxiety. These include: the self-report

Multidimensional Anxiety Scale for Children (MASC, March, Parker, Sullivan, Stallings, & Conners, 1997); the teacher and parent questionnaire Behavioural Assessment System for Children (Mahan & Matson, 2011); the self-report Spence Children's Anxiety Scale (SCAS, Spence, 1998) and the self-report Revised Children's Manifest Anxiety Scale (RCMAS, Reynolds, 1980).

However, the Diagnostic and Statistical Manual (DSM) lists symptoms and eight criteria that mental health professionals commonly use to diagnose an individual's social anxiety (Kamphuis & Noordhof, 2009). According to Bögels et al. (2010), the DSM IV's (APA, 2000) designation of a categorically defined subtype of social anxiety has come into question. Instead, she suggests conceptualising social anxiety disorder (SAD) as existing on a continuum, from a lesser to greater severity as a function of the number of feared and avoided social situations.

Bögels et al. (2010) highlighted further critical considerations, such as the utility of including a DSM-V (APA, 2013) specifier indicating a predominantly performance variety of SAD. Another specifier is based on the individual's fear of showing anxiety symptoms, such as blushing. Perhaps in response to this, the condition known as social phobia in DSM-IV (APA, 2000) has been renamed social anxiety disorder in the fifth edition of the DSM.

According to Kupfer and Regier (2013), this change reflects a new and broader understanding of the condition in a variety of social situations. Previously, social phobia was primarily diagnosed if an individual felt extreme discomfort or fear when performing in front of others. With the DSM-V (APA, 2013), social anxiety can be diagnosed because of an individual's response in a variety of social situations. Typical social situations may include going out for a meal or conversing with others, particularly if others are unfamiliar.

Kupfer and Regier (2013) go on to argue that the DSM-V (APA, 2013) makes claims to recognise that social anxiety disorder extends beyond shyness and is often considerably disabling. I would exercise a note of caution in this instance as the DSM-V (APA, 2013) does not make a clear distinction between shyness and social anxiety. As it does not explain the potential similarities and differences between the two, I am not inclined to accept this claim without restraint.

Furthermore, unlike in DSM-IV (APA, 2000), which requires that the individual recognise that his or her response is excessive or unreasonable, the DSM-V (APA, 2013) criteria shift that judgment to the clinician (Pomeroy & Anderson, 2013). I would argue that this shift in

positioning may serve to accentuate power imbalances between individuals and professionals. Enabling a professional to exercise judgement over an individual might perpetuate a top-down approach to the individual's emotional wellbeing and should therefore be accepted with caution. Although the DSM-V (APA, 2013) is commonly used in the clinical diagnosis of social anxiety, its limitations need to be considered.

Psychosocial impact: the importance of intervention

According to Beidel and Alfano (2011), socially anxious children and adolescents often experience heightened distress when engaged in performance situations. They find it difficult to read aloud or speak in front of others. They worry about how their behaviour will be perceived and more usually pre-determine that outsiders will view their actions as stupid. Beidel and Alfano (2011) continue their argument and claim that socially anxious individuals will engage in negative self-imagery and are often convinced that they will under-perform in social situations. As a result, they tend to avoid difficult social or intellectual tasks due to a fear of failure and rejection.

This viewpoint is supported by Pina, Zerr, Gonzales and Ortiz (2009), and Dube and Orpinas (2009), who claim that for many children and adolescents, their social anxiety is a factor in their avoidance of social situations and school refusal. Given that schools are public arenas with numerous social expectations, several socially anxious pupils find regular school attendance problematic (Dube & Orpinas, 2009; Pina et al., 2009). When present at school, these pupils often find it difficult to make friends and mix with their peers. They are frequently identified by their inability to interact with others and avoidance of social situations (Dube & Orpinas, 2009; Grandison, 2011; Heyne, Sauter, Van Widenfelt, Vermeiren, & Westenberg, 2011). These patterns of avoidant behaviour often manifest themselves later in life. Socially anxious individuals are thought to experience delays in achieving age appropriate and developmental milestones. This is evident in their less active social lives and tendency to marry and move away from home later (Baer & Garland, 2005; Donovan & Spence, 2000; Gest, 1997).

According to Baer and Garland (2005), despite these persistent difficulties, many socially anxious individuals are typically reticent to seek help and tend to be quiet and shy. This has more than likely resulted in the wider under-recognition and under-treatment of child and adolescent social anxiety disorders (Baer & Garland, 2005). Without the necessary support and intervention, individuals may in the long-term be at increased risk of other factors,

including other anxiety disorders, depression, conduct disorders and substance and drug abuse (Pina et al., 2009).

Social anxiety: treatments and treatment effects

Therapeutic interventions aimed at supporting socially anxious children have included mindfulness meditation (V. Brady & Whitman, 2012), solution-focused therapy (George, 2008) and psychotherapy (Baez, 2005). However, Cognitive Behavioural Therapy (CBT) is the most commonly practised approach used to treat anxiety related difficulties in children and adolescents (Bramham et al., 2009; Chiu; Dimauro, Domingues, Fernandez, & Tolin, 2013; Hedman et al., 2011; Prosser, 2011).

Roth and Fonagy (1996) have claimed that the roots of CBT are in classical learning theory (condition and operant learning) and social learning theory. The cognitive element is concerned with finding alternative, helpful thoughts to use to counteract children and adolescents' negative thoughts. The behavioural part is about desensitising the individual to their anxiety through gradually increasing exposure to the fear-provoking situation. Kendall et al (2005) explained that common to all CBT programmes is the child or adolescents' engagement in hierarchy-based exposure tasks. Using a graduated approach, the individual experiences anxious distress in real or imagined anxiety-provoking situations. Relaxation skills, problem-solving skills and counter-conditioning skills are all examples of the potential mechanisms required to mediate the relationship between exposure treatment and a meaningful decrease in anxiety responses.

There is an emergent body of empirical research which suggests that CBT interventions might be effective in the treatment of child and adolescent social anxiety (Barrett, Sonderegger, & Xenos, 2003; Liddle & Macmillan, 2010; Manassis et al., 2010; Masia-Warner et al., 2005; Stallard, Simpson, Anderson, & Goddard, 2008). The findings of Silverman, Pina and Viswesvaran's (2008) meta-analysis supported the overall efficacy of CBT interventions on the reduction of adolescents' social anxieties.

This meta-analysis of individual CBT and group CBT interventions for children with social anxiety met criteria for 'probably efficacious' (W. Silverman et al., 2008). CBT sessions generally numbered between 3-24 sessions, and studies were only reviewed if they included a follow-up period. However, it should be noted that the authors did not provide the overall age range for the adolescents included in their review or justify how they included studies based on participants' age.

Review focus: efficacy of school-based CBT interventions for children adolescents

CBT interventions for children and adolescents with social anxiety have been conducted within clinical settings (Melfsen et al., 2011) and schools (Masia Warner, Fisher, Shrout, Rathor, & Klein, 2007). More recently, there has been an increase in the application of CBT based interventions in schools across the UK and elsewhere. Liddle & Macmillan (2010) have suggested that CBT interventions may have the potential to improve emotional wellbeing and educational outcomes for children in Scottish schools. Galla (2012) also found positive pre-test, post-test and one year follow-up treatment effects for a modularised school-based CBT intervention.

Although an evidence base appears to exist in relation to the post-intervention benefits of CBT based interventions on an individual's level of social anxiety (Barrett et al., 2003; Liddle & Macmillan, 2010; Manassis et al., 2010; Masia-Warner et al., 2005; Stallard et al., 2008), a gap in the literature seems to exist in terms of the benefits of school-based interventions at both post-intervention and follow-up points post-intervention. In particular, post-intervention benefits appear inconclusive as, unlike Galla (2012), other studies, such Ginsburg and Drake (2002) and Miller, Short, Garland and Clark (2010), have not included follow-up data or monitored participants' progress over time.

This gap in the literature furnishes the present review's investigation into school-based CBT interventions with children and adolescents aged 8-18 years old with social anxiety. Given the data available, it will consider the short-term post-intervention effects of school-based CBT based interventions. Wherever possible, the potential longer-term follow up effects will also be examined. Subsequently, this systematic review will investigate the effectiveness of school-based CBT interventions for children and adolescents with social anxiety related difficulties. My review question is:

'How effective are school-based CBT interventions for children and adolescents with social anxiety-related difficulties?'

In clearly identifying my review question, I initiated the first stage of Petticrew and Robert's (2008) systematic review methods process (see method section as follows).

1:2 Method

This review used the systematic methods detailed by Petticrew and Roberts (2008). The seven stages are summarised in Table 1.

Stage 1: Clearly define the question that the review is setting out to answer (has already been established.

Table 1: The seven stages in carrying out a systematic review

stage	Petticrew and Robert's (2008) systematic review methods
1	Clearly define the question that the review is setting out to answer, or the hypothesis that the review will test (see review question page 14)
2	Determine the types of studies that need to be located in order to answer the question
3	Carry out a comprehensive literature search to locate those studies
4	Screen the results of that search, sifting through and deciding which of the retrieved studies might fully meet the inclusion criteria. Those studies that meet the inclusion will need a more detailed examination
5	Critically appraise the included studies
6	Synthesise the studies, finding commonalties and points of variation within them
7	Disseminate the findings of the review

Stage 2: Petticrew and Robert's (2008) –Determining the types of studies that need to be located in order to answer the research question

Identifying and describing studies: the initial search

The search was conducted in five phases, as shown in Table 2. All literature searches were conducted between August 2012 and October 2012.

Table 2: Five phase literature search

phase	Literature search
1	Literature dated 2007-2012 was searched in line with Cronin, Ryan and Coughlan's guidance that a maximum time frame of 5 to 10 years is usually placed on the age of the work to be included in a literature review (Cronin, Ryan, & Coughlan, 2008)
2	Literature dated 2002-2007 was searched. It was deemed appropriate to expand the search to include studies dated 2002-2007 due to the restricted amount of literature dated 2007-2012 that was initially generated
3	Citation searches
4	Hand searches
5	Search of the grey literature as detailed in Appendix 1

Stage 3: Petticrew and Robert's (2008) –Carry out a comprehensive literature search to locate those studies

Search terms

To locate relevant studies, a combination of search terms was used to search the University of Newcastle's electronic databases. In line with Harvard's (2007) recommendations, search term words were truncated and 'wildcard words' were used to expand the search as appropriate. The Macmillan dictionary e-thesaurus (2009-2013) was used to ensure that appropriate synonyms were included in the treatment target terms, the setting terms and the subject terms' categories. The search terms used can be found in Table 3.

Table 3: Database search terms

Database search terms
intervention terms
Cognitive Behavioural Therapy (CBT)
setting terms
school*/educat*/class*/school-age*/secondary school*/high school*/ primary school
treatment target terms
social*anxi*/social anxiety*
subject terms
child*/adolesc*/ young pe*/teenage*/youth*/ pupil*

Electronic databases searched

The following electronic databases were searched, as seen in Table 4.

Table 4: Electronic databases searched

Electronic databases searched
ProQuest
EBSCO
Education Databases
Ovid
Scopus
Web of Knowledge
First Search
Medline

Hand searches

Hand searches of academic and professional journals were conducted in addition to the generic database searches. Journals were selected and searched if they were judged to be relevant to the focus of the review question. See Table 5 for the academic and professional journals searched.

Table 5: The academic and professional journals searched

Academic and professional journals searched
Journal of Anxiety Disorders
Journal of Behaviour Therapy and Experimental Psychiatry
Educational Psychology in Practice
Journal of Clinical Psychology
Journal of Applied School Psychology
British Journal of Special Education
Journal of Depression and Anxiety

Grey literature

Grey literature is literature that is semi-published, unpublished and/or not available through the usual bibliographic sources, such as databases or indexes (Coad, 2006). I searched this to identify any gaps in the published academic literature and to address issues of publication bias (Dickersin, 1990). See Appendix 1.

Stage 4: Petticrew and Robert's (2008) –Screening the results of that search, sifting through and deciding which of the retrieved studies might fully meet the inclusion criteria.

The inclusion criteria

The inclusion criteria detail which studies are to be included in the systematic review, based on a set of preconditions that each study must meet in order to address the review question. The inclusion criteria process was conducted in three phases:

Figure 1: The inclusion criteria process

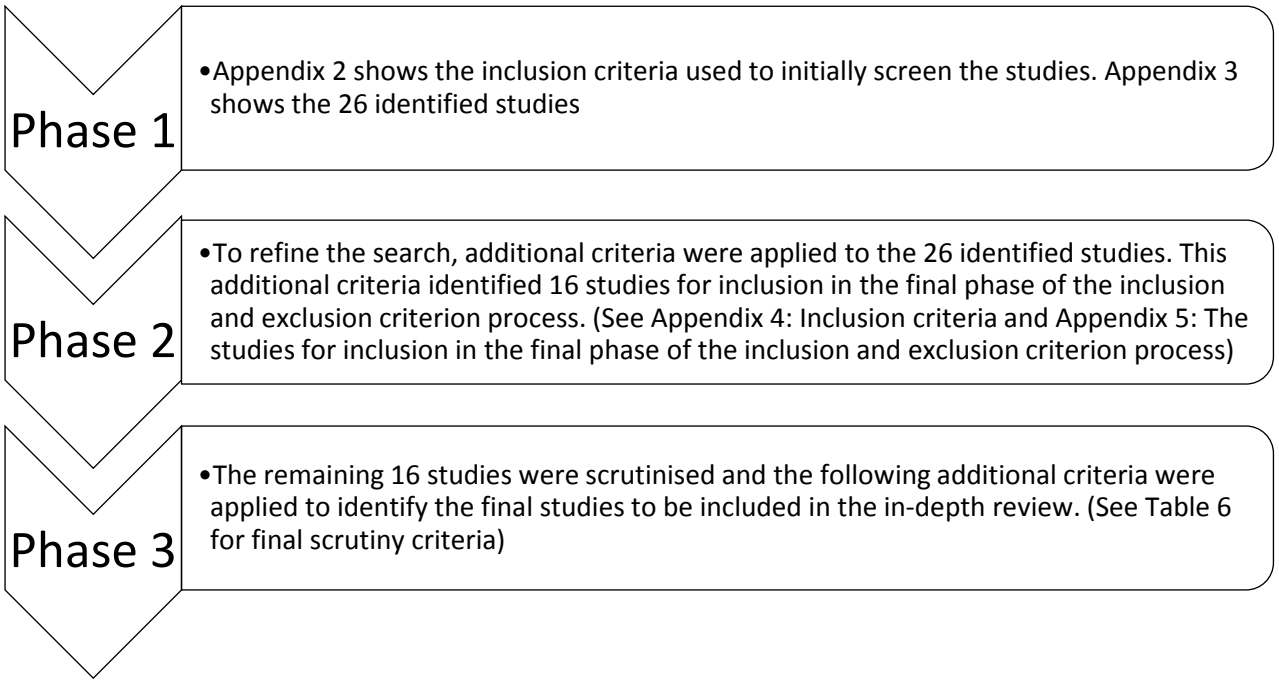


Table 6: Final scrutiny criteria

Final scrutiny criteria
Participants
Children and adolescents between the aged of 8 and 18 years old
Settings
School
Intervention
- Interventions described as CBT (Cognitive Behavioural Therapy), delivered on an individual or group basis –interventions or control measures that were completed solely within the usual school-day and within the usual school environment - Studies that followed a manualised or evidence-based CBT initiative such as *FRIENDS* or *Worry Dragon*
Study design
The treatment outcomes were explicitly stated and included at least one or more of the following: managing social anxiety, reducing social anxiety or preventing social anxiety
Time period
Studies were completed between 2002-2012
Location
Worldwide
Language
Studies were reported in English

Detailed description of studies in the in-depth review

The 12 studies identified as meeting the in-depth inclusion criteria were analysed and mapped-out according to the following descriptors in Table 7 (see also Appendix 7 –mapping out the studies).

Table 7: Descriptors used to map out the studies identified as meeting the in-depth inclusion

	Descriptors used to map out the studies
A	Who delivered the intervention: for example psychology research students, teachers or other professionals
B	Participants: numbers, gender, ages (to include participants aged 8 to 18 years old) where given
C	Context: the type of school and geographical location in which the studies were conducted
D	Focus: if the intervention was conducted on an individual or group basis and the duration of the sessions
E	Design: whether a control condition was used and the input the control group received. Other information included how the groups were allocated, for example by a process of random allocation
F	Use of a CBT manual: was a workbook used or not
G	Methods/sources of evidence: how the data was collated and evaluated, for example the use of self-report, teachers' or parents' questionnaires
H	Follow-up: if and when follow-up measures were administered into the studies' design Gains made: the studies' measures, for example the Spence Child Anxiety Scale (SCAS) and any significant effects found
I	Effect size: where Cohen's d* effect sizes were not given, these were calculated using the University of Colorado, Colorado Springs (2000) online calculator. Cohen's d is defined as the difference between two means divided by the standard deviation for the data. The meaning of effect size can vary by context, but generally according to Thalheimer and Cook (2002) it is understood that a score of: 0.8 of a standard deviation unit = a large effect size 0.5 of a standard deviation unit = a moderate effect size 0.2 of a standard deviation unit = a small effect size
	*Cohen's d was selected over other effect size measurements as it has two main advantages. Firstly, it is a commonly understood and used measure and, secondly, it allows for comparisons to be made across published studies (Thalheimer & Cook. S, 2002).

This process identified 11 studies to be included in the in-depth review. See Appendix 6.

Stage 5: Petticrew and Robert's (2008) –Critically appraising the studies

General characteristics of the studies included in the in-depth review

The characteristics of the 11 studies included in the in-depth review are summarised in Appendix 10. The synthesis shows that all of the studies n=11 focused on school-based CBT interventions. N=3 studies conducted the intervention on a classroom basis and n=8 studies conducted the intervention on a smaller group basis.

A third of the studies (n=3) were conducted in Australia, a further third (n=4) in Canada, and the remainder (n=1) in America (n=1), Germany (n=1), and England and Scotland (n=1). All of the studies (n= 12) used an opportunity sample, which is often favoured by social researchers as they can use the knowledge and attributes of the researcher to identify a sample (A. Brady, 2006). The researcher's local knowledge of an area on which to base a study or the researcher's past experiences may be used to contact participants or gatekeepers (A. Brady, 2006).

All of the studies targeted participants with specific difficulties of childhood anxiety. N=5 of the studies focused on other issues of emotional wellbeing, namely participants' depressive symptoms and levels of self-esteem. Sample sizes varied considerably between the studies: range =12 to 693, mean 323.25 and SD 264.65. The intervention group sessions varied in length between 45-60 minutes each week and lasted between 8-10 weeks. N=8 studies provided follow-up data and these varied from 4-17 months post-intervention.

Experimental design of the studies included in the in-depth review

N=9 of the studies included a wait list control group verses an intervention group and all of the participants were randomly allocated to either condition. Some studies took additional measures to ensure internal validity. For example, Barratt, Lock and Farrell (2005) asked programme facilitators to complete programme integrity checklists. Miller, Laye-Gindhu, Bennett, Liu, Gold, Marsh, Olson and Waechtler (2011) required teachers to complete a checklist at the end of each intervention session to indicate their level of compliance in following the manual's session content.

The nature of the intervention received by participants in the control groups varied across the studies. Children in Miller, Laye-Gindhu, Liu, March, Thordarson and Garland's (Miller et al., 2011b) attention control condition received a story-reading session in place of the FRIENDS intervention, and children in Roberts, Kane, Bishop, Cross, Fenton and Hart's (2010) study received health education lessons, although these lessons were similar in

content to the CBT intervention. Essau, Conradt, Sasagawa and Ollendick (2012) and Misfud (2005) stated that the children in the control groups were invited to participate in the CBT intervention at a later date.

Liddle and Macmillan's (2010) study compared the effectiveness of a FRIENDS intervention programme across cohorts of participants with all participants receiving the same intervention. Stallard et al (2008) evaluated a whole classroom FRIENDS initiative with participants' progress being assessed against their own baseline scores, as opposed to the effectiveness of the intervention on participants within a control condition. These studies were judged less methodologically sound due to factors such as the 'history threat'. The history threat explains that it might not be the intervention programme that caused the outcome; rather, it might be some other historical event such as another school-based project or normal teaching. Other factors included the 'maturation threat'. The maturation effect explains how the children might have had the exact same outcome even if they had never received the intervention programme (William, 2006). Without the comparison of a control group, the researchers might be measuring the normal maturation or growth rate in participants' understanding that occurs as part of growing-up (William, 2006).

All of the studies (N=12) made the purpose for conducting their research explicit. For example, Ginsburg and Drake (2002) wanted to examine the effectiveness of a CBT intervention programme on participants' levels of anxiety while assessing the therapeutic factors of the CBT intervention. Essau (2012) sought to overcome the gaps in the literature by examining the effectiveness of a universal school-based FRIENDS programme. Implicit within all of the studies was the underlying desire for each to be submitted for publication, which makes the issue of publication bias pertinent and subject to consideration (Dickersin, 1990).

In mapping out the studies, two studies by Stallard et al. (2008), and Liddle and Macmillan (2010), did not provide enough information to enable effect sizes to be calculated and were therefore excluded. This left nine remaining studies to be evaluated using the Weight of Evidence (WoE) (2009) tool. See Table 8.

1:3 Weight of Evidence

Stage 6: Petticrew and Robert's (2008) –Synthesising the studies, finding commonalties and points of variation within them

Assessing quality of studies and weight of evidence (WoE)

The nine remaining studies were assessed using the Evidence for Policy and Practice Information and Co-ordinating (EPPI-Centre) (2009) weight of evidence (WoE) tool. The WoE framework aims to offer a clear and transparent method in which to assess the overall quality and weighting of each study. The WoEs were based on the three separate criteria presented in Table 8 below.

Table 8: Weight of Evidence Framework

Criteria	Weight of Evidence (WoE)
A	The trustworthiness of the results judged by the quality of the study within the accepted norms for undertaking the particular type of research design used in the study (methodological quality)
B	The appropriateness of the use of that study design for addressing the systematic review's research question (methodological relevance)
C	The appropriateness of the focus of the research for answering the review question (topic relevance)
D	Judgment of the overall weight of evidence (WoE) based on the assessments made for each of the criteria A-C (The Evidence for Policy and Practice Information and Co-ordinating Centre, 2009)

Following the process above, the ten remaining studies were assessed against the given criteria with judgments made about each study's weight of evidence. See Appendix 12.

An overall weight of evidence judgment for each study can be found in Table 9.

Table 9: Weight of Evidence (WoE) table

	Weight of Evidence (WoE)			
study	A: The trustworthiness of the results judged by the quality of the study within the accepted norms for undertaking the particular type of research design used in the study (methodological quality)	B: The appropriateness of the use of the study's design for addressing the systematic review's research question (methodological relevance)	C: The appropriateness of the focus of the research for answering the review question (topic relevance)	D: Judgment of overall weight of evidence (WoE) based on the assessments made for each of the criteria A-C
(Barrett et al., 2005)	low/medium	medium/high	medium	medium
(Barrett, Farrell, Ollendick, & Dadds, 2006)	low/medium	medium/high	medium	medium
(Essau et al., 2012)	medium/high	medium/high	high	medium/high
(Ginsburg & Drake, 2002)	low/medium	medium/high	medium	medium
(Miller et al., 2010)	low/medium	medium/high	medium	medium
(Miller et al., 2011)	high	medium/high	medium	medium/high
(Miller et al., 2011a)*	high	medium/high	High	medium
(Miller et al., 2011b)*	low/medium	medium/high	High	medium
(C. C. Mifsud & R. M. R. M. Rapee, 2005)	low/medium	medium/high	medium	medium
(Roberts et al., 2010)	low/medium	medium/high	medium	medium
Total studies				**9**

*This research was presented in one paper as two studies

Each of the nine studies was judged for quality using the EPPI-Centre's WoE tool (2009).

Weight of Evidence A

When considering WoE A, five studies made a reasonable attempt to assess the programme's fidelity with the use of facilitator checklists (Ginsburg & Drake, 2002; Miller et al., 2011; Miller et al., 2011a; Miller et al., 2010) . However, one main issue which arose when considering WoE A, the study's methodological rigour, was the study's lack of clarity around the use of the wait list control group and how their conditions differed to those of the intervention group. Miller et al (2011a) and Miller et al's (2011) studies were judged to have a high WoE A as this distinction was made. Roberts et al (2010) also made a distinction, however, and their study was judged to have a low to medium weight of evidence as the Aussie Optimum Programme (AOP) CBT intervention and the control group's 'health programme' were similar. The authors acknowledged that lessons had a similar learning outcome and were related to self-management and interpersonal skills. This made it difficult to distinguish the full effectiveness or impact of the intervention on participants' levels of anxiety.

The remaining six studies were awarded a low to medium WoE A for omitting this information (Barrett, 2005; Barrett & Pahl, 2006; Ginsburg & Drake, 2002; C. C. Mifsud & R. M. R. M. Rapee, 2005; Miller et al., 2011; Miller et al., 2010). Essau's (2005) study was judged to have a medium to high WoE A as, although a distinction was made, attempts were not made to assess their programme's fidelity.

Weight of Evidence B

In relation to WoE B, methodological relevance, most of the studies (n= 8) were awarded a medium to high WOE rating as they used an appropriate wait list control verses intervention group design. However, Miller et al (2011) acknowledged that the specific data analysis they chose was complicated by the fact that schools in the wait list condition eventually received the treatment programme after data collection at time two of their research design (Miller et al., 2011). This meant that at time three there were no longer any students acting as a true control group. Subsequently, without a true control group at time three, the authors recognised that their research design was incomplete (Miller et al., 2011). Due to this, Miller et al's (2011) study was awarded a low to medium WoE B rating.

Weight of Evidence C

Weight of Evidence C relates to the primary focus of the review, regarding the effectiveness of CBT school-based interventions on children and adolescents' levels of social anxiety. All ten studies focused on school-based CBT interventions and children and adolescents' social anxiety. However, each differed in how the participants' levels of social anxiety were measured and reported. Essau et al's (2012) study and Miller et al's study (2011b), unlike the majority of the studies (N= 6), reported the children's social anxiety subtest scores separately from their other scores. These scores were reported separately from, for example, their generalised anxiety and separation anxiety scores. Subsequently, the results of these were of particular relevance to the review question and the authors were awarded a high WOE C rating.

Overall Weight of Evidence D

Based on the assessments made for each WoE criterion from A to C, Table 9 indicates that seven of the nine studies were judged to have a medium overall WoE, with three studies having a medium to high overall WoE.

1:4 Outcomes and effectiveness

Post-intervention effects

Table 10 provides a summary of the results according to the post-intervention outcomes for each of the ten studies. The table shows that five of the studies (Barrett et al., 2005; Essau et al., 2012; Ginsburg & Drake, 2002; C. Mifsud & R. M. Rapee, 2005; Miller et al., 2010) found the CBT interventions to be effective post-intervention.

It should be noted that Misfud and Rapee's (2005) study found that the CBT intervention was effective according only to the children's self-report scores. Given the low return rate of data by parents the authors considered it inappropriate to include these results in their statistical analysis. It is therefore not possible to assess the post-intervention effects on participants' levels of anxiety according to their parents' responses.

Essau et al (2012) provided subtests results for participants' measures of social anxiety at post-intervention. The authors claimed that the overall social anxiety score for children in the intervention group did not differ significantly from children in the wait list control condition (intervention condition, mean= 4.23, SD= 2.9 and wait list control condition= mean= 5.0, SD= 2.9).

Barratt et al (2005) reported CBT interventions to be effective post-intervention despite small effect sizes. Notwithstanding potentially more significant effect sizes, Ginsberg et al's (2002) and Miller et al's (2010) limited sample sizes (Ginsburg & Drake, 2002, n= 12) and (Miller et al., 2010, n= 33) reduced the impact and generalisability of their findings. One study (Barrett et al., 2006) was defined as a long-term follow-up study, and four of the studies (Miller et al., 2011; Miller et al., 2011a; Roberts et al., 2010) did not find the CBT interventions to be effective post-intervention.

Overall, it was judged difficult to make comparisons between the studies. Different outcome measures were used dependent on the study. In addition, the success criteria and types of instruments used varied across each study.

Table 10: Results according to post-intervention follow-up outcomes

results according to post-intervention follow-up outcomes			
Study	Outcome variable	Significant gains made?	*Effect size/s**
(Barrett et al., 2005)	The Spence Child Anxiety Scale (SCAS)	Y n n	CBT intervention high risk group effect size: 0.21 CBT intervention moderate risk group effect size: 0.06 CBT intervention low risk group effect size: 0.08
(Miller et al., 2010)	Multidimensional Anxiety Scale for Children (MASC)	y y	CBT intervention group effect size: 0.30 CBT intervention at risk group effect size: 0.75
(Ginsburg & Drake, 2002)	Anxiety Disorder Interview Schedule –Clinicians Impairment Rating Scale (ADIS-CIR) Screen for Child Anxiety Related Emotional Disorders (SCARED) Social Anxiety Scale for Adolescents (SAS-A)	Y y y y y	CBT intervention group effect size: 2.70 CBT intervention Attention support (AS) group effect size: 0.56 CBT intervention group effect size: 0.28 CBT Attention support (AS) group effect size: 0.07 CBT intervention group effect size: 0.54 CBT Attention support (AS) group effect size: 0.28
(Miller et al., 2011)	Multidimensional Anxiety Scale for Children (MASC) (MASC) social anxiety subset	N n	CBT intervention group effect size: 0.12 CBT intervention group subtest effect size: 0.020

(Miller et al., 2011a)	Multidimensional Anxiety Scale for Children (MASC) The Behavioural Assessment System for Children (BASC-Parent) The Behavioural Assessment System for Children (BASC-Teacher)	N n n	CBT intervention group effect size: 0.08 CBT intervention group effect size: 0.53 CBT intervention group effect size: 0.59
(Miller et al., 2011b)	Multidimensional Anxiety Scale for Children (MASC) The Behavioural Assessment System for Children (BASC-Parent) The Behavioural Assessment System for Children (BASC-Teacher)	n n n	CBT intervention group effect size: 0.18 CBT intervention group effect size: 0.60 CBT intervention group effect size: 0.18
(Roberts et al., 2010)	The Revised Children's Manifest Anxiety Scale (RCMAS)	N	CBT intervention group effect size: 0.14
(C. C. Mifsud & R. M. R. M. Rapee, 2005)	Spence Children's Anxiety Scale (SCAS) Spence Children's Anxiety Scale (SCAS-Parent)	Y -	CBT intervention group effect size: 0.35 incomplete data due to low response rate
(Essau et al., 2012)	The Spence Children's Anxiety Scale (SCAS) The Spence Children's Anxiety Scale (SCAS) social anxiety subset	Y n	CBT intervention group effect size: 0.20 CBT intervention group subtest effect size: 0.27
(Barrett et al., 2006)	Spence Children's Anxiety Scale (SCAS) Revised Children's Manifest Anxiety Scale (RCMAS)	n/a a long term study	- -
*Cohen's d suggests that d=0.2 be considered a small effect size, 0.5 represents a medium effect size and 0.8 a large effect size (Thalheimer & Cook. S, 2002)			

Long-term effects at follow-up points after the initial post-test measures

Table 11 provides a summary of the longer-term outcome effects for the ten studies. The studies' follow-up periods ranged from 2.5-36 months post-intervention, which made it difficult to compare data across the studies. Two of the studies, Miller et al. (2010) and Ginsberg and Drake (2002), did not include a longer-term follow-up measure in their studies' design.

Seven studies (Barrett et al., 2006; Barrett et al., 2005; Essau et al., 2012; C. C. Mifsud & R. M. R. M. Rapee, 2005; Miller et al., 2011; Miller et al., 2011a; Roberts et al., 2010) provided follow-up information. Four studies (Barrett et al., 2006; Barrett et al., 2005; Essau et al., 2012; C. C. Mifsud & R. M. R. M. Rapee, 2005) found the CBT interventions to be effective on a longer-term basis.

Although Misfud and Rapee's (2005) study found the intervention to be effective according to children's self-report scores, the authors provided incomplete longer-term follow-up data due to parental low questionnaire response rate. Barratt et al (2005) found the intervention to be effective at a 12-month follow-up period, despite insignificant effect sizes. Barratt et al's (2006) study evaluated the longer-term effectiveness of the CBT FRIENDS programme. Accordingly, children in year six found the intervention to be effective at 12, 24 and 36 months follow-up periods based on their self-report measures of social anxiety questionnaire answers, with girls reporting significantly lower anxiety scores at 12 and 24 month periods, but not at 36 month follow up. However, the findings indicated that children in year nine did not find the intervention to be effective.

Essau et al (2012) found the intervention to be effective at six and 12 months follow-up periods. However, the researchers acknowledged that participants in the intervention group, presumably with more time to practice, continued to get better throughout the follow-up period, whereas the participants from the control group stayed the same or deteriorated (Essau et al., 2012).

Essau et al (2012) also provided subset results for participants' measures of social anxiety at six and 12 month follow-up periods. Despite no significant post-intervention effects at six and 12 month follow-up periods for children aged 9-10 years old, significant interaction effects were found for children aged 11-12 years old. These reductions were significantly greater at the 12-month follow-up period. Miller, Laye-Gindhu, Bennett et al.'s (2011) study provided subset scores for participants measures of social anxiety at 6-month follow-up. No significant reductions of participants' levels of social anxiety were found.

Table 11: Results according to longer-term follow-up outcomes

Study	Outcome variable	Significant gains made?	Effect size/s*
(Barrett et al., 2005)	The Spence Child Anxiety Scale (SCAS)	y y n	CBT group high risk group at 12 months follow-up 0.38 CBT group medium risk group at 12 month follow-up 0.17 CBT group low risk group at 12 month follow-up 0.14
(Miller et al., 2010)	No follow-up	-	-
(Ginsburg & Drake, 2002)	No follow-up	-	-
(Miller et al., 2011)	Multidimensional Anxiety Scale for Children (MASC) Multidimensional Anxiety Scale for Children (MASC) social anxiety subset	n n	CBT group 6 month follow-up 0.18 CBT group 6 month follow-up 0.020
(Miller et al., 2011a)	Multidimensional Anxiety Scale for Children (MASC) The Behavioural Assessment System for Children (BASC - Parent) The Behavioural Assessment System for Children (BASC - Teacher) 	n n n n n n	CBT group 5 months follow-up 0.08 CBT group 17 months follow-up 0.11 CBT group 5 months follow-up 0.43 CBT group 17 months follow-up 0.45 CBT group 5 months follow-up 0.49 CBT group 17 months follow-up 0.43
(Miller et al., 2011b)	Multidimensional Anxiety Scale for Children (MASC)	n	CBT group 5 months follow-up 0.60

		n	CBT group 17 months follow-up 0.16
	The Behavioural Assessment System for Children (BASC - Parent)	n	CBT group 5 months follow-up: not enough data to calculate due to low response rate
		n	CBT groups 17 months follow-up 0.2
	The Behavioural Assessment System for Children (BASC-Teacher)	n	CBT groups 5 months not enough data to calculate due to low response rate
		n	CBT groups 17 months 0.14
(Roberts et al., 2010)	The Revised Children's Manifest Anxiety Scale (RCMAS)	n	CBT groups 6 months follow-up 0.0017
		n	CBT groups 18 months follow-up 0.17
(C. C. Mifsud & R. M. R. M. Rapee, 2005)	Spence Children's Anxiety Scale (SCAS)	y	CBT groups 4 months follow-up 0.57
	Spence Children's Anxiety Scale (SCAS - Parent)	Incomplete data due to parent's low response rate	-
(Essau et al., 2012)	The Spence Children's Anxiety Scale (SCAS)	y	CBT groups 6 month follow-up 0.47
		y	CBT groups 12 month follow –up 0.69
	(SCAS) social anxiety subset	y	CBT groups 6 month follow-up: 0.33
		y	CBT groups 12 month follow-up 0.69

(Barrett et al., 2006)	The Spence Children's Anxiety Scale (SCAS)	y	CBT groups grade 6 at 12 months follow-up 0.55
		y	CBT group grade 6 at 24 months follow-up 0.58
		y	CBT group grade 6 at 36 months follow-up 0.41
		n	CBT group grade 9 at 12 months follow-up 0.59
		n	CBT group grade 9 at 12 months follow-up 0.17
		n	CBT group grade 9 at 24 months follow-up 0.41
		n	CBT group grade 9 at 36 months follow-up 0.59
	Revised Children's Manifest Anxiety Scale (RCMAS)	y	CBT group grade 6 at 12 months follow-up 0.39
		y	CBT group grade 6 at 24 months follow-up 0.70
		y	CBT group grade 6 at 36 months follow-up 0.08
		n	CBT group grade 9 at 12 months follow-up 0.04

		n n	CBT group grade 9 at 24 months follow-up 0.04 CBT group grade 9 at 36 months follow-up 0.05
*Cohen's d suggests that d=0.2 be considered a small effect size, 0.5 represents a medium effect sie and 0.8 a large effect size (Thalheimer & Cook. S, 2002)			

1:5 Concluding comments

Stage 7: Petticrew and Robert's (2008) –Disseminating the findings of the review

Summary

As mentioned by Barratt et al (2006), CBT is widely recognised and used as an evidence-based intervention to manage anxious symptoms in children and adolescents. Manualised interventions, such as the FRIENDS programme, have provided some evidence to suggest that CBT can reduce adolescents anxieties on a short term, post-test basis. Research has been conducted in to the effectiveness of CBT interventions on individual's levels of social anxiety on a longer-term basis. Although it appears that currently not enough evidence exists to support the effectiveness of CBT on a longer-term basis on an individual's levels of social anxiety, universal CBT interventions have been developed and integrated into schools. In particular, primary school CBT initiatives have been adapted to fit within the curriculum and taught by classroom teachers and teaching support staff (Roberts et al., 2010). With an appreciation of the increased popularity of CBT in schools, this review sought to collate and evaluate articles which may be of use to educationalists, teachers and support staff.

Strengths and limitations of the review

Over half of the studies included in this review, (n = 6) of the final 9 investigated CBT interventions were solely in relation to child and adolescent anxiety disorders. However, Barrett et al (2005), Essau et al (2012), Barrett et al (2006) and Roberts (2010) explored additional factors, such as the use of CBT to treat adolescents' low mood difficulties, self-harm tendencies, perfectionism and suicidal behaviours. Hence, a possible limitation of this review might be that when analysing these studies, it was potentially harder to examine the main variable (social anxiety) and to assess the effectiveness of the intervention on this alone, without the possible influence of other confounding variables.

However, a possible strength of this review is that it aimed to evaluate the trustworthiness of each individual study. The Evidence for Policy and Practice Information and Co-ordinating (EPPI-Centre) (2009) weight of evidence (WOE) tool was used to assess the ten studies included in the in-depth review and to determine an overall WOE judgement for each (see Table 9). Conversely, WOE judgements could be perceived as subjective. The WOE tool was referred to and applied by myself using my own subjective interpretation of both the framework itself and the studies. Should I have asked my research supervisor to review and verify my WOE judgements, this might have increased confidence in the robustness of my findings.

My development of the studies' inclusion and exclusion criteria might also signal another limitation of my systematic review. I aimed to set out clear inclusion and exclusion criteria from which to assess each potential study for inclusion in the in-depth review. However, my research supervisor was not used to validate the selected keyword inclusion or exclusion terms. Despite my best efforts, it may be argued that decisions were perhaps unintentionally biased and weighted towards my own personal value judgements.

Another shortcoming that might be applicable was that although this review focused on socially anxious children and adolescents, the majority, (n= 7) of the (n= 9) identified studies, did not provide a more detailed analysis into participants' subset social anxiety scores. At times, subset social anxiety results were analysed and reported as part of the overall anxiety measures. This potentially minimised the extent to which CBT interventions specifically in relation to adolescents' social anxiety could be linked.

Reflections upon the practical implications of CBT for professional practice

Based on the findings of my literature review, it might be inferred that manualised CBT interventions provide practitioners with a step-by-step guide in which to use as a basis to address adolescents social anxiety difficulties. CBT interventions can be carried out within a realistic time-frame of between 8-10 weeks. Most usually, intervention group sessions vary in length between 45-60 minutes each week. Subsequently, it is possible to conduct pre-test and post-test measures of adolescents' levels of social anxiety. This has led me to reflect that the culmination of these factors might explain why the use of CBT is currently gaining popularity in schools (Liddle & Macmillan, 2010). Particularly as CBT programs are often designed to be delivered by professionals including teachers, school counsellors and psychologists (Barrett et al., 2006). Also based on the findings of my review, CBT may have some practical implications for professional practice as it might affect positive change on adolescents' levels of social anxiety on a short-term, post-test basis. However, based on the findings of my literature review, not enough evidence currently exists to suggest that CBT is effective on a longer-term basis due to studies' lack of follow-up data and low/medium methodological quality (based on studies' Weight of Evidence judgments).

As a result, I reason that there is not enough evidence to warrant the view that CBT has long-term effectiveness.

Final reflections

Currently, the majority of research and work in relation to child and adolescent anxiety has been conducted outside the United Kingdom (UK). With reference to the general characteristics of the ten studies included in this in-depth review, research was conducted in Australia (n= 3), Canada, (n= 4), America (n= 1), and Germany (n= 1). Initially, two UK based studies, Liddle and Macmillan (2010) and Stallard (2008) were identified but excluded as insufficient data meant that effect sizes could not be calculated. This review aimed to identify and address the significant gap in the amount of UK-based work in the field. It also intended to shape the way towards a future piece of UK-based empirical research centred on child and adolescent anxiety. Therefore, there are a number of different directions which subsequent research into CBT school-based interventions with children and adolescents may take.

For example, this systematic review did not set out to investigate the potential differences between individual CBT interventions and group-based CBT interventions. Group interventions may be a cost effective way to offer participants the opportunity to share and learn from their personal experiences (Bramham et al., 2009). Alternately, some individuals may find group CBT interventions more interpersonally challenging in comparison to individually focused CBT sessions (Angelo, Miller, Zoellner, & Feeny, 2008). Subsequently, a future study may seek to examine individual vs. group interventions as this analysis fell outside of the present review's remit.

Furthermore, this literature review focused specifically on school-based CBT interventions for social anxiety, while subsequent work may investigate other interventions, including narrative psychology approaches (Esquivel & Flanagan, 2007; Mortola & Carlson, 2003; White, 1990), solution approaches (Franklin, Moore, & Hopson, 2008; Gingerich & Wabeke, 2001; Stobie, Boyle, & Woolfson, 2005) and personal construct psychology approaches (Kelly, 1955). A prospective piece of research may also seek to explore outcomes for children and adolescents beyond symptom reduction. An individual's sense of self may warrant further investigation, similarly to parents' and teachers' perceptions about possible opportunities and barriers to anxious children's and adolescents' education, career and life chances beyond school.

Chapter 2:

Bridging document

This bridging document has the following aims:

- To discuss how I developed my research focus
- To explain my choice of research methodologies
- To reflect upon the ethical considerations which informed my research

Abstract
This document will briefly summarise the findings of the systematic review of the literature. It will chart how I developed my research focus in light of a critical appraisal of the

effectiveness of school-based CBT interventions on individuals' levels of social anxiety. It will explain why my research took a holistic approach to child development and wellbeing beyond symptom reduction. With reference to my personal TEP placement experience and literature on pre-compulsory school transitions and participants' views, it will explain why I decided to carry out a small scale piece of qualitative LA research. My choice and use of research methods will be discussed and consideration will be given to how my research question might align with Bronfenbrenner's ecological systems theory (Bronfenbrenner, 1979, 1998). The ethical factors that informed my work will also be addressed. This document will serve to reflect upon the potential for my research to give voice to participants in matters that may be considered to be of importance in the support of socially anxious adolescents.

2:1 Introduction

The systematic review addressed the effectiveness of school-based CBT Interventions for anxious children and adolescents. The findings of the review prompted me to reflect upon the possible limitations of CBT, particularly as CBT in itself has come under scrutiny. According to Ryle (2012), although CBT may be cost effective it locates happiness within the

individual and ignores ecological aspects of wellbeing. He makes claims that CBT works on the premise that individuals can ensure their own emotional wellbeing regardless of social context. However, it may not always be possible for individuals to be active agents for change within their own lives. Factors such as their family background, social position and economic status may impact on their ability to manage their own emotional wellbeing and to effect positive change (Ryle, 2012).

Similarly, a further critique has made claims that CBT fits predominantly within a medical model which serves to pathologise individuals to the exclusion of understanding their personal and subjective experiences (Kantrowitz & Ballou, 1993). CBT operates on the assumption that undesirable behaviour is learnt, and therefore can be unlearnt. Complex human processes might then be reduced to measurable and observable behaviours to the exclusion of 'the bigger picture'. The specific individual living in a certain context gets overlooked (Kantrowitz & Ballou, 1993). Kantrowitz and Ballou (1993) further query how those delivering CBT interventions decide what undesirable behaviour is, what desirable behaviour constitutes, and who and what has to change.

In addition, the review attempted to assess the effectiveness of school-based CBT interventions on adolescents' levels of social anxiety with the use of a quantitative synthesis of existing research data. In these studies, no attempts were made to consider factors other than quantifiable measures of symptom reduction. None of the studies included provided any qualitative data. Each study asked participants to complete quantitative self-report anxiety questionnaires. Combining this quantitative approach with descriptive and qualitative information would perhaps allow adolescents to expand upon their responses. Additionally, there is a lack of qualitative information regarding parental perceptions about their anxious child's experiences of key life events. This information might contribute to a fuller understanding of the underlying environmental influences which impact on their children's ability to cope and function in the future.

Hence, the reporting of only statistical information emphasised the potential for my research to take a deeper exploration into participants' views and subjective experiences. Coupled with earlier critiques of CBT (Kantrowitz & Ballou, 1993; Ryle, 2012), it also emphasised the potential for my research to take a more holistic and contextual approach to understanding adolescents' emotional wellbeing. These reflections re-directed the focus of my investigation towards an exploration of children's and adolescents' views and perceptions about important life events and changes.

2:2 Developing a research focus

Adolescents' views

My reflections on the systematic literature review led me to consider the need to look beyond symptom reduction. I wanted to look at adolescents' wider experiences and to locate individuals' experiences of social anxiety within a more holistic context. It also highlighted the necessity to gather the views of adolescents in an attempt to understand their 'lived experiences' better (Husserl, 1970).

The Government has made claims that Local Authorities (LAs) must have regard for:

- the views, wishes and feelings of the child or young person, and their parents

and

- the involvement of children, parents and young people in decision making

(Department for Education, 2013b, p12).

This appears to be congruent with some of the academic literature on child participation. These emphasise the importance of offering children the opportunity to participate in safe, inclusive and engaging research opportunities. Such opportunities should not only enable them to express their views but also to deliberate on strategies to assist them in the formation of their views (Lundy, 2007; Todd, 2007).

With the above considerations in mind, it seemed pertinent to conduct a piece of research which sought to understand and offer an interpretation of the views of socially anxious children and adolescents.

Post-school transitions

Definition of a key term

Before I continue with this section and for clarity, I feel it necessary to define my understanding of the term "post-school transitions". By this term, I refer to adolescents' transitions from compulsory school at the age of 16 years old to the adult world whereby they are likely to enter into further education, work training or employment. My use of this term appears to be consistent with the wider literature (Aston, Dewson, Loukas, & Dyson, 2005; Dewson, Aston, Bates, Ritchie, & Dyson, 2004; Kochhar-Bryant & Margo Vreeburg, 2006; Polat, Kalambouka, Boyle, & Nelson, 2001).

During my time on placement within a LA, I worked next to a LA hospital school for anxious pupils. Pupils in attendance at the hospital school were referred via Child and Adolescent Mental Health Services (CAMHS). CAMHS accept referrals from a range of different agencies, including the adolescent's school, GP and self-referrals. These adolescents had no formal diagnosis but were identified by CAMHS as displaying signs of social anxiety disorder. In conversation with the hospital school's manager, the SEN manager felt that CAMHS were perhaps careful not to diagnose an anxiety disorder as to do so may hinder anxious adolescents' attempts to re-integrate back into mainstream school (an official diagnosis may imply that are unable to make attempts to re-integrate). However, each adolescent's social anxieties were to the best of my knowledge consistent with Kring's (2013) working definition of social anxiety.

During my time on placement, I had become increasingly aware that many of these socially anxious pupils struggled to cope with educational transitions. According to the LA's SEN manager, anxious pupils must return back into their mainstream school on completion of their six-eight week period of intervention work with CAMHS. Two anxious adolescents referred to within my research had undertaken a CBT programme of work with CAMHS. One pupil had not undertaken CBT work with CAMHS. Theoretically, on completion of their work with CAMHS, anxious adolescents should have developed the necessary coping strategies and tools in order to enter back into their mainstream school.

However, one anxious pupil had informed hospital teaching staff that she had found CBT work ineffective, another had offered no feedback and one pupil was not in a position to comment (having never embarked on a programme of CBT work). Common to all was that, despite targeted intervention work, each anxious adolescent continued to struggle in social situations and to manage their anxieties. Therefore, the LA had yet to enforce this requirement. In all cases to date, the LA had been empathetic to the adolescents' requests to stay at the hospital school and had allowed them to remain.

Subsequently, at the time of writing this document, all pupils in the hospital school, on the basis of their anxieties, had found it difficult to cope with the transition from their mainstream school to the hospital school and from the hospital school back into their mainstream school. As yet, none had successfully integrated back into their mainstream school. I reflected on how socially anxious adolescents would manage the transition from mainstream school into the adult world, particularly as they already struggled with existing transitions.

According to Ecclestone, Hayes, Biesta and Hughes (2009) transition, at any point in life, is a complex interplay between the individual person and their particular social and cultural biography (identity), ability to shape their own destiny (agency) and the economic and social contexts of class, race and gender from which and into which they are moving (structure). Together these factors affect the capacity of the individual adolescent to manage change.

One major normative life transition is the shift from adolescence to young adulthood, when individuals leave behind so-called youthful freedom and begin to take responsibility for different aspects of their lives (Raymore, Barber, & Eccles, 2001). Given that socially anxious pupils had struggled to transition back into mainstream school, I was led to reflect upon the EP's role within an adolescent pre-sixteen year old's transition into the adult world. I began to consider how I might support the development of pre-school transition planning processes for young people with social anxiety. I reasoned that this was a possible area of focus, given that LA EPs had extremely little, if any, casework experience of supporting adolescents (socially anxious or otherwise) with their pre-sixteen compulsory school transitions.

As a result, I arranged to meet with the LA's Principal Educational Psychologist (PEP). I explained my research ideas and, in negotiation with her, it was agreed that I could design and carry out a piece of empirical research with a focus on:

What are socially anxious adolescents' perceptions of their transitions from school to post school?

<u>Reflecting upon the practical implications of CBT for professional practice; a further rationale for research</u>

During my time at the LA, I had yet to carry out any direct CBT casework. I had also not yet had the opportunity to meet with individuals who had undergone a program of CBT. I was aware that my research area might have led me to carry out a CBT-focused piece of work. This might have included me delivering and evaluating a school-based CBT intervention. I might have also been in a position to meet with anxious adolescents in an attempt to explore their views and perceptions of CBT. However my literature review highlighted that not enough evidence currently exists to suggest that CBT is effective on a longer-term basis. This is due to studies' lack of follow-up data and low/medium methodological quality (based on studies' Weight of Evidence judgments). These findings, coupled with the unreported and potentially 'negative' experiences of at least one adolescent within my potential sample. had already contributed to a shift in my thinking and research focus.

Subsequently, I felt it was likely to be unproductive and possibly damaging to facilitate an existing CBT intervention or indeed to initiate a new exploration into anxious adolescents' views and perceptions of CBT. In light of the realistic time-frame in which I had to carry out my research it was unlikely that I would have been able to fully assess the longer-term (for example 6 months and 12 months) follow-up effects of CBT on individual's levels of social anxiety. Ethically, I felt compelled not to put myself in a position in which I might cause potential emotional harm to adolescents. This was an important consideration, particularly as adolescents in attendance at the Hospital School had already experienced much upset in relation to their prior experiences of education and encounters with some LA professionals. In a concerted effort not to ask adolescents to delve in to difficult matters or to betray adolescents' trust, I made a decision to ensure that my own research had scope to focus on possible success factors within adolescents' lives. This opened up the possibility for me to initiate a qualitative piece of research with a focus beyond or outside the scope of CBT.

Shift in research focus

Unfortunately, in meeting with adolescents' parents, I was made aware that although parents consented to my work, the anxious adolescents themselves were unwilling. Parents explained that their children were unwilling to give their consent due to their social anxieties and difficulty in meeting new people. However, I attempted not to pathologise adolescents' behaviour with the recognition that they might have declined for a number of reasons. For example, adolescents may have refused to work with me as the subject matter may, for some, have been considered "boring" or irrelevant. Perhaps, as Hill (2006) argues, adolescents often have little control over the opportunities that arise for them to express their views to adults. Therefore some exercise choice or agency by declining to take part in research or consultation. At this point, it was necessary for me to re-think my research question and to shift the angle of my research. Returning back to my earlier reflections, about the necessity to take into consideration each individual's perceptions and contextual factors, I reasoned that I could warrant an investigation into the following question:

What are parents' perceptions of their socially anxious adolescents' transitions from school to post school?

This research question was consistent with certain studies of parent participation (deFur, Todd-Allen, & Getzel, 2001; Raymore et al., 2001; Vyverman & Vettenburg, 2009). According to deFur, Todd-Allen & Getzel (2001), research that has explored factors influencing post-secondary transition outcomes have reported family involvement as key to

successful post-school transitions for young adults with special educational needs. This view is supported by Comer & Haynes (1991), who argue that meaningful involvement of parents in children's schooling can enhance the educational process. Parents can offer their insights and knowledge and contribute to the professional skills of school staff, in ways that strengthen academic and social programmes.

However, in order to address my research question more fully, it was felt necessary to carry out another search of the literature: In returning back to the systematic methods of Petticrew and Robert's (2008), I reasoned I would be in a better position to determine additional

Database search terms
participants terms
parent* carer*

Phase	Literature search
1	Literature dated 2004-2014 was searched in line with Cronin, Ryan and Coughlan's guidance that a maximum time frame of 5 to 10 years is usually placed on the age of the work to be included in a literature review (Cronin et al., 2008)
2	Citation searches
3	Hand searches

studies to answer my research question. This search was conducted in 3 phases, as shown in Table 12. All searches were conducted between 17th September 2014 and 13th October 2014.

Table 12: 3 phase literature search

To locate relevant studies, a combination of search terms was used to search the University of Newcastle's electronic databases. In line with Harvard's (2007) recommendations, search term words were truncated and 'wildcard words' were used to expand the search as appropriate. The Macmillan dictionary e-thesaurus (2009-2014) was used to ensure that appropriate synonyms were included in the treatment target terms, the setting terms and the subject terms' categories. The search terms used can be found in Table 13 and Appendix 13.

Table 13: Database search terms

setting terms
school*/educat*/class*/school-age*/secondary school*/high school*/work*/college*/further education*/training*/job*/employment*/
hospital*/paedi*/health*/service*
mediating factor terms
social*anxi*/social anxiety*
mediating factor terms
transition*
subject terms
child*/adolesc*/ young pe*/teenage*/youth*/ pupil*/ paedi*

The following electronic databases were searched, as seen in Table 14.

Table 14: Electronic databases searched

Electronic databases searched
ProQuest
EBSCO
Ovid
Scopus
Web of Knowledge
First Search
Medline

As before, hand searches of academic and professional journals were conducted in addition to the generic database searches. Journals were selected and searched if they were judged to be relevant to the focus of the research question. See Table 15 for the academic and professional journals searched. In addition to re-searching previously identified journals, other journals were included and searched if they were judged to be of relevance to the research question.

Table 15: The academic and professional journals searched

Academic and professional journals searched
Parenting, Science and Practice
Journal of Adolescence

Journal of Youth and Adolescence
Journal of Anxiety Disorders
Educational Psychology in Practice
Journal of Applied School Psychology
Journal of Depression and Anxiety
Social Psychology of Education: An International Journal

This process enabled me to identify 10 studies with a focus on adolescents' transition from school to adulthood. This literature was as follows; (Elffers & Oort, 2013; J. Graham, 2005; J. R. Graham, Shier, & Eisenstat, 2014; Karin Du, Corney, Broadbent, & Papadopoulos, 2012; Kochhar-Bryant & Margo Vreeburg, 2006; Lang, 2010; K. Roth & Columna, 2011; Salmela-aro & Tuominen-soini, 2010; Salmela-Aro & Tynkkynen, 2010; Yates, 2005). I refer to this literature later in the sections entitled; The transition from school to adulthood, *Discussion and reflection on the implications of the research for EP practice* and *Concluding comments and implications of empirical research for EP practice sections.* Furthermore I return back to book sections in (Jindal-Snape & Miller, 2010) and articles from *Psychological Perspectives on Transitions* (Educational and Child Psychology, 2012) throughout these sections.

Although not entirely centred on the transition needs of anxious adolescents specifically, four studies (Bhakta, Rooney, Wyatt, Roussonnis, & Chamberlain, 2000), (Clarizia et al., 2009) (McNamara et al., 2014) and (Murcott, 2014) brought to the forefront some issues of interest which warranted further discussion in relation to transition from paediatric health services to adult health services. This literature is referred to in the *Discussion* and *Reflection on the implications of the research for EP practice* sections.

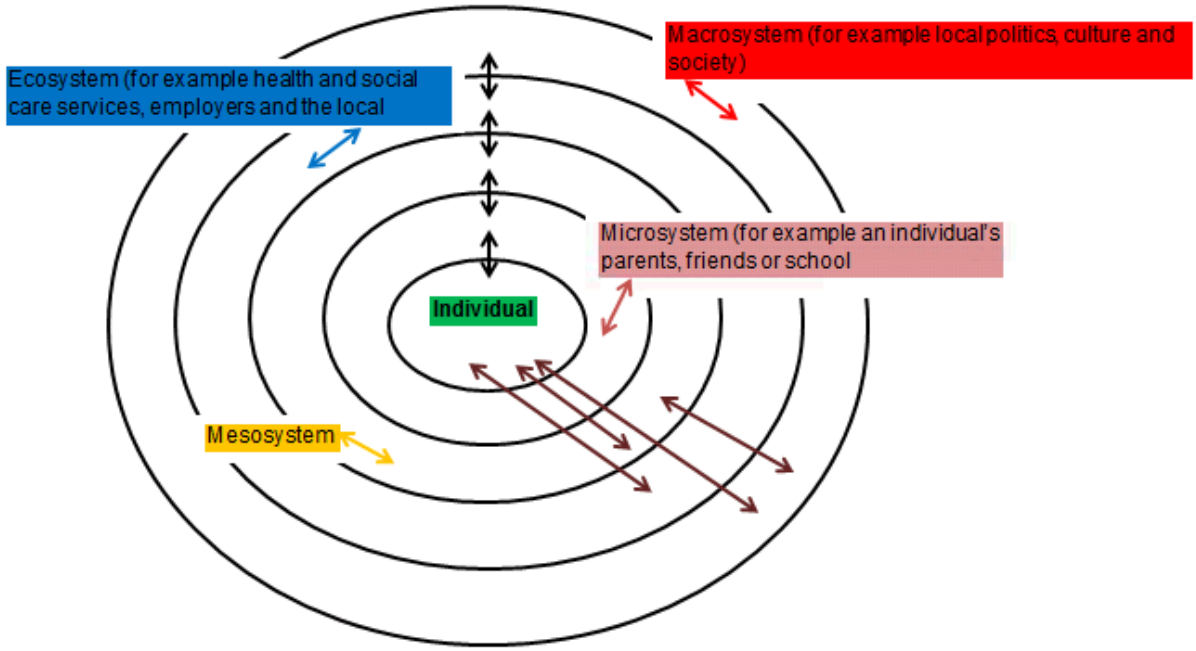
My overall difficulty in finding directly relevant literature in relation to anxious adolescents specifically, appeared to highlight a gap in the existing literature. The LA had in recent years developed an Autism Spectrum Disorder (ASD) transition planning protocol for year five primary school aged pupils. In addressing this gap, my research aimed to feed into the LA's transition planning processes by making both a contribution to the academic body of knowledge and professional EP practice. I hoped to do this in drawing upon my research to

create an opportunity in which a similar protocol could be devised for anxious pupils. Perhaps key to the successful development of such a protocol would involve parental perspectives on anxious pupils' support needs and how these might be met. In making an active attempt to reflect and offer an interpretation of parents' views, my research may fits with recent government policies. For example, the Special Educational Needs Code of Practice 0-25 years requires LAs:

"to support and involve the child and his or her parent, or the young person, in carrying out their functions and to have regard to their views, wishes and feelings. This includes their aspirations for adult life" (Department for Education, 2014a, p110).

Furthermore, I reasoned that my research question was closely aligned with Bronfenbrenner's ecological systems theory (Bronfenbrenner, 1979, 1998). This details how four bi-directional factors, the individual, the microsystem, the exosystem and the macrosystem influence an individual's personal growth and development. In order to understand human development, the entire ecological system in which personal growth occurs must be considered. See Figure 2.

Figure 2: Bronfenbrenner's (1979) ecological model of child development



My interpretation of Bronfenbrenner's (1979) model offers an explanation as to how it might be possible to have different layers of being "within" an individual's ecosystem. As part of this, I felt able to position myself within socially anxious adolescents' ecological systems. As a TEP, I appreciated that I was unlikely to be positioned within their microsystems as I was to have no direct contact. However, I aimed to support change in the mesosystem in working from the level of the ecosystem with parents to inform LA practice.

Having shifted my research focus, I approached my LA PEP and anxious adolescents' parents once more with my revised research question. Both parties consented to my study. Subsequently, I was able to invite the participation of, and to interview, three parents from an opportunity sample of LA hospital school parents. I later analysed participants' data with the use of IPA. As part of this process, I sought to reflect on and offer an interpretation of the parents' views. In this way, I aimed to give a voice to parents who might not otherwise be heard.

Although I shifted the focus because of practical reasons, my research was embedded within current government initiatives. In addition, this line of enquiry was still pertinent to my commitment to exploring the broader impact of adolescents' anxieties on their pre-sixteen transitions into the adult world.

2:3 Research methodology and design

Starks, Brown and Trinidad (2007) have explained that discourse analysis is concerned with understanding how people use language to create and enact identities and activities. Conversely, grounded theory is centred on developing an exploratory theory of basic social process. Phenomenology is concerned with describing the lived experiences of a phenomenon, which was central to my research question. Therefore Interpretative Phonological Analysis (IPA) was chosen as a qualitative method of data analysis

IPA is also founded on the basic assumption that individuals are experts on their own lives (Howitt, 2013). It is primarily interested in how participants make sense of their lived experiences. It centres on participants' subjective experiences of the world, rather than the objective nature of the social or material world (J. Smith & Osborne, 2003). Unlike positivist approaches, IPA does not make any claims about the external world or seek to test preconceived hypotheses (J. Smith, 2009). It does not question whether participants' accounts of what happened to them are 'true' or 'false'; rather, the key focus of IPA is how participants experience the situation or the event.

In this sense, IPA subscribes to relativist ontology (J. Smith, 2009). This complements my critical realist worldview as, although critical realists retain an ontological realism (there is a real world that exists independently of our perceptions, theories, and constructions), they do accept a form of epistemological constructivism and relativism (with the assumption that our understanding of the world is inevitably a construction from our own perspective and standpoint (Maxwell, 2012). This fits my own research that sought to understand factors within parents' lives from their own personal perspectives.

Larkin, Watts and Clifton (2006) have stated that IPA has its theoretical origins in phenomenology, hermeneutics and symbolic interactionism. It has two complementary commitments, the phenomenological requirement to understand and 'give voice' to the concerns of participants; and the interpretative requirement to contextualize and 'make sense' of these claims and concerns from a psychological perspective (Larkin et al., 2006). IPA assumes that individuals, unlike the objects of the natural world, are conscious, purposive actors who have ideas about their world and attach meaning about what is going on around them (Robson, 2011). What matters is how individuals experience the situation or event (Willig, 2008). With this idiographic focus, IPA logically lends itself to single case studies or studies with small sample sizes (Howitt, 2013; J. Smith & Osborne, 2003).

Semi-structured interviews are the most common method of data collection in IPA (J. Smith, 2009). In keeping with this, I utilised semi-structured interviews as a tool to access adolescents' views and personal experiences. However, I was aware that although the primary concern of IPA is the lived experience, the end result is always an account of how the researcher has interpreted the participant's expression of their thoughts. This is a double hermeneutic (J. Smith, 2009).

Smith and Osborn (2003:51) use the term 'double hermeneutic' to emphasise the two interpretations involved in this process. The first is the participants' "*meaning-making*", (i.e. interpreting their own experiences) and the second is the researcher's "*sense-making*" (i.e. interpreting the participant's account).

Although I was aware of differing approaches to interviewing, such as positivist, constructionalist and emotionalist, I adopted an emotionalist approach (D. Silverman, 2010). Emotionalist approaches encourage the researcher and interviewee to engage in interactions beyond that of fact sharing. Interviewees are invited to reflect upon their lived experiences and are viewed as experiencing subjects who actively make sense of their social worlds (D. Silverman, 2010).

This is not to deny that emotionalist approaches to interviewing have been criticised, for example, the "free" nature of the interview process may allow for the interviewer to manipulate or distort interviewee's responses (Ikeda, 2007). Despite this issue, I adopted this approach because my primary aim was to generate data which gave an authentic insight into people's experiences (D. Silverman, 2010). Ultimately, my use of semi-structured interviews sought to uphold the understanding that qualitative research methods are often flexible and fluid and are therefore suited to understanding the meanings, interpretations and subjective experiences of vulnerable groups (Liamputtong, 2007).

2:4 Ethics and reflexivity

Throughout the interview process, I understood that as a psychologist in training I was required to adhere to the Health Care Professional Council's (HCPC, 2009) Standards of Conduct, Performance and Ethics. This required acting in the best interests of service users, keeping high standards of personal conduct, and communicating effectively with others (HCPC, 2009, p3). With some preliminary background information about the hospital school for anxious pupils, I was aware that my research sample could include parents identified as having their own emotional wellbeing difficulties. This information was particularly pertinent

then, given that I was likely to be working with some parents who might be viewed as vulnerable, hidden and marginalised (Liamputtong, 2007).

As a result, I was careful to debrief each participant at the start and end of each interview. I reminded each parent about my professional role and my mandatory course requirements, which were to produce a piece of work to disseminate across the LA and to the wider academic community. This ensured I did not 'do rapport' by 'faking friendship' with parents (Liamputtong, 2007:3).

From the onset of my research project, I actively sought to develop trusting relationships with participants. "Nicole" (parent 2) specifically raised the matter of trust between professionals and parents. I perceived this to be an "ethically important moment" (Guillemin & Gillam, 2004:262) and I realised how, as a reflexive researcher, I needed to step back and take a critical look at my role in the research process (Guillemin & Gillam, 2004). Subsequently, wherever possible, I included parents in each stage of the research process. For example, I made contact with each parent during the data analysis stage of my research. I did this to verify that my interpretations of their responses provided an accurate reflection of their views and to regain their consent to disseminate this information within the LA. With this respect for "ethics in practice" (Guillemin & Gillam, 2004:263), I also explained the motivations behind the use of their information. I worked in this way as a necessity to move beyond a process of procedural ethics towards being both mindful and active in protecting parents, and myself, from harm and undue risks (Guillemin & Gillam, 2004). In attending to the above discussion points I attempted to carry out research *with* rather than *on* participants (Liamputtong, 2007), In doing so I aimed to address imbalances of power and facilitate trust and mutual respect between myself and parents as I hope the following piece of work demonstrates.

Chapter 3:

What are parents' perceptions of their socially anxious adolescents' transitions from school to post school?

3:1 Introduction

Anxiety in adolescence

Compared with their peers, socially anxious adolescents (as defined earlier with the use of Kring and Johnson's (2013) definition on page 10 of the systematic review), overall life chances and outcomes are at higher risk of being disproportionately poor (Blumenthal, Leen-Feldner, Frala, Badour, & Ham, 2010; Henker, Whalen, Jamner, & Delfino, 2002; Silk, Davis, McMakin, Dahl, & Forbes, 2012). Links have been identified between social anxiety disorders and poor school attendance (Dube & Orpinas, 2009; Last & Strauss, 1990; Pina et al., 2009). Socially anxious adolescence will often school refuse (Grandison, 2011; Heyne et al., 2011). Subsequently, they are at increased risk of educational underachievement and failure to attend university (Last & Strauss, 1990).

On a longer term basis, socially anxious adolescents are prone to alcohol and illicit drug dependency and continued mental health difficulties (Woodward & Fergusson, 2001). These difficulties can become so pronounced that socially anxious adolescents can be defined as having a SEN need if the individual's physical or mental impairment has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities (Morris, 2001). Given these difficulties, it might be expected that some anxious adolescents will struggle to cope with the transition beyond secondary school into the adult world

Post-school transitions

Transitions are fundamental features of social life and represent periods of change and adaption (Dunsmuir & Stringer, 2012). The transition beyond secondary school into the adult world is a period of anxiety and uncertainty for many children and adolescents (Jindal-Snape & Miller, 2010). Arnold and Baker (2012) argue that for adolescents aged sixteen to twenty four, the shift from adolescence to young adulthood involves both predictable and unpredictable changes. They are likely to encounter challenges in their roles, relationships and responsibilities. According to Dwyer and Wyn (2003) as young adults they are expected to act with greater maturity and to negotiate more equal relationships with their teachers,

parents and colleagues. They are also required to make independent decisions and to manage their study and work commitments with equally important commitments in their personal lives.

According to Graham, (2014) for those adolescents who enter directly into the work place after school, there appears to be a misalignment between post-secondary education demand and labour market supply. As such, there is a disconnect between labour market demand and the educational training and acquired skills of adolescents. In industrialised countries, immigrant and domestically born ethno-racial minority adolescents face additional systemic barriers. These include; pervasive inter-generational poverty, experiences of discrimination, racism and social isolation (J. R. Graham et al., 2014). Although it cannot be assumed that German employment systems will be the same as UK employment systems, Lang's (2010) German-based study has also made claims that the issue of employment is increasingly more problematic for many adolescents. In particular, adolescents with migrant backgrounds, low academic achievement or early school leavers often need additional help to manage the transition from school in to work.

Yates (2005) has raised the issue of gender in relation to adolescents' post-school transitions. She has made claims that it is reasonable to expect that young women's work trajectories might differ from those of young men's. In recent times, working mothers have become the norm rather than the exception. While women no longer automatically withdraw from the labour force upon marrying or after having a child, it remains common for women with young children to interrupt their careers for both childbearing and childrearing. Women may also choose more intermittent or seasonal work that correlates with school or other childrearing activities (Yates, 2005).

Such increased demands and responsibilities may account for why Halpern (1994) refers to the transition from adolescence to young adulthood as a change from the adolescent behaving primarily as a student to assuming emergent adult roles in the community. These roles include employment, participating in post-secondary education, maintaining a home, becoming involved in the community, and experiencing satisfactory personal and social relationships. According to Graham (2005) however adolescents with a mild or moderate level of SEN are often confident that they will have a fulfilling and inclusive life in the community. Despite this, they are frequently the most under-employed and unemployed group of people in society. This is consistent with the view that adolescents with SENs are at increased risk of being Not in Education Employment of Training (NEETS) (Seddon,

Hazenberg, & Denny, 2013). Consequently some adolescents do require additional support to ease the process of transition (Arnold & Baker, 2012).

Perhaps unsurprisingly then, Dunsmuir and Stringer (2012) hold the view that recent debate has focused on the most appropriate ways that professionals can prepare for and support adolescent's transitions into adulthood. This is in recognition that for potentially vulnerable individuals transition can represent a period of stress and disruption (Dunsmuir & Stringer, 2012). Consistent with this view, Topping and Foggie (2010) conducted and evaluated a project which deployed key workers to support the post-school transition of adolescents at risk of social exclusion. Although the findings of a small-scale study are unlikely to be widely generalisable the project was generally reported to be highly valued by adolescents (Topping & Foggie, 2010). Contributing to the effectiveness of this project was the use of interactive behaviours by keyworkers to develop transferable skills and build active independence in adolescents. Such interactive behaviours included key workers modelling, scaffolding and encouraging adolescents to develop their independence, employability and self-sufficiency skills. The ability to use public transport, for example, was found to enhance adolescents' independence by enabling them to access recreational pursuits without having to rely on their parents to give them a lift (Topping & Foggie, 2010). This may explain why Yaeda (2010) holds the view that transition is not a one-off event. Instead, all professionals involved in adolescents' transitions must have the ability and skills to offer comprehensive services from a lifespan developmental perspective.

Yaeda's (2010) views may be consistent with the argument that school-related encouragement and support at home plays an important role in adolescents' attitudes about transitions in to further education (Elffers & Oort, 2013). As part of this, Byrnes (2012) suggests that engaging collaboratively with the adults closet to the individual is a crucial aspect of professionals' practice. As such parents and carers are seen as being central to the clear definition of problems and the development of a good understanding of adolescents' strengths and areas for development (2012) . However, despite this expectation for professionals to work collaboratively with parents, Kochhar-Byrant and Margo Vreeburg (2006) argue that major problems have been encountered in the insufficient quantity of staff members. This has resulted in the often huge caseloads of existing staff for coordinating transition services and accommodating parents and adolescents with SENs (Kochhar-Bryant & Margo Vreeburg, 2006).

In addition to the matter of collaborative working, Salmela-Aro and Tynkkynen, (2010) have made claims that adolescents prior experiences of school are associated with various

adjustment outcomes. Poor academic performance and academic failure is related to psychological stress and negative effect in post-school transitions. High academic attainment is related to high emotional wellbeing and protects against maladjustment (Salmela-Aro & Tynkkynen, 2010). This may support Karin Du et al's (2012) views that it is necessary to consider social and emotional factors as part of adolescents' school to work transitions. Particularly as adolescents' resilience to face school to work transitional challenges can be enhanced by increasing knowledge of suicide risk factors and sources of social and emotional support. Moreover, adolescents identified as socially isolated have found informal peer support helpful to aid the process of transition (Karin Du et al., 2012)

In addition to such support, Salmela-aro and Tuominen-soini (2010) found that high life satisfaction might aid transition from school to further education or vocational training. High life satisfaction may enable adolescents to value in causing adolescents to persist longer in the face of failure but also to know when to quit. Although Salmela-aro and Tuominen-soini (2010) do not define their conceptualisation of the term 'high life satisfaction' they claimed to have found that that adolescents' life satisfaction increased during the transition from comprehensive school to further education and vocational training. Self-esteem and academic achievement predicted the level of life satisfaction during the transition. Moreover, embarking on an academic track was predicted by a high level of life satisfaction. Finally, among girls, an increase in life satisfaction during the transition predicted school engagement and academic attainment later on (Salmela-aro & Tuominen-soini, 2010) .

<u>The transition from paediatric health services to adult health services</u>

According to Bhakta (2000), there is a need for the change from adolescent health-care to adult health-care to be a guided educational and therapeutic process, rather than an administrative event. However, Peter, Forke, Ginsburg, Schwarz and Smart (2009) have argued that currently this is not always the case. Instead, many adolescents and their parents have described the change in service philosophy between child and adult services as disorganised and confusing, especially in relation to the role and involvement of families. In light of this, Roth and Columna (2011) have asserted that families, school-based professionals and local agencies should all be active participants in transition planning. Teachers for example have not always used parents as a valuable resource when planning for pupils' transitions. Subsequently, there must be a greater emphasis for greater collaboration between parents and professionals at all natural transition points (K. Roth & Columna, 2011).

To confound matters, McNamara (2014) have made claims that there is a lack of standardised practice nationwide regarding the service transition boundaries between child mental health and adult mental health. This includes an absence of written transition policies and protocols, and minimal formal interaction between child and adult services (McNamara et al., 2014). Similar views have been expressed by Clarizia et al (2009) who have argued that the shift in child-centred to adult-centred health care has posed a challenge in the transition from childhood to adulthood for adolescents with additional needs.

Perhaps in response to this the Government's *No Health without Mental Health* Strategy (2011) and has focused on the need to provide adolescents and their parents with appropriate and accessible information and advice. This is a necessity in order for adolescents and parents to exercise choice and participate in decisions about which adult services adolescents receive. Subsequently, although adult and child services are often driven and designed in different ways, by looking at the way existing services are designed (and the practices that drive them), this can then lead to the improvement of transitions of care (Murcott, 2014). Overall, the literature appears to indicate that successful transition programs must be responsive to the needs of adolescents, parents and health care providers (Bhakta et al., 2000; Clarizia et al., 2009; McNamara et al., 2014; Murcott, 2014).

Transition planning: parents' voices

Post-school transition planning for adolescents with additional needs has created a certain amount of tension between parents and professionals (deFur et al., 2001). Parents have not always felt part of the decision making process with professionals often assuming that parents have the necessary information to make informed decisions (Smart, 2004). Parents may also believe that professionals perceive them as less knowledgeable, less important or devalued, particularly if they are 'stay-home' parents or if they disagree with professionals' decisions (Logsdon, 2013).

Where a pupil has additional support needs it is essential and perhaps more commonly accepted that professionals, parents, and pupils should work collaboratively and consultatively to determine each pupil's additional needs and future goals (and to develop an effective plan to achieve these) (Bakken & Obiakor, 2008; Department for Education, 2011; Department for Education & Health, 2013; Jones, O'Sullivan, & Rouse, 2004). The Government has also advocated parental participation. Its SEN Green paper published in (2011), and its recent Children and Families' Bill (2013a) emphasised that parents should have greater control and choice.

Policy makers state that children with SEN may require a different approach, or additional support from specialist services in comparison to their peers. Policy makers also emphasise that parents know their children best and subsequently policy should allow parents more influence over support for their child with access to personalised funding, with the option to participate in local decisions and a clear choice of schools (Department for Education, 2011, 2013a). Additionally, the Special Educational Needs and Disability Code of Practice: 0 to 25 years specifies LA's are required to:

> 'to support and involve the child and his or her parent, or the young person, in carrying out their functions and to have regard to their views, wishes and feelings. This includes their aspirations for adult life'
>
> (Department for Education, 2014b, p112)

This policy stipulates that:

> 'Local Authorities **must** ensure that the relevant services they provide cooperate in helping children and young people prepare or adulthood'
>
> (Department for Education, 2014b, p114)

As part of an individual's 0-25 year old Education, Health and Care Assessment Plan, psychological advice must be sought from an educational psychologist (Department for Education, 2014b, p145). This requires consideration of the EP's role and contribution in relation to post-school transition planning. This may be the case as my LA experience to date has highlighted how much of an EP's casework currently finishes at the point pupils leave school.

3:2 Rationale for the research

Hence, the Government's (Department for Education, 2011, 2013b, 2014a, 2014b) recent directives might be used as a rationale for my research project in addition to the discussion points raised in the preceding section. The majority of research on adolescents and educational transitions has focused on the support needs of children and adolescents with medical and physical conditions or mental health difficulties more broadly (Dewson et al., 2004; Green, 2008; Maras & Aveling, 2006; Polat et al., 2001). There appears to be little literature on the transition of anxious adolescents from school to post school contexts. This study attempts to address the gap by exploring factors which might enhance the transition experience of a small group of adolescents in a local context.

Regardless of the nature of individual need, research indicates that parents are a key protective factor for their children during their educational transitions within their adolescence years (Goupil, Tasse, Garcin, & Dore, 2002; Hetherington et al., 2010; Lord, Eccles, & McCarthy, 1994; Martinez, Conroy, & Cerreto, 2012; Smart, 2004). For example, many parents have learnt to become advocates to secure appropriate services for their vulnerable children, and particularly those with mental health difficulties (Smart, 2004). Parents have advocated for their children despite their frustrations with a lack of coherence and transparency in service delivery (Weafer, 2010). Given the significant contribution parents have made to ensure favourable outcomes for their children, this research actively aims to give voice to parents' views in relation to their child's pre-compulsory school transition into adulthood. To offer a reflection and interpretation of the key issues that parents perceive in relation to their child's transition, pre-compulsory school transition planning processes for adolescents with social anxiety may be better informed.

Research aims

Much research has focused on the transition needs of children with SENs more broadly (Dewson et al., 2004; Green, 2008; Maras & Aveling, 2006; Polat et al., 2001). My research aimed to refer specifically to the parents of adolescents identified as having social anxiety attending the LA's hospital school for anxious pupils. All anxious pupils in attendance at the hospital school had been referred via Child and Adolescent Mental Health Service (CAMHS) due to their severe anxieties. Each anxious pupil was schooled outside of their mainstream setting, although they remained on their mainstream school's official attendance register.

My research aimed to gain an insight into the views of a small number of parents about their children's transition from school into the adult world. I endeavoured to reflect on and offer an interpretation of parents' views, drawing upon these to inform the LA's transition planning processes. I aimed to consider the wider implications of my research findings for EP practice. My research project aimed to make a useful contribution at a local level in addressing this research question:

What are parents' perceptions of their socially anxious adolescents' transitions from school to post school?

In addressing this question, parents were invited to reflect upon possible obstacles and opportunities which might affect their children's transition from school into further education, work or training. The term adolescents will be understood as: 'young people between the ages of 10 and 19 years' (World Health Organisation, 2014).

3:3 Method

Semi-structured interviews were used to explore participants' views and personal experiences. During the Interpretative Phenomenological Analysis (IPA) data analysis phase (see Smith (2009) p,55) I was aware of Smith and Osborn's double hermeneutic' (2003:51) to emphasise the two interpretations involved in this process. The first is the participants' "*meaning-making*" (i.e. interpreting their own experiences) and the second is the researcher's "*sense-making*" (i.e. interpreting the participant's account).
(Dube & Orpinas, 2009; Last & Strauss, 1990; Pina et al., 2009).

3:4 Demographic information about the LA

Context

The research was carried out in a LA hospital school for pupils with severe anxieties in the North East of England. The hospital school itself was situated along the corridor directly opposite the EPS. Some of my EP colleagues had had direct (non-CBT) casework experience working with anxious adolescents. I had not worked with any anxious pupils at the hospital school. At the time of writing, the hospital school comprised approximately ten secondary school-aged pupils. Two qualified primary school teachers co-taught lessons. As pupils were in year groups ranging from 8 to 10, each pupil mainly worked towards their own national curriculum objectives. However, on occasion, pupils did have scope to work in pairs and small groups. Pupils' academic work was set by their mainstream school. The hospital school teachers maintained close contact with each pupil's mainstream school to share information and to ensure a joined-up approach to pupils' academic progress. The hospital school environment itself might have been described as "nurturing" and "inviting" with adolescents' work on the wall and "colourful" displays.

Adolescents in attendance at the hospital school were referred via Child and Adolescent Mental Health Services (CAMHS). CAMHS accept referrals from a range of different agencies, including the adolescent's school, GP and parent-referrals. The adolescents as discussed in this study had no official diagnosis or Statement of Special Educational Needs (SEN) were identified by CAMHS as displaying signs of social anxiety disorder. In conversation with the hospital school's manager, it was felt that CAMHS were perhaps careful not to diagnose an anxiety disorder as to do so might hinder anxious adolescents' attempts to re-integrate back into mainstream school (an official diagnosis may imply that

are unable to make attempts to re-integrate). However, each adolescents' social anxieties were, to the best of my knowledge, consistent with Kring and Johnson's (2013) working definition of social anxiety on page 10 having spoken with their parents and SEN manager. According to the SEN Manager, the LA started transition planning in year 8. As part of their mandatory 6-8 weeks LA review meetings, each anxious pupil and their parents were invited to discuss adolescents' transitions back into mainstream school and beyond. However, as mentioned previously, not a single anxious adolescent had successfully transitioned back into mainstream school.

Participants

Participants were selected from an opportunity sample. The participants were three parents who had children in attendance at the LA's hospital school for pupils with medical needs and severe anxieties. Two parents were in employment, one parent might have been described as a stay-at-home parent. The anxious adolescents as referred to in this study had siblings not in attendance at the hospital school. All of the sample were female. Participants and their families lived locally. At the time of carrying out the research, the pupils were in year ten and were due to transition out of compulsory education in the following academic year.

3:5 Ethics

I adhered to the University of Newcastle's research ethics process and full ethical approval was sought and granted in advance of starting the research (see Appendix 8). Table 16 details how ethical considerations were addressed during the interview process.

Table 16: Ethical considerations

Table of ethical considerations and supporting justifications	
Ethical consideration	Justification
<u>Providing participants with a detailed explanation of the research process</u> Before interviews, parents were invited to read and sign on agreement a project information letter and consent. See Appendix 9. I gave each participant my contact details. I explained that I was available to address any concerns or to answer any questions. I also made it clear that they had the right to decline to participate at any point and that this would not prejudice them or their access to services. Should they decline to consent to participate their data (paper and electronic) would be destroyed.	A detailed explanation of the research process was provided with a regard for parents' emotional wellbeing. This regard was founded in my recognition that to be an ethically skilled qualitative researcher involved more than respecting the integrity of the participants. As Brinkmann and Kvale (2005) have explained, an ethical researcher also needs to take into account the cultural context of their research. As a result, it is important to consider how the knowledge produced will circulate and affect both individuals and wider society. I was aware that during the interview process, parents would most likely share sensitive information. The interview process itself would invariably provide me, as a stranger, with access to parents' inner thoughts and personal life experiences to (Brinkmann & Kvale, 2005). Therefore, I needed to treat them and their information with due care and respect. I also recognised the potential for power imbalances to exist between myself as an academic researcher and LA Trainee and adolescents' parents. For example, as I was on placement at a small LA, parents were surely aware that I worked closely with many LA professions as part of my day-to-day casework. Subsequently, parents may have felt that in openly sharing their views with me they might compromise their relationship with the LA. This might affect their children's access to LA

	services, particularly should parents' views have differed to those of the LA (or should I have provided unfavourable feedback to the LA which portrayed parents or the LA in a negative light). Therefore it was imperative that I stressed to parents that they had the right too to decline to participate at any point.
<u>Providing participants with transparent and clear information</u> Participants were made aware that their interviews would be transcribed by either myself or a professional transcriber. They were informed that their data would be anonymised and that their audio transcripts would be anonymised as parent one, parent two and so on. I explained that their anonymised information would be used to inform my doctoral research project and that I might later submit this for publication within the public arena, including the wider academic community.	I perceived it imperative that participants had a full and transparent description of how his or her information would be used and disseminated, in order for them to make an informed decision to participate. Given that each parent lived within a relatively small and self-contained LA, I understood that it was my responsibility to minimise potential harm to participants, particularly as I had the potential to make private matters public (Kvale, 2006).
<u>Keeping interviews focused on the research question</u> I kept interviews focused on the research question, without deviating towards other personal matters within participants' lives (such as about their personal finances, friendships etc.). Therefore, although I still remained in a position of power in that I had set the research agenda according to my research interests, I believe that I strove to be an ethically competent qualitative researcher (Kvale, 2006).	On a pragmatic basis, it would have been easier for me to have glossed over deeper ethical matters. As Kvale (2006) notices, it is often tempting for qualitative interviewers to, when under external pressure from a deadline, to profit from a warm personal relation with their participants. This sometimes ethically stretches the respect of their participants' privacy to get some empirical information on tape (Kvale, 2006). However to counteract this, as Kvale (2006) suggests, I made a concerted effort not to trespass on participants' lives and instead to be as respectful as possible. I did this by asking parents questions which, as closely as possible, adhered to the research question.

3:6 Data Generation procedure

Interviews were conducted in a quiet LA meeting room at a mutually convenient time. In line with Smith et al (2003) and Laenen's (2009) IPA process suggestions, a semi-structured interview schedule was devised (see Appendix 10). The interview schedule was used as a tool in which to explore parents' views about their children's transition from post-sixteen education. Open-ended questions (e.g. "Can you tell me how you feel about your child's forthcoming transition out of the home and hospital school?") were accompanied with prompts (e.g. "What are you worried about?" "What are you looking forward to?"), when necessary. Interview questions were guided by Munn-Giddings (2012) and Smith et al's (2003) how to design an interview schedule recommendations. To avoid parents thinking that I expected either a negative or positive response, I kept my interview questions balanced by asking them about both potential obstacles and possible success factors (see Appendix 10). This was consistent with my epistemological position that encourages participants to reflect upon their own personal realities and lived experiences (Scott, 2005, 2007).

As suggested by Munn-Giddings et al (2012), the interview schedule was used as a working framework rather than a strictly enforced structure. Although the interview schedule was used to guide the interview, responses to interview questions were probed to expand upon points of interest. On average, interviews lasted between forty minutes and one hour and twenty minutes. Each interview was audio recorded and transcribed verbatim.

3:7 Data analysis

The interview transcripts were analysed using Smith's (2009) IPA data analysis process, as presented in Table 17.

Table 17: Smith's (2009) IPA process

	Smith et al's (2009) IPA process
Phase	**Description of process**
phase 1	To become familiar with the first interview transcript, I read it several times. I listened to the participant's audio recording at the same time as reading their interview transcript. I then noted down my initial thoughts and reflections about the information provided. My initial notes were handwritten. I then decided to record my reflections into the right hand margin of the participant's electronic interview transcript.
phase 2	The participant's transcript was re-read. I explored the participant's transcript in an attempt to identify emergent themes and to offer an interpretation of meaning (J. Smith, 2009). These emergent themes were separated on a linguistic, descriptive and conceptual basis (J. Smith, 2009, p84).
phase 3	The preliminary themes were then typed-up on a separate Microsoft Word document. I moved these around the document to think about how they might link together. At this point, I attempted to identify over-arching themes which appeared to connect groups of sub-themes. The participant's actual words and my own personal interpretations of their words were reflected in these themes. I applied psychological theory to my interpretations of the participant's information.
phase 4	I referred back to the original interview transcript to validate these preliminary themes and over-arching groupings. I created a word-processed table with the columns, over-arching themes, sub themes, line number from original transcript and participant's words. I completed this and made sure to demonstrate how themes emerged in citing and using the parent's exact words. Their words were taken directly from the parent interview transcripts.
phase 5	Stages 1-4 were repeated for the remaining two interview transcripts.
phase 6	I collated the preliminary analysis of the themes for each parent. I pooled each parent's initial analysis of themes together into an amalgamated summary of main themes. I used this summary of main themes to aid my data analysis for the entire group. I then searched the entire group's information to identify potential patterns across the participants' information.
phase 7	Congruent with IPA practice, this analysis phase involved the need for the selection and de-selection of some early themes. I abandoned themes if they were unrelated or irrelevant to my research question (J. Smith, 2009, p96).
phase 8	Superordinate themes were identified and split into themes. I devised a table to include each superordinate theme with each sub theme underneath. I used quotations taken from the parent's interview transcripts to evidence each theme. Participants were given pseudonyms to protect their confidentiality and to anonymise their information. This table of themes provided an overview of the main areas to be addressed within the remaining body of empirical work.

Quality and rigour

To ensure quality and academic rigour within my own research, I drew upon Lincoln and Guba's (1985) *Four Criteria for Assessing the Trustworthiness of Naturalist Enquiries* to inform my work. I chose to use Lincoln and Guba's (1985) guidance as their work appeared to align with my own research focus and was also widely recognised and cited within the literature, (see (Clark & Scheurich, 2008; Greene, 2008; Hardiman, 1989; Rodwell, 1987; Tierney, 1988; Yoong, 1986). I also chose to use this guidance to ensure that I held myself, my thought processes and research decisions up to scrutiny.

Table 18 details how I addressed issues of credibility, transferability, dependability and conformability with reference to Lincoln and Guba's (1985) criteria points. In addition, for quality assurance purposes, an audit trail example pages of an interview transcription table is given in Appendix 11.

Table 18: Lincoln and Guba's (1985) Four Criteria for Assessing the Trustworthiness of Naturalist Enquiries

Lincoln and Guba's (1985) Four Criteria for Assessing the Trustworthiness of Naturalist Enquiries		
criteria point	**Factors for consideration**	**How I addressed this criteria point**
A: **credibility**	How can the researcher establish confidence in the "truth" of the findings of a particular inquiry for the participants in the context in which the inquiry was carried out?	• I made use of appropriate, well-recognised IPA (J. Smith, 2009) research methods • I ensured my methods of data analysis were open and subject to scrutiny. For example, I provided my research supervisor with my full interview transcripts. • I ensured I was honest with participants. For example, I spoke with each participant on having analysed interview transcripts. I explained my interpretations and checked these were an accurate reflection of participants' views. I re-sought and gained participants consent before including this information in my final project write-up • During each interview, I used iterative questions and statements to check my own understanding and to minimise the potential for misunderstandings to occur between participants and myself. See this section of Nicole's transcript below to illustrate this point: *Nicole: "So they must, you know, to just be in that job (teaching) you've got to have some basic understanding and compassion to children, even children who go to school every day might have something going on in their lives. You've got to have that about you, that's got to be your nature, surely, that, not the attitude of, you know, here's a young girl who's really down and struggling to get into school because of it, and if you get that response back…"* Me: "Definitely. It feels like the relationship with teachers, then, isn't it, and having that awareness and, I guess, empathy for that young person?" *Nicole: "Yeah, I mean, some were really good when we tried to get her back, and they let her sit at the very back of the classroom, they'd give her work to do alone, but in the class group."* Me: "Okay." *Nicole: And, you know, same subjects, like, "Can't do anything".* Me: "Right, right,, okay, so not being flexible, then, in terms of thinking outside of the box

		and, “Well, how can we perhaps change this a bit, just, you know, that’s how we’re going to do it”.”
B: **transferability**	How can the researcher determine the degree to which the findings of a particular inquiry may have applicability in other contexts or with other participants	• I made use of reflective commentary throughout the research process. For example, during the data analysis phase of my research project, I reflected upon emerging themes and the potential for these to relate to other areas or participants. I also offered my own interpretation of Bronfenbrenner’s (1979) (1998) ecological model of child development as applied to my own research question. See page 76. • I carried out extensive background reading on social anxiety (Kring & Johnson, 2013) , educational transitions (Jindal-Snape & Miller, 2010) and parental views (Smart, 2004) to establish the context and relevance of my research. • To determine the relevance and applicability of my project, I also considered the implications of my work for EP practice. I did this with reference to the literature and the conclusions inferred from my own research project. See empirical research discussion section, page 68.
C: **dependability**	How can the researcher determine whether the findings of an inquiry would be consistently repeated if the inquiry were replicated with the same (or similar) participants in the same (or similar) context?	• I provided an in-depth description of my chosen research methods. See methods section page 51. In this section, I shared detailed methodological information about my study’s background context, ethical processes, participants and data generation procedures. • I referred to my use of Smith's (2009) IPA data analysis process to allow my study to be repeated. See Smith's (2009) IPA process page 56.
D: **confirmability**	How can the researcher establish the degree to which the findings of an inquiry are a function solely of participants and conditions of the inquiry and not of the biases, motivations, interests, perspectives, and so on of the inquirer	• I made explicit reference to my own personal ontological and epistemological assumptions. See page 10 of my systematic review of the literature and page 45 of my bridging document where I make my critical realist (Scott, 2005, 2007) position clear • I acknowledged the limitations in addition to the strengths of my research project. I recognised the potential effects these limitations might have had on my study’s overall design and conclusions. See the summary and conclusion section of my research project on page 68. • I made use of a participants ‘quotations table to record each participant’s exact words and to audit trail my data analysis. See Appendix 1.

3:8 A reflection and interpretation of parents' responses

The analysis presented in Table 19 focuses upon themes relevant to the research question. Analysis revealed four superordinate themes and five sub-themes. These are listed in the table followed by supporting data extracted from each participant's transcripts.

Much time and thought was given to the final selection of the superordinate theme and sub-themes. As detailed in Table 16, I listened to each parent's interview recording several times to develop meaning from the information. As a result, parents' actual words and my interpretation of these were at the forefront of my mind when devising a main matrix of themes. In line with Smith's IPA (2009) process, I filtered emergent themes on the basis they addressed my research question. As part of this, I took a holistic approach to the analysis of parent responses. I attempted to capture and reflect their main viewpoints with reference to their use of speech in conjunction with more subtle forms of communication. These included my experience of parents' tone and intonation of voice, body language and apparent felt response to questions during the interview process. Subsequently, I sincerely intend for the preceding themes to represent a robust, empathetic and fair amalgamation and interpretation of the information shared by parents.

Table 19: The superordinate and main themes identified alongside supporting exemplar quotations extracted from transcribed interviews

Superordinate and main themes identified alongside supporting exemplar quotations extracted from transcribed interviews		
superordinate theme	**Themes**	Supporting quotations *(Parent 1: Lisa, Parent 2: Nicole, Parent 3: Daniel)** ***Pseudonyms have been used to anonymise participants and to protect their confidentiality.**
Service delivery	Continuation of services for anxious adolescents	**Lisa**: "I'm quite concerned, I don't know what they can do, because if it just, I don't know what else the LA Hospital offer and how far their service goes, so I can't imagine her being able to go to the college." **Nicole**: "I know that there was MIND, a place called MIND but I don't know if it closed down... I don't know if they didn't have the funding for it. I think CAMHS, I think she can still go there until she is about eighteen I think." **Daniel**: "I think I would like to try and get the continuous care going so the link at the minute with CAMHS and the whole hospital I would like to try and keep going but I don't know how that would continue into adult life but I would like to see some sort of handover from the child to young adult services into the full adult services."
	Lack of parental knowledge about services for anxious adolescents	**Lisa**: "I don't know what help is out there after this. I am sure the hospital school manager, teacher A and teacher B and teacher will keep me informed..." **Nicole**: "So, but I'm unaware of what is actually an alternative available from home, you know, after Home Hospital, so I don't know" **Daniel**: (researcher's question: "In terms of when she leaves are you aware of any local support in terms of helping with her anxieties or to help... to think about you as a family and what might be useful for her?" Daniel's response "Other than services available via the GP and the mental health which we have sort of have links with on and off with "x"... erm… "
Coping with change	Adolescent's ability to manage social situations	**Lisa**: "Going to meet people you know people her own age and slightly older she doesn't feel comfortable around them at all." **Nicole**: "I just think it would be a struggle, with all the people." **Daniel**: "The main concern is going into... I don't think she will be attracted into this sort of environment but going into a work environment where she has to be with groups of other people and closed space for a long period of time without any means of just being able to walk away herself... People, routines, she sometimes says that she gets scared of conversations where she isn't expecting the conversation or... I don't know how to word it... when people talk to her unexpectedly and she isn't prepared to deal with the interaction."
	Adolescents avoidance of the issue of transition	**Lisa**: "Not really cos it frightens her the thought that she has to go somewhere outside of here and it really scares her so whenever you mention it, it just seems to make her more anxious and she won't really get drawn into a conversation about it." **Nicole**: "And then in September, see at that point, I'll be getting stressed out because I don't

		know what's happening in her world, what I need to do, and when I ask her I don't often get a very nice response." **Daniel**: "I don't think she actually knows erm... I think she has got a lot of different ideas floating around in her head of what she would like to do and whether they match it with the reality of the situation I don't know erm... we don't talk a lot about that sort of thing because it tends to be where we would start to have a conversation and she will just close down and say I don't want to talk about this right now."
Fresh starts	Possibility for adolescents to start a new phase of their life and to have different experiences	**Lisa**: (researcher's question: "I am wondering if she is worried that this is going to continue in a different situation and she might encounter those same types of teachers and walking around in the corridor...?") Lisa's response: "I have tried to tell her it's different in college and it's a bit more relaxed…" **Nicole**: "Yeah, I mean, she might take that as a whole new start, you know, she could. I've an idea she'll think, right, this is a new start, new level of education, new stage in my life and, you know, it could give her that positivity, motivation to go on." **Daniel**: "I don't know erm... I really don't... I think it will be something that she will feel a bit lost for a while or she will just forget it and just move onto the next part of her life whatever that is so I think she can break these connections with things quite easily and not feel any sort of loss about it I think is..."

Superordinate theme – service delivery

Theme –Continuation of services for anxious adolescents

I interpreted all three parents' comments to reflect their desire for mental health services for anxious adolescents to extend beyond the age of compulsory education into adulthood. As Daniel's quotation may illustrate, parents appeared keen for services to maintain a continuity of care, he commented:

> *Daniel: "I think I would like to try and get the continuous care going so the link at the minute with CAMHS and the whole hospital I would like to try and keep going but I don't know how that would continue into adult life but I would like to see some sort of handover from the child to young adult services into the full adult services."*

Parents referred directly to the National Health Service's (NHS), Child and Adolescent Mental Health Service (CAMHS), the mental health charity MIND and the adolescent's existing hospital school for anxious pupils. I believe that participants were saying there is a lack of clarity about services into adulthood and that parents were unsure if services extended into adulthood. For example, Nicole queried if MIND had ceased to operate due to a lack of funding, she remarked:

> *Nicole: "I know that there was MIND, a place called MIND but I don't know if it closed down... I don't know if they didn't have the funding for it."*

I interpreted Lisa's use of the word "concerned" to encapsulate the parent's overall views as every parent expressed uncertainty about the continuation of services for anxious adolescents. This uncertainty seemed to underlie a future worry about Lisa's daughter when she commented:

> *Lisa: "I'm quite concerned, I don't know what they can do, because if it just, I don't know what else the LA Hospital offer and how far their service goes, so I can't imagine her being able to go to the college."*

Theme –Lack of parental knowledge about services for anxious adolescents

In addition to parents' desire for services to continue, I interpreted their information to reflect a lack of understanding and awareness about services for anxious adolescents. With reference to sources of support beyond the hospital school for anxious pupils, I believe that Lisa was saying she was unsure when she remarked:

Lisa: "...I don't know what help is out there after this (the hospital school)…"

I also interpreted Lisa's response to reflect a tentative assumption that staff at the hospital school would provide her with the necessary information. I believe this was illustrated when she commented:

Lisa: "...I am sure the hospital school manager, teacher A and teacher B will keep me informed..."

Lisa's lack of knowledge appeared to be consistent with the other parents' experiences. For example, an interpretation of Daniel's choice of words implied that communication was inconsistent between parents and professionals. Daniel commented:

Daniel: "…other than services available via the GP and the mental health which we have sort of have links with on and off with "mental health caseworker"... erm… "

However, in addition to a possible lack of information, I believe that Nicole was also saying she had felt "stupid"" in adolescents' LA transition review meetings. Nicole commented:

Nicole: "…maybe it's me, maybe I'm just stupid.."

Angell, Stoner and Shelden (2009) have made claims that trust has been identified as a first step in creating collaborative relationships. Trust is essential to influencing parents' attitudes and participation in their children's educational programs and raising overall school achievement (Angell et al., 2009). My understanding of Nicole's words prompted me to reflect further upon issues of trust. According to Wellner (2012) between parents and educational leaders is necessary for effective long-term partnerships and ultimately to support and improve the teaching and learning process for children. On hearing Nicole's words, I became even more acutely aware of the potential for me to, inadvertently, break participants' trust. Having already thought about and read in-depth about ethical matters (Guillemin & Gillam, 2004; Kvale, 2006; Meltzoff, 2005), I made a conscious decision to keep such issues at the forefront of my mind. I had already intended for my final research project, and the research process itself, to amplify parents' voices. I had also already, with my best efforts, attempted to minimise any potential harm to participants. See participants' information letter and consent form (Appendix 9) and The University of Newcastle's ethical approval form (Appendix 8). However, my interpretation of Nicole's words resonated with

me on both a personal and professional basis. I was reminded of the need for myself to continue to carry out my research in a way that extended beyond "box-ticking" and "form-filling". I was particularly aware of this in the knowledge that parents of pupils with additional needs often undergo a great deal of stress and come to professionals for help with vital specialised tasks, including; assessment, placement, progress monitoring, and maintenance of their child's ongoing needs (Wellner, 2012). As a result, I made a decision to actively take time to reflect upon how I might ensure parents, to the best of my ability, parents never feel "stupid" within the context of a LA meeting, academic research or elsewhere. My reflections appeared to be consistent with Graham-Clay's (2005) views that professionals should appreciate that every positive interchange with parents will serve to increase trust and build stronger relationships, not only with individual parents, but ultimately with the broader community as well.

Superordinate theme –Coping with change

Theme –Adolescents' ability to manage social situations

In addition to parents' lack of information about available sources of support, I believe that anxious adolescents' difficulty in coping with social situations was perceived by parents as a further barrier. I believe that Lisa was saying that her daughter would struggle,

> *Lisa: "…to meet people you know people her own age and slightly older she doesn't feel comfortable around them at all."*

This appeared to reflect the other parents' views. For example, Daniel made a similar point. Although in contrast to Nicole's and Lisa's views, I interpreted his transcript to place a greater emphasis on potential barriers within the workplace. He remarked that his daughter might struggle:

> *Daniel: "…going into a work environment where she has to be with groups of other people and closed space for a long period of time without any means of just being able to walk away herself... People, routines, she sometimes says that she gets scared of conversations where she isn't expecting the conversation or... I don't know how to word it... when people talk to her unexpectedly and she isn't prepared to deal with the interaction."*

Theme –Adolescents' avoidance of the issue of transition

In light of anxious adolescents' patterns of avoidant behaviour, their desire not to discuss the matter of transition might be expected. Each participant mentioned that their child was

unwilling to talk about their pre-compulsory school transition. I believe that Daniel was saying that his daughter was firm in her refusal to avoid the issue. He commented,

> *Daniel: "... we don't talk a lot about that sort of thing (the transition) because it tends to be where we would start to have a conversation and she will just close down and say I don't want to talk about this right now."*

I interpreted Nicole's choice of words as echoed by Lisa's to encapsulate the participant's frustrations in their unsuccessful attempts to broach the matter of transition. Nicole commented:

> *Nicole: "And then in September, see at that point, I'll be getting stressed out because I don't know what's happening in her world, what I need to do, and when I ask her I don't often get a very nice response."*

> *Lisa: "Not really cos it frightens her the thought that she has to go somewhere outside of here and it really scares her so whenever you mention it (the transition) it just seems to make her more anxious and she won't really get drawn into a conversation about it."*

Superordinate theme –Fresh starts

Despite these perceived barriers, every parent remarked on the possibility for adolescents to start a new phase of their life. For example, I believe that Nicole was saying that the transition would provide her daughter with the opportunity to make a fresh start, she remarked:

> Nicole: "Yeah, I mean, she might take that as a whole new start, you know, she could. I've an idea she'll think, right, this is a new start, new level of education, new stage in my life and, you know, it could give her that positivity, motivation to go on."

Daniel appeared to share similar views to Nicole and I believe that he was saying that his child might feel in a position to move on to the next phase of her life. He remarked that his daughter might:

> *Daniel: "…feel a bit lost for a while or she will just forget it and just move onto the next part of her life…"*

Although Nicole and Daniel appeared to have similar views, I interpreted Lisa's views to differ slightly. I believe that Lisa was saying that it was necessary for Lisa herself to highlight

the possibility for a fresh start for her child, rather than her child being in a position to perceive this opportunity herself. She remarked:

> *Lisa: "I have tried to tell her it's different in college and it's a bit more relaxed…"*

My overall analysis of the participant data appeared to suggest that all anxious adolescents had experienced numerous difficulties, including poor relationships with some of their mainstream school teachers, poor school attendance and possible stigmatisation due to their mental health issues. This section of Daniel's transcript appears to touch on some of these difficulties, he commented:

> *Daniel: "…I remember a parents' evening we went to where a lot of teachers didn't even know why she was off school (laughs)... erm... some thought it was just because she was a truant…I could see their faces and I was thinking you are not going to change your teaching style or the way they behaved and I don't know whether the school had that joined up approach or were keyed up to deal with mental health issues…."*

3:9 Discussion

My research question facilitated a qualitative exploration into parents' perceptions of their socially anxious adolescents' transitions from school to post school. A summary and interpretation of participants' views appeared to suggest that parents were concerned about the continuation of services for anxious adolescents. Parents appeared to lack information about service for anxious adolescents. They also appeared to worry about their children's ability to cope with change and manage social situations. To confound matters, parents perceived that anxious adolescents were unwilling to discuss the matter of transition. Despite these potentially adverse factors, parents seemed to look forward to the possibility of the children having the opportunity to make a fresh start beyond school.

These parents' views may support the idea that the shift in child-centred to adult-centred health care has posed a challenge in the transition from childhood to adulthood for adolescents with additional needs Clarizia et al (Clarizia et al., 2009). Lamb and Murphy's (2013) debate about the so-called Child and Adolescent Mental Health Services to Adult Mental Health Services divide (or the 'CAMHS-AMHS divide') highlights similar concerns. This debate has generally focused on reported difficulties in the transition from CAMHS to adult care AMHS. The consequence of these service differences is that adolescents in

receipt of a service from CAMHS may find that on reaching adulthood their condition and presentation has not changed but secondary care AMHS are not configured to provide for them (Lamb & Murphy, 2013).This issue appears to be confounded by the minimal formal interaction between child and adult services (McNamara et al., 2014)

In addition, parents and adolescents often want services to extend into adulthood, but when there is no alternative service available in primary care or the voluntary sector, adolescents and their families are often left to cope alone (Lamb & Murphy, 2013). Hence, in times of transition and at the level of the exosystem (Bronfenbrenner, 1979, 1998) there may be a need for practitioners to address the issue of stress experienced by parents and their lack of social support (Algood, Hong, Gourdine, & Williams, 2011). This approach to work is likely to be pertinent given that the government:

"identifies transition from CAMHS to adult services as a priority for action"

(Department for Education, 2014a, p123).

In line with this, the Government's *No Health Without Mental Health Strategy* (2011) has focused on the need to provide parents with accurate and up to date information. As part of this, there appears to be a need for greater collaboration between parents and professionals at all natural transition points (K. Roth & Columna, 2011). It would also seem that to engage parents and to keep them informed, transitions need to be viewed as an ongoing process rather than a one off event (Bhakta et al., 2000).

In relation to parents' possible worries about adolescents inability to cope in social situations, participants' views might be expected given that social anxiety is associated with the avoidance of social situations (Kashdan & Herbert, 2001). In avoiding social situations, anxious adolescents are less likely to develop the social skills required to interact, which means they are more likely to avoid social situations. This perpetuates a 'vicious circle' (Kashdan & Herbert, 2001) . In light of adolescents' patterns of avoidant behaviour, this may also explain how adolescents as referred to within my own study possibly appeared unwilling to discuss the matter of transition with their parents.

Some of the potential difficulties as discussed by parents within this study may not be uncommon. For example, as Gearing, Brewer, Schwalbe, MacKenzie and Ibrahim (2013) argue, individuals with mental illness often experience discrimination, paternalistic treatment, and avoidance. Hence, stigma is associated with lower well-being and from the perspective

of the stigmatised, these experiences constitute a stressor and impair recovery from mental illness. Subsequently, both subtle and blatant forms of stigma constitute a barrier to recovery and may be interpreted as attempts to increase social distance and reinforce the existing social order (Gearing et al., 2013). Given this, it may be reasonable to infer that anxious adolescents may benefit from a fresh start with distance from any, perhaps, prior experiences of stigma. Effers and Oort (2013) hold the view that some adolescents depict transition as a fresh new start, others depict this as an unwelcome threshold. However, parents within my sample appeared to share the view that adolescents might perceive transition in a 'positive' light. This is consistent with results that showed that adolescents' life satisfaction increased during the transition from comprehensive school to further education (Salmela-aro & Tuominen-soini, 2010).

3:10 Summary

The current study was an investigation into parents' perceptions of their children's transition from pre-sixteen compulsory education into the adult world. Adolescents were attending the LA hospital school for anxious pupils due to their social anxieties. Three parents were interviewed with the use of a semi-structured interview schedule. Parents were invited to reflect upon their perceptions of their socially anxious adolescents' transitions from school to post school. Parents were invited to reflect upon possible obstacles and opportunities which might affect their children's transition from school into adulthood. IPA was used as a method of data analysis.

In answer to the research question, I interpreted the views and experiences of parents expressed in interview to suggest that parents were keen for child mental health services for anxious adolescents to continue beyond school into adulthood. This appeared to be consistent with certain literature on child mental health to adult mental health provision planning (Lamb & Murphy, 2013).

Parents' responses also appeared to indicate that despite their desire for services to continue, parents lacked information. As some literature has suggested a lack of parental knowledge about services for adolescents is not uncommon (Peter et al., 2009; Smart, 2004).

In addressing the research question, a further potential barrier was the adolescent's inability to manage social situations. Parents seemed concerned about their children's difficulty in mixing with others and in coping with the increased social demands associated in going to

college or work. Participants' views might have been expected given that many anxious adolescents struggle to manage in social situations (Kashdan & Herbert, 2001). According to parents' responses, anxious adolescents were also unwilling to discuss the matter of transition. This might be expected and potentially attributed to their avoidant patterns of behaviour (Dube & Orpinas, 2009; Grandison, 2011; Heyne et al., 2011).

3:11 Strengths and limitations of my research

My research was conducted outside of a clinical setting. Maxwell's (2012) views may identify a potential strength of my work, the recognition that research conducted in this way may provide a better insight into individuals' lived, real life, experiences as opposed to extrapolating data from a clinical setting.

My use of IPA enabled me to offer a reflection and interpretation of a small sample of parents' views. Although it is unlikely that my data analysis could be widely generalisable, my research might be perceived as valid in its attempts to explore reoccurring themes and patterns within the participants' data (Maxwell, 2012).

Willig (2008) acknowledges some criticisms levelled at IPA, including IPA's reliance or perhaps over-reliance on language (Willig, 2008). She queries if we can assume that participants can always articulate themselves via language. Although I was fortunate to be in a position to interview highly articulate participants, Willig (2008) might have grounds to query if language can capture the subtle meaning of an individual's experiences, or if language is a true reflection of what people experience. However, I attempted to counteract this during the analysis phase of the project by taking into consideration the participant's intonation of voice, body language and apparent felt responses to interview questions.

Furthermore, should I have had the opportunity to work with adolescents themselves, it is most likely that their views would have been equally interesting yet contrasting to those of their parents. Future research might seek to explore and offer an interpretation of anxious adolescents' views in answer to the research question. Their views may offer an alternate insight into the subject matter and may create an opportunity for different themes to emerge.

<u>The original contribution of my empirical study</u>

My research focused on parental views on anxious adolescents' transitions from post-16 compulsory school into adulthood. In relation to my research question, my work sought to provide a small number of parents with the opportunity to voice their concerns and to reflect

upon possible success factors. With use of qualitative research methods, local parents were invited to reflect upon local matters. To the best of my knowledge, my research has been the first of its kind to offer an insight in to the perceived transition support needs specifically of anxious pupils as they move into adulthood. This may be pertinent in light of the Government's recent legislation that stipulates that adolescents must be supported to make successful transitions from school into adulthood (Department for Education, 2014b). Although my research was never intended to be widely generalisable, the dissemination of my research may inform transition planning processes for anxious pupils at a local level. Subsequently, my research may make an original contribution to ensuring that parental views are actively sought and used as a basis to inform LA decision making.

3:12 Concluding comments and implications of empirical research for EP Practice

My overall reflections and interpretation of parents' views led me to reflect upon Bronfenbrenner's (1979) conceptual model of child development (see Figure 3, page 76). My conceptualisation of his model depicts bi-directional relationships between and within socially anxious adolescents' ecological system. As part of this model, I would argue that EPs may have a role to play in supporting adolescents to make successful transitions into the adult world. I would argue, based on the interpretations of this study, that greater efforts should be made to encourage anxious adolescents to transition back into mainstream school.

Yaeda (2010) has suggested a sequential individual plan for education, training, employment, transition and community living for adolescents with additional needs. At the level of the ecosystem, EPs might attempt this in working with others to support adolescents to transition back to mainstream school on a gradual basis. To achieve this, EPs might be in a position to consider the development of a formal LA *anxious adolescents' transition planning protocol* to inform adolescent's individual transition plans. Should anxious adolescents be in a position to develop the necessary coping skills to make a successful transition back into mainstream school, they might be better equipped for life within the adult world.

Given adolescents' social anxieties and difficulties in meeting new people, such a protocol might incorporate a framework in which to facilitate anxious adolescents' ability to develop

relationships with key transitional figures at the earliest opportunity. These key figures may include higher education teachers and employers. This approach to work aligns with recent codes of practice at the level of the macrosystem (Department for Education, 2013a, 2014a). To facilitate such approaches to work, adolescents' progress might be enabled with a "plan, do, review" approach to work (Kolb, 1984). This may be pertinent as Dunsmuir and Stringer (2012) emphasises the continuing investment in rigorous evaluation incentives, with an aim to develop and build effective transition programmes and practices. This approach to work also supports the argument that adolescent should be encouraged to foster interactive relationships with key transitional figures (Topping & Foggie, 2010). These relationships should be developed as central to any transition planning processes (Murcott, 2014; Topping & Foggie, 2010).

According to (Dunsmuir & Stringer, 2012) many EP's are working to develop innovative approaches to support transition processes in an attempt to provide opportunities for adolescents to adopt constructive ways of coping with change, encourage adaptability and build resilience. Based on my own research, future work might also include a piece of action research (Doerre Ross, 1984) which may be used as a method to aid the practical development of such a transition protocol. Parents, EPs and other representatives from the LA should be invited to contribute their ideas. Although it is impossible to be certain, it is likely that individuals would share a common goal and desire for socially anxious adolescents to achieve and be emotionally fulfilled. Such an approach might make steps towards addressing the critical gap between current transition operational practices and best practice guidelines (McNamara et al., 2014). It might also demonstrate a commitment to creating a 'seamless' transition from secondary school to college or employment for adolescents with SENs (Kochhar-Bryant & Margo Vreeburg, 2006).

As mentioned previously, I believe that Nicole was saying that she had felt "stupid" in the context of a LA meeting. Towards the end of my research journey, I agreed with my PEP to present and to disseminate my research to the LA. Clearly, I had already intended to provide feedback based on my research's key emergent themes such as "the continuation of services for anxious adolescents" and "lack of parental information about services for anxious adolescents". However, my understanding of Nicole's words made me decide to also place an emphasis on "soft" or perhaps more "subtle" aspects of parental participation. As part of my own research process I had for example, inadvertently, not paid close attention to some environmental factors. In checking that parents had easy access to refreshments and in ensuring that the LA interview room temperature was adequate, parents might have felt even more relaxed. This also would have been consistent with the views of Graham-Clay

(2005) who argue that parents are not looking for a cold, professional approach from professionals. Rather, professionals who develop a "personal touch" in their communication style achieve enhanced relationships. This increased trust may positively influence not only parents' perceptions of education professionals but also parents' participation in their children's education (Angell et al., 2009). Byrne's (2012) research findings support this view having found that the informal nature of the contact with the EP had a positive impact on parental accessibility to the EPS. Subsequently, the ways in which this informal engagement can be replicated to support greater parental confidence in other areas of SEN, and the implications for service delivery continue to be an important consideration for the EPS.

In addition, I had made attempts to think about interview seating arrangements, on reflection however, I might have asked each parent where they would have liked to sit (instead of myself making the assumption that my own seating arrangements would address any potential power imbalances). All participants lived locally, however, in retrospect I was led to reflect that in relation to my day-day LA casework I had often forgotten to ask parents if they required directions to the LA's EPS office (or indeed if they required directions or signposting around the LA's EPS building on arrival). Once again, I was led to think that perhaps one or maybe a culmination of such factors might make a parent feel "stupid".

As a result, I resolved to think about how I might develop my own practice in addressing such matters in the future, for example asking parents where they would like to sit or checking in advance of a meeting that refreshments are available. As part of my feedback to the LA, I made a decision to invite colleagues to reflect upon their own professional practice. With reference to my own research and the literature, I was keen to highlight the potential for "customer-friendly" environments to reflect how highly communication with parents is valued by professionals (Graham-Clay, 2005). From a personal perspective, I had already concerted not to assume that parents, merely by their physical presence, are always in a position to participate in LA processes. To make sure that wherever possible parents do feel able to contribute, I had already started to pay much closer attention in my day-to-day casework to, for example to my eye-contact, body language and use of jargon free language. I had also already made sure to, subtly, check parents' understanding of the information being shared when in LA transition meetings (and in some cases offering to meet with parents outside of meetings). This ongoing, deeper level of conceptual and practice-based reflection also seemed to align with Bhakta's (2000) views that adolescents' transitions should be perceived and treated as an educational and therapeutic process for all concerned, rather than an administrative event (Bhakta et al., 2000). I also feel that these deeper reflections are consistent with Clarizia's (2009) views that parents should be actively

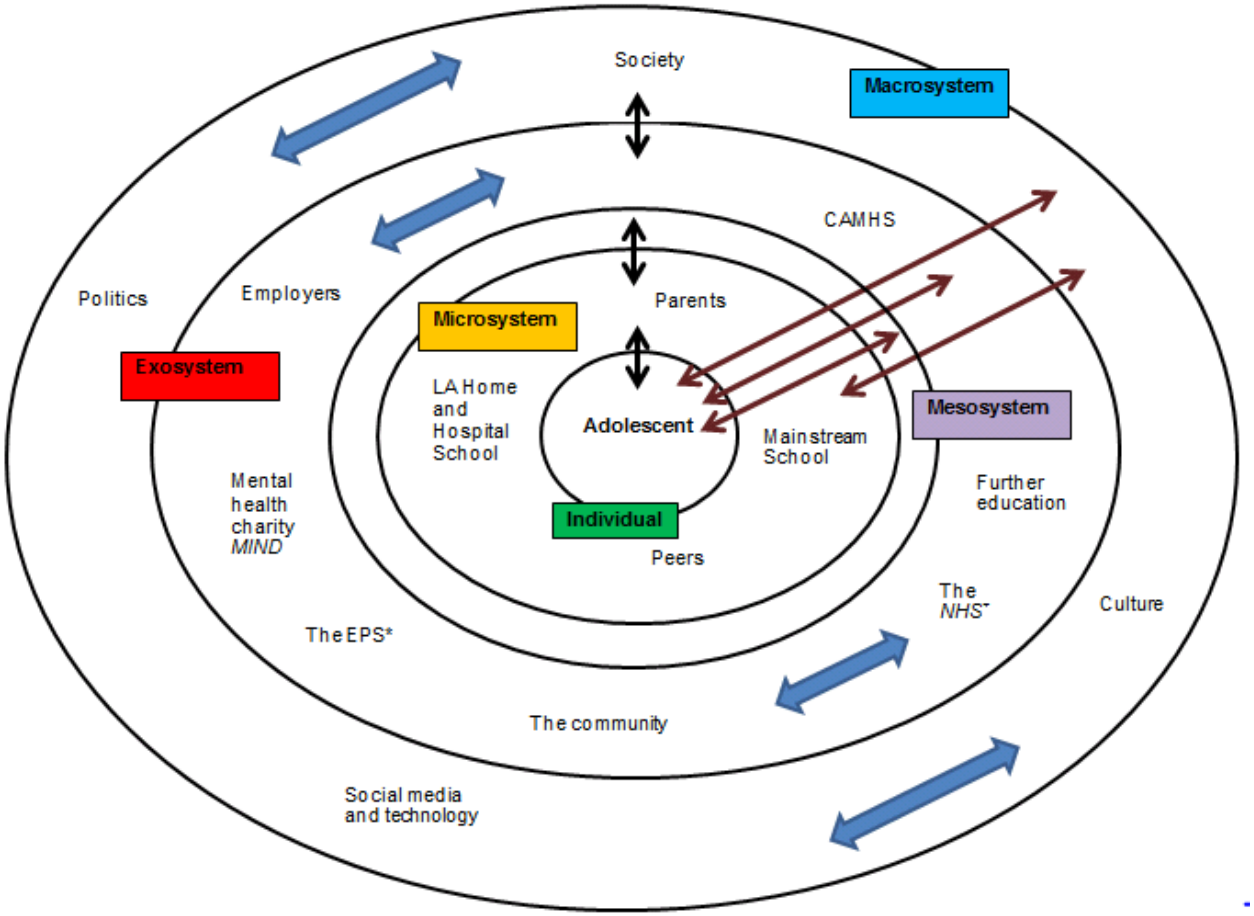
supported and encouraged to be active agents of decision making as part of adolescents' transition planning processes (Clarizia et al., 2009).

My over-arching message to colleagues within the LA was to rest on the premise that as professionals we cannot assume parents have the necessary knowledge to make informed decisions. Parents may need support to make decisions, as a result EPs and other professionals may need to reflect deeply about not only which and why information is shared but *how* information is shared. I reason this to be imperative as trust and collaboration between parents and professionals is the foremost approach to effective educational planning (Wellner, 2012). With these reflections in mind, I may be in a position to share my research with LA colleagues in an attempt ensure that future LA transition planning work remains committed to greater collaboration between parents and professionals (K. Roth & Columna, 2011; Wellner, 2012).

At the time of writing, these reflections continue to inform my own thinking and practice, primarily as Nicole's words "touched me" and will continue to motivate me towards making sure this is the case as a qualified EP. In keeping with this, the following section of Lisa's transcript may encapsulate parents' and possibly most professionals' overall wishes for anxious adolescents. I believe that Lisa was saying that she wants her daughter to be happy when she concluded,

Lisa: 'I would like to think of her in University with a... you know something she really wants to do and be really really happy and really passing whatever she wants to do and going on to be fabulous (laughing)...'

Figure 3: A conceptualisation of child development applied to socially anxious adolescents. Model adapted from Bronfenbrenner's ecological model (1979).



*The term *EPS* refers to *The Educational Psychology Service.* +*The term NHS* refers to *The National Health Service*

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Appendices

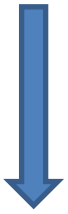
Appendix 1: The stages of the systematic review

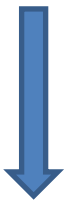
Database search	
literature dated 2007-2012 search dates: 28.08.2012 - 03/09/2012 literature dated 2002-2006 search dates: 06/09/2012 - 07/09/2012 total duration of literature search: 28/08/2012 - 26/10/2012	8. (Essau et al., 2012) 9. (Nobel, Manassis, & Wilansky-Traynor, 2012) 10. (Miller et al., 2010) 11. (Balle & Tortella-Feliu, 2010) 12. (Manassis et al., 2010) 13. (Miller et al., 2011a) (Miller et al., 2011b)

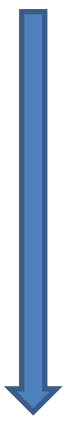
	key terms
database searched EBSCO date of search 01/09/2012	intervention terms CBT (Cognitive Behavioural Therapy) (mental health setting terms school*/educat*/class*/school-age*/secondary school*/high school*/ primary school 14. (Tomba et al., 2010)
	treatment target terms: social*anxi*/social anxiety* subject terms: child*/adolesc*/ young pe*/teenage*/youth*/ pupil*

	Step 1: Search for literature dated 2007-2012
database searched	ProQuest
date of search	studies located
28/08/2012	1. (Masia Warner et al., 2007) 2. (Ginsburg, Becker, Drazdowski, & Tein, 2012) 3. (Stallard et al., 2008) 4. (Aydin, Tekinsav Sütcü, & Sorias, 2010) 5. (Roberts et al., 2010) 6. (Miller et al., 2011) 7. (Galla et al., 2012)
database searched	ProQuest

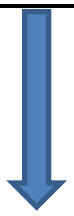
date of search	studies located
03/09/2013	None
database searched	Ovid
date of search	studies located
03/09/2013	None
database searched	Web of Knowledge
date of search	studies located
03/09/2013	None



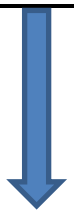




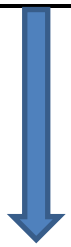
database searched	Education databases
date of search	studies located
02/09/2012	15. (Liddle & Macmillan, 2010) 16. (Garcia-Lopez, Muela, Espinosa-Fernandez, & Diaz-Castela, 2009)
database searched	First Search
date of search	studies located
02/09/2012	None



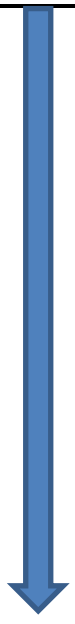
Total number of studies found	16



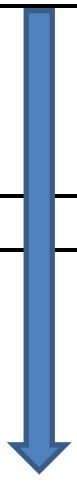
	Step 3: citation searches
Date of citation search	studies located
13/09/2012	1. (Ruini et al., 2009)



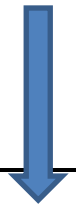
Total of studies found	1



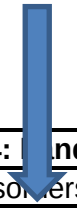
Step 2: Search for literature dated 2002-2007	
database searched	ProQuest
date of search	studies located
06/09/2012	1. (Bernstein, Layne, Egan, & Tennison, 2005) 2. (Masia-Warner et al., 2005) 3. (C. Mifsud & R. M. Rapee, 2005) 4. (Barrett & Pahl, 2006) 5. (Barrett et al., 2005) 6. (Barrett et al., 2003) 7. (Ginsburg & Drake, 2002)
database searched	EBSCO
date of search	studies located
07/09/2012	None
database searched	Education database
date of search	studies located
07/09/2012	None
database searched	FirstSearch
date of search	studies located
07/09/2012	None
database searched	Medline
date of search	studies located
07/09/2012	None
database searched	Ovid
date of search	studies located
07/09/2012	None
database searched	Scopus
date of search	studies located
07/09/2012	None
database searched	Web of Knowledge
date of search	studies located
07/09/2012	None



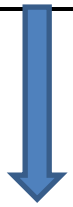
Total of studies	7



found	

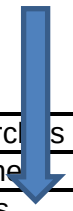


Step 4: [illegible]nd searches	
date of search	Journal of Anxiety Disorders
14/09/2012	studies located
	1. (Heyne et al., 2011)
	2. (Waters, Zimmer-Gembeck, & Farrell, 2012)
date of search	Journal of Behaviour Therapy and Experimental Psychiatry
14/09/2012	studies located
	3. (Muris, Meesters, & van Melick, 2002)
date of search	Educational Psychology in Practice
14/09/2012	studies located
	None
date of search	Journal of Clinical Psychology
14/09/2012	studies located
	None
date of search	Journal of Applied School Psychology
14/09/2012	studies located
	None
date of search	Journal of School Psychology
14/09/2012	studies located
	None
date of search	British Journal of Special Education
14/09/2013	studies located
	None
	Depression and anxiety
	studies located
	none

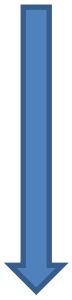


Total of studies found	3

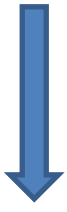
total number of [illegible]ticles located



database searches	23
citation searches	1
hand searches	3
total	26



Step 5: Grey literature search	
date of search	Ethos (Electronic Thesis Online)
18/10/2012	studies located
	1. (Gobrial, 2010) 2. (Grandison, 2011) 3. (Wright, 2010) 4. (Paul, 2011)
date of search	Grey Literature Network Service
18/10/2012	studies located
	5. (Newey, 2002)
date of search	studies located
18/10/2012	The University of Newcastle Library Search; Theses and Dissertations; Print Theses; Library catalogue; Local collections; Theses
date of search	studies located
18/10/2012	None
date of search	Proquest theses
19/10/2012	studies located
	6. (Chiu, 2010)
date of search	Proquest conference papers
25/10/2012	Material found
	7. (Mortberg, Clark, & Bejerot, 2011) 8. (Hedman et al., 2011) 9. (Gil-Bernal & Hernandez-Guzman, 2010)



	Government publications and legislation*
26/10/2012	*In addition to the previously used search terms, government documents were searched using the term * mental health
	material found: The Department of Health
	10. No health without mental health: implementation framework, (2012) 11. Healthy lives, healthy people: our strategy for public health in England, (2010) 12. Keeping children and adolescents in mind: the Government's full response to the independent review of CAMHS, (2010) 13. Health lives, brighter futures, (2009)
26/10/2012	Department for children, schools and families (delivered by The National Archives)
	14. The Children's Plan, Building Brighter Futures (2007) 15. Every Child Matters (ECM) 2003 16. Children Act (1989), (2004)
	Material found: Office of the United Nations High Commissioner of Human Rights
26/10/2012	17. United Nations Convention on the Rights of the Child (The United Nations Committee on the Rights of the Child, 1989)
date of search	WorldCat
26/10/2012	18. (D. Smith, 1980) 19. (Prosser, 2011) 20. Zeiner, A, 2009

Total number of grey literature resources found	
Ethos (Electronic Thesis Online)	4
Grey Literature Network Service	1
Proquest theses	1
Proquest conference papers	3
Department of Health	4
Department for Children, Schools and Families	3
Office of the United Nations High Commissioner of Human Rights	1
WorldCat theses	3
Total	**20**

Appendix 2: The initial inclusion criteria

This process identified 26 studies which met the initial screening inclusion criteria. See Appendix 3.

Inclusion criteria
Participants
Participants identified as having no additional special educational needs or medical needs, for example autism or Down Syndrome
Settings
School-based
Intervention
- CBT interventions that were completed independently of other intervention/s (i.e. motivational interviewing) - Studies concerned with children's levels of social anxiety as opposed to their parents' levels of social anxiety
Study design
Studies that included outcome data of at least one social anxiety/social anxiety dependent variable
Time period
No additional criteria
Location
No additional criteria
Language
No additional criteria

Appendix 3: The studies identified as meeting the initial screening criteria

	Studies identified as meeting the initial screening criteria
	study
1	(Masia Warner et al., 2007)
2	(Ginsburg et al., 2012)
3	(Stallard et al., 2008)
4	(Aydin et al., 2010)
5	(Roberts et al., 2010)
6	(Miller et al., 2011)
7	(Galla et al., 2012)
8	(Essau et al., 2012)
9	(Nobel et al., 2012)
10	(Miller et al., 2010)
11	(Balle & Tortella-Feliu, 2010)
12	(Manassis et al., 2010)
13	(Miller et al., 2011a)
14	(Tomba et al., 2010)
15	(Liddle & Macmillan, 2010)
16	(Garcia-Lopez et al., 2009)
17	(Bernstein et al., 2005)
18	(Masia-Warner et al., 2005)
19	(C. Mifsud & R. M. Rapee, 2005)
20	(Barrett & Pahl, 2006)
21	(Barrett et al., 2005)
22	(Barrett et al., 2003)
23	(Ginsburg & Drake, 2002)
24	(Ruini et al., 2009)
25	(Heyne et al., 2011)
26	(Waters et al., 2012)
27	(Muris et al., 2002)
Total studies	**26**

Appendix 4: Inclusion criteria
Phase 2

To refine the search, additional criteria were applied to the 26 identified studies. See Table below.

Secondary inclusion criterion

Inclusion Criteria
Participants
Children and adolescents between the aged of 8 and 18 years old
Settings
School
Intervention
Interventions described as CBT (Cognitive Behavioural Therapy), delivered on an individual or group basis
Study design
The treatment outcomes were explicitly stated and included at least one or more of the following: managing social anxiety, reducing social anxiety or preventing social anxiety
Time period
Studies were completed between 2002-2012
Location
Worldwide
Language
Studies were reported in English

Appendix 5: The studies for inclusion in the final phase of the inclusion and exclusion criterion process

The 16 studies for inclusion in the final phase of the inclusion and exclusion criterion process.

The 16 studies for inclusion in the final phase of the inclusion and exclusion criterion process		
	study	suitable for inclusion based on the in-depth inclusion criteria
1	(Masia Warner et al., 2007)	✓
2	(Ginsburg et al., 2012)	X
3	(Stallard et al., 2008)	✓
4	(Aydin et al., 2010)	✓
5	(Roberts et al., 2010)	✓
6	(Miller et al., 2011)	✓
7	(Galla et al., 2012)	X
8	(Essau et al., 2012)	✓
9	(Nobel et al., 2012)	x
10	(Miller et al., 2010)	✓
11	(Balle & Tortella-Feliu, 2010)	✓
12	(Manassis et al., 2010)	✓
13	(Miller et al., 2011a) (Miller et al., 2011b)	✓
14	(Tomba et al., 2010)	X
15	(Liddle & Macmillan, 2010)	✓
16	(Garcia-Lopez et al., 2009)	X
17	(Bernstein et al., 2005)	X
18	(Masia-Warner et al., 2005)	✓
19	(C. Mifsud & R. M. Rapee, 2005)	✓
20	(Barrett & Pahl, 2006)	✓
21	(Barrett et al., 2005)	✓
22	(Barrett et al., 2003)	X
23	(Ginsburg & Drake, 2002)	✓
24	(Ruini et al., 2009)	X
25	(Heyne et al., 2011)	X
26	(Waters et al., 2012)	X
27	(Muris et al., 2002)	X
Total studies for inclusion in the in-depth review		**15**

Appendix 6: The 12 studies to be included in the final review

The 12 studies to be included in the final review		
	study	suitable for inclusion based on the in-depth inclusion criteria
1	(Masia Warner et al., 2007)	✓
2	(Stallard et al., 2008)	✓
3	(Aydin et al., 2010)	✓
4	(Roberts et al., 2010)	✓
5	(Miller et al., 2011)	✓
6	(Essau et al., 2012)	✓
7	(Miller et al., 2010)	✓
8	(Balle & Tortella-Feliu, 2010)	✓
9	(Manassis et al., 2010)	✓
10	(Miller et al., 2011a) (Miller et al., 2011b)	✓
11	(Liddle & Macmillan, 2010)	✓
12	(Masia-Warner et al., 2005)	✓
13	(C. Mifsud & R. M. Rapee, 2005)	✓
14	(Barrett & Pahl, 2006)	✓
15	(Barrett et al., 2005)	✓
16	(Ginsburg & Drake, 2002)	✓
Total studies for inclusion in the in-depth review		11

Appendix 7: Mapping out the studies

Study	*Who conducted the intervention*	*Participants*		*Context*	*Focus (group/individual) and duration*	*Design*	*Use of an intervention workbook or manual*	*Methods/ sources of evidence*	*Follow up*	*Gains made (* = significant effect .p < 0.05)*	*Effect size (d)*
		N	Age								
(Barrett et al., 2005)	A clinical master's trained psychologist or doctoral candidate conducted all intervention groups	423 participants in the cognitive-behavioural intervention group 269 participants in the monitoring control group 693 participants in total	9–16 years old	seven pre-selected schools in the metropolitan area of Brisbane, Australia	15 intervention groups were run in the classroom with between 20-30 participants in each group	intervention verses control The FRIENDS programme intervention consisted of 10 weekly 45–60-minute sessions and 2 booster sessions, which are conducted 1 and 3 months following completion of intervention The programme also incorporated a family skills component, consisting of 4, 2-hour parent workshop	Yes, a FRIENDS workbook	Self-report measures pre- and post-assessment	12-month follow-up intervals.	The Spence Child Anxiety Scale (SCAS)* CBT high risk group CBT moderate risk group CBT low risk group: 12-months follow-up* CBT high risk group CBT moderate risk group CBT low risk group:	 0.21 0.06 0.08 0.38 0.14 0.14

Study	***Who conducted the intervention***	***Participants***		***Context***	***Focus (group/individual) and duration***	***Design***	***Use of an intervention workbook or manual***	***Methods/ sources of evidence***	***Follow up***	***Gains made (* = significant effect .p < 0.05)***	***Effect size (d)***
		N	Age								
(Barrett & Pahl, 2006)	Teachers and clinically trained Psychology postgraduate students	334 students in Grade 7 and 335 students in Grade 10 669 participants in total	10-14 years old	Schools, rather than participants were selected as the unit of random assignment; with schools randomly assigned to either an intervention condition or a control condition	x3 intervention schools and x3 control schools Schools were matched in pairs based on geographical location, and 1 school from each pair was randomly assigned to either an intervention or a control condition.	intervention verses control The FRIENDS intervention consisted of 10 sessions of approximately 70 minutes each, with 1 session scheduled per week over a 10-week term There were 2 booster sessions in the program, which were implemented in the following term	A FRIENDS workbook	Self-report questionnaires	12 month 24 month 36 month	Spence Children's Anxiety Scale (SCAS) CBT grade 6 at 12 months* CBT grade 6 at 24 months* CBT grade 6 at 36 months* CBT grade 9 at 12 months CBT grade 9 at 24 months CBT grade 9 at 36 months Revised Children's Manifest Anxiety Scale (RCMAS) CBT grade 6 at 12 months* CBT grade 6 at 24 months* CBT grade 6 at 36 months* CBT grade 9 at 12 months CBT grade 9 at 24 months CBT grade 9 at 36 months	 0.55 0.41 0.59 0.17 0.41 0.59 0.58 0.39 0.70 0.08 0.04 0.04 0.05

Study	***Who conducted the intervention***	***Participants***		***Context***	***Focus (group/individual) and duration***	***Design***	***Use of an intervention workbook or manual***	***Methods/ sources of evidence***	***Follow up***	***Gains made (* = significant effect .p < 0.05)***	***Effect size (d)***
		N	Age								
(Essau et al., 2012)	6 graduate students in Clinical Child Psychology	346 males, 292 females 638 participants in total	9-12 years old	14 schools in rural and urban areas in North Rhine-Westphalia, Germany	Group, 10-weekly sessions and x2 booster sessions	Intervention verses control. The intervention group participated in 10 weekly sessions of the FRIENDS programme and 2 booster sessions, with each session lasting about 60 minutes. The FRIENDS programme also included four group sessions for parents, which were conducted at separate times from the child sessions. Children in the control group were invited to participate in the FRIENDS programme 6 months later	Yes, a FRIENDS workbook	Self-report questionnaires	6 and 12 months	The Spence Children's Anxiety Scale (SCAS)* CBT 6 months follow-up* CBT 12 months follow-up* CBT SCAS social anxiety subset: CBT SCAS 6 month follow-up CBT SCAS 12 month follow-up	0.20 0.47 0.69 0.27 0.33 0.69

Study	***Who conducted the intervention***	***Participants***		***Context***	***Focus (group/individual) and duration***	***Design***	***Use of an intervention workbook or manual***	***Methods/ sources of evidence***	***Follow up***	***Gains made (* = significant effect .p < 0.05)***	***Effect size (d)***
		N	Age								
(Ginsburg & Drake, 2002)	2 graduate students in Psychology	10 females 2 males	14-17 years old mean age 15.6	Participants attended an urban high school in Baltimore	Group, 10 sessions over a 10-week period. Each session lasted 45 minutes 6 participants in the intervention group 6 participants in the control group	Intervention verses control group participants were randomly allocated to either a CBT or AS (attention support) control group cohort B Participants were randomly assigned to 1 of 2 groups in both primary school and 1 secondary school Parents were invited to attend 2 information sessions about the FRIENDS programme during the 10-week period	Yes, a CBT manual	Self-report questionnaires	None	Anxiety Disorder Interview Schedule-Clinicians Impairment Rating Scale (ADIS-CIR)* CBT group Attention support (AS) group* Screen for Child Anxiety Related Emotional Disorders (SCARED) CBT group Attention support (AS) group Social Anxiety Scale for Adolescents (SAS-A) CBT group Attention support (AS) group	2.70 0.56 0.28 0.07 0.54 0.28

Study	***Who conducted the intervention***	***Participants***		***Context***	***Focus (group/individual) and duration***	***Design***	***Use of an intervention workbook or manual***	***Methods/ sources of evidence***	***Follow up***	***Gains made (* = significant effect .p < 0.05)***	***Effect size (d)***
		N	Age								
(Miller et al., 2010)	5 female teachers	73 intervention group 43 wait list control group 118 participants in total 58 male 58 female	7- 12 years old	3 randomly selected schools in a metropolitan area The schools were then randomly assigned to either the Taming Worry Dragons (TWD) programme condition or to the wait list control condition	Classroom sessions over and 8-week period. Duration of session unknown	Intervention verses control 4 classrooms in the TWD intervention group 1 classroom the control group After the post-intervention data were collected the wait-list classes then received the TWD programme	Yes, a Taming Worry Dragons (TWD) CBT manual	Child-self report questionnaires	None	Multidimensional Anxiety Scale for Children (MASC) total CBT sample CBT at risk participants*	0.30 0.75
(Miller et al., 2011)	Classroom teachers and school counsellors	553 participants males and females were represented equally with 50.1% girls	Children in grades 2- 7 mean age of participants 9.77 years SD .99	Participants were recruited from 20 elementary schools across three school districts in western Canada	Group, 9-weekly sessions. Duration of each session unknown	8 schools were randomly assigned to either the active intervention with enriched FRIENDS n= 69. 7 were randomly assigned to the wait list control condition n= 264. The students in the wait list condition received the intervention programme following data collection	Yes, a culturally enriched FRIENDS workbook	Child self-report questionnaires	6 months	Multidimensional Anxiety Scale for Children (MASC) total CBT sample social anxiety subset: (MASC) 6 months follow-up	0.12 0.020 0.18

Study	***Who conducted the intervention***	***Participants***		***Context***	***Focus (group/individual) and duration***	***Design***	***Use of an intervention workbook or manual***	***Methods/ sources of evidence***	***Follow up***	***Gains made (* = significant effect .p < 0.05)***	***Effect size (d)***
		N	Age								
(Miller et al., 2011a)	A trained school person (i.e., teacher) paired with a trained school counsellor (or trained psychology graduate student).	191 children	48% girls with a mean age of 10.1 SD .93).	Schools were matched by socioeconomic status and randomly assigned to either intervention (FRIENDS) or attention control.	The FRIENDS targeted intervention was conducted in small groups, over 9 weekly 1-h sessions at school during the regular school day.	The randomization of the schools occurred at the school-level, rather than classroom The study included participants from 17 schools	Yes a FRIENDS manual	Self-report questionnaire	5 months 17 months	Multidimensional Anxiety Scale for Children (MASC) CBT 5 months follow-up* CBT 17 months follow-up The Behavioural Assessment System for Children (BASC- Parent) CBT 5 months follow-up CBT 17 months follow-up The Behavioural Assessment System for Children(BASC-Teacher CBT 5 months follow-up CBT 17 months follow-up	0.08 0.08 0.11 0.53 0.43 0.45 0.59 0.49 0.43

Study	***Who conducted the intervention***	***Participants***		***Context***	***Focus (group/individual) and duration***	***Design***	***Use of an intervention workbook or manual***	***Methods/ sources of evidence***	***Follow up***	***Gains made (* = significant effect .p < 0.05)***	***Effect size (d)***
(Miller et al., 2011b)	A trained school person (i.e., teacher) paired with a trained school counsellor (or trained psychology graduate student)	253 children	54% were girls age of 9.8 SD .78)	Schools were matched by socioeconomic status and randomly assigned to either intervention (FRIENDS) or attention control	The FRIENDS universal intervention was conducted in classrooms over 9 weekly 1-h sessions at school during the regular school day. The FRIENDS universal intervention was conducted in classrooms, over 9 weekly 1-h sessions at school during the regular school day.	The randomization occurred at the school-level, rather than classroom Study 2 included participants from 7 schools (14 classrooms)	Yes a FRIENDS manual	Self-report questionnaires	5 months follow-up 17 months follow-up	The Behavioural Assessment System for Children CBT 5 months follow-up CBT 17 months follow-up The Behavioural Assessment System for Children (BASC-Parent) 5 months follow-up 17 months follow-up The Behavioural Assessment System for Children(BASC-Teacher) 5 months follow-up 17 months follow-up	0.18 : 0.60 0.16 0.60 not enough data 0.2 0.18 not enough data 0.14

Study	***Who conducted the intervention***	***Participants***		***Context***	***Focus (group/individual) and duration***	***Design***	***Use of an intervention workbook or manual***	***Methods/ sources of evidence***	***Follow up***	***Gains made (* = significant effect .p < 0.05)***	***Effect size (d)***
		N	Age								
(C. C. Mifsud & R. M. R. M. Rapee, 2005)	11 school counsellors and 11 mental health workers	50 children in the intervention group 41 wait listed	9-10 years old mean age of 9.5 years (SD = 0.69) and 59% were female	Participants were recruited from 9 schools from a district in Western Australia	groups, 8 session delivered on a weekly basis. 1 hour per session.	Intervention verses control 9 schools were randomly allocated to either active intervention or wait list control group 5 schools were allocated for intervention to commence in the following term and 4 schools were allocated to a wait list control group to receive treatment in the last term of the school year, leaving	Yes, a Cool Kids Workbook	child, parent and teacher checklists	none	Spence Children's Anxiety Scale (SCAS)* CBT 4 months follow-up* Spence Children's Anxiety Scale (SCAS-Parent) CBT 4 month follow-up	0.35 0.57 0.69 Parents did not provide enough information for sufficient data analysis

Study	***Who conducted the intervention***	***Participants***		***Context***	***Focus (group/individual) and duration***	***Design***	***Use of an intervention workbook or manual***	***Methods/ sources of evidence***	***Follow up***	***Gains made (* = significant effect .p < 0.05)***	***Effect size (d)***
		N	Age								
(Roberts et al., 2010)	teachers	496 Grade 7 students, aged between 11 and 13 years mean age 11.99, SD .33 .	274 students (54.8% n= 151 females) in the intervention group 222 53.4%, n=119 females) in the control group	Participants were selected from 12 government primary schools in Perth, Western Australia	Group, x10 60 minutes lessons	Intervention verses control control group teachers implemented 20 regular health education lessons relating to self-management and interpersonal skills.	Yes, The Aussie Optimism Programme workbook	Child and parent questionnaires	6 months 18 months	The Revised Children's Manifest Anxiety Scale (RCMAS) CBT at 16 months follow up CBT at 18 months follow up	0.14 0.0017 0.17
(Stallard et al., 2008) The study did not follow a control group verses wait list control group design	School nurses	107 children	9-10 years old	Participants were recruited from 4 classes from 3 junior schools in Bath and North East Somerset	10 sessions in total Classroom, the FRIENDS program was provided as part of the school curriculum over the course of 1 academic term (10 weeks). The programme was provided to whole classes of children	No comparison or control group- a 12 month follow-up school-based trial classroom based Intervention	Yes, a FRIENDS Workbook	Self-report questionnaires	3 months 12 months	Spence Children's Anxiety Scale (SCAS) Total anxiety score*: Social anxiety score: 3 month follow-up Total anxiety score*: Social anxiety score: 12-months follow-up Total anxiety score*: Social anxiety score:	Not enough information.
Total											**12**

Appendix 8: The University of Newcastle's completed ethics form

Newcastle University

APPLICATION FOR APPROVAL OF A RESEARCH PROGRAMME
INVOLVING HUMAN PARTICIPANTS AND NOT SUBJECT TO CLINICAL ETHICS PROCEDURES (NRES)

KHIS Project No. *(if the project is for external funding)* ☐☐ ☐☐☐☐☐☐
Please consult with your faculty Grants and Contracts Officer

This application form is to be used by **STAFF** and **STUDENTS** seeking ethical approval for an **individual research project or programme** involving the study of human subjects in a non-clinical setting. Where the study involves a clinical setting or material derived from a clinical setting (e.g. tissue, blood or other bodily fluids, patient records, intervention procedures etc.) ethical approval or advice must be sought through the systems operated by the National Research Ethics Service – see http://www.nres.npsa.nhs.uk . A completed version of this document should be emailed to the Secretary of your appropriate Ethics Committee in the University. *Applications must be completed on this form; attachments will not be accepted other than those requested on this form. This form has been designed to be completed electronically; no handwritten applications will be accepted.*

Research must NOT begin until approval has been received from the appropriate Ethics Committee.

CATEGORY: ☐ **UNDERGRADUATE research** X **POSTGRADUATE research** ☐ **STAFF research**

PROGRAMME/PROJECT TITLE:
Potential obstacles for young anxious adolescents; what are parent's perceptions of their children's transition from pre sixteen compulsory education?

NAME OF RESEARCHER(S): Louise Sawyerr

NAME OF SUPERVISOR(S) (for undergraduate or postgraduate research)**:** Dr Wilma Barrow

DATE: 25th July 2013

DECLARATION BY RESEARCHERS

The information contained in this application is accurate. I have attempted to identify all risks that may arise in conducting this research and acknowledge my obligations and the rights of the participants.

Researcher(s) Name: Louise Sawyerr Date 25th July 2013

Supervisor Name: Date / /

(Office Use Only)

The appropriate Ethics Committee has considered the ethical aspects of this proposal. The committee recommends that the programme/project be:

☐ approved ☐ deferred ☐ not approved

Signed: **Print Name:** **Date** **...../...../.....**

Ethics Committee concerned:

PART A

1. YOUR CONTACT DETAILS

Please provide contact details for all researchers named on this application:

Louise Sawyerr l.sawyerr@ncl.ac.uk

2. TYPE OF PROGRAMME/PROJECT

Please mark ONE box to indicate the predominant nature of this programme/project.

Questionnaire/Survey ☐

e.g., surveys of members of particular groups/organisations, mail out questionnaires, street surveys

Experiment ☐

e.g., participants completing tasks under controlled conditions, use of tasks/methods other than or in addition to questionnaires/surveys.

Observational ☐

e.g., observing people behave in a natural setting or in a laboratory

d) Other X

Please describe: semi-structured interviews

3. PARTICIPANTS

		YES	*NO*	*N/A*
A)	***WILL YOU INFORM PARTICIPANTS THAT THEIR PARTICIPATION IS VOLUNTARY?***	***X***	☐	
B)	***WILL YOU INFORM PARTICIPANTS THAT THEY MAY WITHDRAW FROM THE RESEARCH AT ANY TIME AND FOR ANY REASON?***	***X***	☐	
C)	***WILL YOU INFORM PARTICIPANTS THAT THEIR DATA WILL BE TREATED WITH FULL CONFIDENTIALITY AND THAT, IF PUBLISHED, IT WILL NOT BE IDENTIFIABLE AS THEIRS?***	***X***	☐	
D)	***WILL YOU OBTAIN WRITTEN CONSENT FOR PARTICIPATION?***	***X***		

E)	***WILL YOU DEBRIEF PARTICIPANTS AT THE END OF THEIR PARTICIPATION (I.E., GIVE THEM AN EXPLANATION OF THE STUDY AND ITS AIMS AND HYPOTHESES)?***	***X***	☐	
F)	***WILL YOU PROVIDE PARTICIPANTS WITH WRITTEN DEBRIEFING (I.E., A SHEET THAT THEY CAN KEEP THAT SHOWS YOUR CONTACT DETAILS AND EXPLANATIONS OF THE STUDY)?***	***X***	☐	
G)	***IF USING A QUESTIONNAIRE, WILL YOU GIVE PARTICIPANTS THE OPTION OF OMITTING QUESTIONS THEY DO NOT WANT TO ANSWER?***	***X***	☐	☐
H)	***IF AN EXPERIMENT, WILL YOU DESCRIBE THE MAIN EXPERIMENTAL PROCEDURES TO PARTICIPANTS IN ADVANCE, SO THAT THEY ARE INFORMED ABOUT WHAT TO EXPECT?***	☐	☐	***X***
I)	***IF THE RESEARCH IS OBSERVATIONAL, WILL YOU ASK PARTICIPANTS FOR THEIR CONSENT TO BEING OBSERVED?***	☐	☐	***X***

IF ANY ANSWERS ARE YES, PLEASE SUPPLY COPIES OF ANY DOCUMENTS IN SUPPORT OF YOUR ANSWERS – E.G. INFORMATION SHEETS, DRAFTS OF QUESTIONNAIRES, ETC.

IMPORTANT ***IF YOU HAVE MARKED*** *NO* ***TO ANY OF THE QUESTIONS ABOVE AND HAVE MARKED*** *BOX A* ***BELOW, PLEASE GIVE AN EXPLANATION (NO MORE THAN 300 WORDS):***

Parents will be provided with an information sheet and consent form to sign in advance of their participation. A letter will inform parents as to the intentions and procedure of the research. I will provide all participants with the option of opting out of the research without an explanation or prejudice towards them.

INSURANCE

PLEASE CONSULT WITH THE APPROPRIATE OFFICER IN THE UNIVERSITY FINANCE OFFICE CONCERNING INSURANCE COVER FOR THE RESEARCH OR INDEMNITY. (GLENYS.BAILEY@NCL.AC.UK; TELEPHONE EXT. 6522)

WHAT ARRANGEMENTS WILL BE MADE FOR INSURANCE AND/OR INDEMNITY TO MEET POTENTIAL LEGAL LIABILITY OF THE UNIVERSITY OR OTHER EXTERNAL FUNDER FOR HARM TO PARTICIPANTS ARISING FROM THE MANAGEMENT OF THE RESEARCH?

WHAT ARRANGEMENTS WILL BE MADE FOR INSURANCE AND/OR INDEMNITY TO MEET THE POTENTIAL LEGAL LIABILITY OF THE UNIVERSITY OR OTHER EXTERNAL FUNDER FOR HARM TO PARTICIPANTS ARISING FROM THE DESIGN OF THE RESEARCH?

WHAT ARRANGEMENTS WILL BE MADE FOR INSURANCE AND/OR INDEMNITY TO MEET THE POTENTIAL LEGAL LIABILITY OF INVESTIGATORS/COLLABORATORS AND, WHERE APPLICABLE, SITE MANAGEMENT ORGANISATIONS, ARISING FROM HARM TO PARTICIPANTS IN THE CONDUCT OF THE RESEARCH?

PLEASE ATTACH APPROPRIATE DOCUMENTS

5. ETHICAL ISSUES

		YES	NO
A)	WILL THIS PROGRAMME/PROJECT INVOLVE DELIBERATELY MISLEADING PARTICIPANTS IN ANY WAY?	☐	X
B)	IS THERE ANY REALISTIC RISK OF ANY PARTICIPANT EXPERIENCING ANY DEGREE OF PHYSICAL OR PSYCHOLOGICAL HARM, DISTRESS OR DISCOMFORT?	☐	X
C)	WILL YOU BE ADMINISTERING DRUGS OR OTHER SUBSTANCES TO YOUR PARTICIPANTS, OR TAKING FLUID OR OTHER SAMPLES FROM THEM?	☐	X
D)	WILL YOUR PARTICIPANTS FALL INTO ANY OF THE FOLLOWING SPECIAL GROUPS?		
	SCHOOLCHILDREN (UNDER 18 YEARS OF AGE)	☐	x
	PEOPLE WITH LEARNING OR COMMUNICATION DISABILITIES	☐	x x
	PEOPLE IN CUSTODY	☐	x
	PEOPLE ENGAGED IN ILLEGAL ACTIVITIES (E.G., DRUG-TAKING)	☐	x
	OTHER VULNERABLE PEOPLE	☐	x

IMPORTANT IF YOU HAVE MARKED YES TO ANY OF THE QUESTIONS ABOVE, THEN YOU MUST MARK BOX B BELOW AND COMPLETE PART B OF THIS FORM.

6. ETHICAL ASSESSMENT

PLEASE MARK ONE BOX:

A	I CONSIDER THAT THIS PROGRAMME/PROJECT HAS NO SIGNIFICANT ETHICAL IMPLICATIONS TO BE BROUGHT BEFORE AN ETHICS COMMITTEE. PROGRAMME/PROJECT SUMMARY. PLEASE PROVIDE A BRIEF DESCRIPTION OF YOUR PROGRAMME/PROJECT. THIS SHOULD BE SUFFICIENT FOR REVIEWERS OF THIS APPLICATION TO ASCERTAIN EXACTLY WHAT YOUR RESEARCH INVOLVES. FOR INSTANCE, IT SHOULD INCLUDE INFORMATION ABOUT THE AIMS OF THE PROGRAMME/PROJECT, AND ALSO THE SOURCES OF YOUR PARTICIPANTS (I.E., TARGET GROUP/S) AND HOW YOU WILL BE RECRUITING THEM. ALSO INCLUDE A BRIEF SUMMARY OF WHAT PARTICIPANTS WILL BE REQUIRED TO DO (E.G., MAIN PROCEDURES, TASKS, TESTS). THIS DESCRIPTION MUST BE IN SIMPLE, EVERYDAY LANGUAGE THAT IS FREE FROM UNNECESSARY TECHNICAL TERMS AND NO MORE THAN 300 WORDS. PLEASE ALSO ATTACH A COPY OF YOUR CONSENT FORM. ALSO ATTACH A COPY OF ANY QUESTIONNAIRES (IF USING THEM IN THIS RESEARCH). YOU DO NOT NEED TO COMPLETE PART B OF THIS FORM.	☐
B	I CONSIDER THAT THIS PROGRAMME/PROJECT MAY HAVE ETHICAL IMPLICATIONS THAT SHOULD BE BROUGHT BEFORE THE ETHICS COMMITTEE, AND/OR IT WILL BE CARRIED OUT WITH CHILDREN OR OTHER VULNERABLE POPULATIONS. IF YOU HAVE MARKED THIS BOX, YOU MUST COMPLETE PART B OF THIS FORM.	x

PART B

YOU NEED ONLY COMPLETE THIS PART IF YOU BELIEVE THAT YOUR PROGRAMME/PROJECT MAY HAVE ETHICAL IMPLICATIONS (E.G., USE OF DECEPTION) AND YOU HAVE MARKED *BOX B* ***ABOVE, OR YOUR PROGRAMME/PROJECT WILL BE CARRIED OUT WITH CHILDREN OR OTHER VULNERABLE POPULATIONS.***

1. PROGRAMME DETAILS

1.1 PROPOSED DURATION OF PROGRAMME ***FROM:*** May 2013 ***TO:*** June 2014

1.2 PROGRAMME/PROJECT OUTLINE AND AIMS: *Briefly describe the aims of this research as well as the main tasks (or tests) that participants will be required to complete. This description must be in everyday language, free from jargon, technical terms or discipline-specific phrases (No more than 300 words).*

I intend to carry out a small scale, qualitative piece of research which will explore how Educational Psychologists (EPs) can best work with parents to facilitate pre-school transitions. The young people concerned have been educated in hospital schools designated for young people who have both medical needs and severe anxieties. The investigation will be conducted in collaboration with two North East LAs. To elicit participants' views I anticipate that I will carry out semi-structured interviews with parents in order to gain a deeper insight into the support needs of young people as they transition into adulthood.

I will transcribe the interviews and I will use a thematic analysis to code the data and identify key themes. This will enable me to identify, from the perspective of different parental perspectives, which factors constitute a successful transition and which factors support and act as a barrier to this. In analysing the interviews, I endeavour to build up an understanding about the key areas which appear to emerge across participants data. I will then disseminate the findings to the LA, the university and participants. I may also submit my final report for publication in an academic journal.

1.3 PROPOSED METHOD: *Provide an outline of the proposed method, including where and how data will be collected, and all tasks that participants will be asked to complete. Present this outline of the method in a step-by-step chronological order, and avoid using jargon and technical terms as much as possible (No more than 700 words).*

The research will have the following stages;

Stage 1:
An informa**t**ion letter and consent from will be given to parents to inform them of the intentions of the research and the process involved (see attached). Parents will be invited to answer interview questions. The aims of the research will be explained to each individual and they will be informed, before the interview starts, that they have the right not to consent to participate. The researcher will emphasise that they are free to withdraw or to abandon the interview at any point without reprisal. Interviews will take place either within the hospital school settings or a LA meeting rooms.

Stage 2:
The participants' interviews will be transcribed and coded using a thematic analysis. Transcripts will be locked in a cabinet and participant data will be numbered and anonymised. The results will be written-up in a report format which will be submitted to the University for assessment. The report will also be disseminated to the LA, participants and possibly published in an academic journal.

Parents will be informed that they may opt out before the end of data collection and transcription phase. All data will be anonymised and confidential. All participants will be thanked for their time and participation and will receive a full verbal and written debrief. See debrief form attached.

1.4 DOES THIS PROGRAMME/PROJECT REQUIRE APPROVAL FROM AN EXTERNAL ETHICS COMMITTEE?

☐ YES x NO

IF YES, HAS APPROVAL ALREADY BEEN GRANTED?

☐ YES (*please attach a copy of the approval letter)*

☐ NO *(please submit a copy of the approval letter as soon as it becomes available. Note that you cannot proceed with data collection until approval has been granted by **all** relevant ethics committees)*

2. PARTICIPANT DETAILS

NUMBER OF PARTICIPANTS REQUIRED: **8-15**

AGE RANGE OF PARTICIPANTS: **11 years old to adult**

2.2 DOES THE RESEARCH SPECIFICALLY TARGET: **(SELECT AS MANY AS APPLICABLE)**

	YES	NO
students or staff of this university	☐	x
adults (over the age of 18 years and competent to give consent)	☐	x
children/legal minors (anyone under the age of 18 years)	☐	X
the elderly	☐	X
people from non-English speaking backgrounds	☐	X
pensioners or welfare recipients	☐	X
anyone who is intellectually or mentally impaired to the extent that they cannot provide consent	☐	X
anyone who has a physical disability	☐	X
patients or clients of professionals	☐	x
anyone who is a prisoner or parolee	☐	X
any other person whose capacity to consent may be compromised	☐	X
any groups where a leader or council of elders may need to give consent on behalf of the participant	☐	X

2.3 SOURCE AND MEANS BY WHICH PARTICIPANTS ARE TO BE RECRUITED

Please provide specific details as to how you will be recruiting participants. Where will your participants be sourced? How will people be told you are doing this research? How will they be approached and asked if they are willing to participate? If you are mailing or phoning people, please explain how you have their names and contact details. Also mention any specific criteria for choosing participants (i.e., exclusion/inclusion criteria) and whether you will provide incentives for participation (e.g., payment). If a recruitment advertisement is to be used for this programme/project, please attach a copy to this application.

Participants to the study will be recruited in the following ways;

Parents will be invited to participate in the research initially via the two LA's Special Educational Needs (SENs) Managers. Should the parent agree, the SEN managers will provide the researcher with the parent's contact details. The researcher will at this point make contact with the parent to explain the

research and its aims and to arrange a face-to-face meeting. At this meeting the parent will be given an information letter and consent form to sign.
No incentives will be provided to participants and they will have the option of opting out at any point without explanation or prejudice towards themselves.

3. MANAGEMENT OF ETHICAL ISSUES

3.1 POTENTIAL RISK TO PARTICIPANTS AND RISK MANAGEMENT PROCEDURES

Identify, as far as possible, all potential risks (small and large) to participants (e.g. physical, psychological, social, legal or economic, etc.) that are associated with the proposed research. Also explain any risk management procedures that will be put in place.

This is a low risk research project. The only potential risks identified lie around potential psychological risks for parents who may feel anxious about discussing their child's current and future prospects. Barriers to their child's success later in life may be discussed, or personal information about their child may be disclosed. The researcher will adhere to relevant safeguarding procedures at all times should a potential child protection matter be raised. Participants may withdraw from the research during the data collection and write-up stages.

3.2 DEBRIEFING

It is a researcher's obligation to ensure that all participants are fully informed of the aims and methodology of the programme/project, and to ensure that participants do not experience any level of distress, discomfort, or unease following a research session. Please describe the debriefing that participants will receive following the study and the exact point at which they will receive the debriefing. Also describe any particular provisions or debriefing procedures that will be in place to ensure that participants feel respected and appreciated after they leave the study. Please attach a copy of the written debriefing sheet that you will give to participants. If you do not plan to provide a written debriefing sheet, please explain why.

Participants will be debriefed immediately following completion of their involvement in the study. In the debrief, participants will be informed about the purpose and aims of the research. They will be assured that all data will be anonymised and remain confidential.

4. INFORMED CONSENT

4.1 PLEASE DESCRIBE THE ARRANGEMENTS YOU ARE MAKING TO INFORM PARTICIPANTS, BEFORE PROVIDING CONSENT, OF WHAT IS INVOLVED IN PARTICIPATING IN YOUR STUDY? ***If you will be providing participants with a written information sheet, please attach it to this application.***

Participants will be informed both verbally and in written form about the study.

(see consent form)

PLEASE DESCRIBE THE ARRANGEMENTS YOU ARE MAKING FOR PARTICIPANTS TO PROVIDE THEIR FULL CONSENT BEFORE DATA COLLECTION BEGINS? ***Participants should be able to provide written consent. Please attach the consent form that you will be using in your programme/project. If you think that gaining consent in this way is inappropriate for your programme/project, then please explain how consent will be obtained and recorded***
(see 2.3)

You have now completed this form. Please email or send this form to the Secretary of your Ethics Committee.

Appendix 9: Information letter to participants and consent form

Dear parent

As a postgraduate Trainee Educational Psychologist from the University of Newcastle, I am required to carry out a piece of research in collaboration with a local authority. I will be conducting an investigation into:

Potential obstacles and opportunities for anxious adolescents; what are parents' perceptions of their children's transition from pre-sixteen compulsory education?

This research aims to explore parental views about factors which may constitute successful transitions and factors which may act as a barrier. The research aims to identify ways of developing practice in transition planning for anxious young people educated within the local authority. You will be invited to reflect upon barriers and support mechanisms to aid post-school transitions. My research will focus on how professionals, parents and young people can best work together to support anxious young people as they transition from school into the adult world.

I aim to gain an insight into parents' views in carrying out a series of one-to-one interviews. We will meet on a mutually convenient date. The session will last for no longer than one hour and will take place in a pre-booked "X" local authority meeting room or classroom. To enhance the investigation, I will ask to audiotape and transcribe your responses to interview questions. All data collected will be treated as confidential and anonymous. It will be used to form the basis of a report to share with you, my University tutors and examiners and the local authority. You can withdraw from this research at any point without justification or prejudice.

Please sign overleaf if you give your consent. For further information on this research please contact Louise Sawyerr l.sawyerr@ncl.ac.uk at;

Louise Sawyerr
c/o Lorna Wilson, Programme Secretary for Educational Psychology
School of ECLS, King George VI Building,
Queen Victoria Road
Newcastle upon Tyne
NE1 7RU

Thank you in anticipation of your support.
Yours faithfully

Louise Sawyerr

Participants' information sheet and consent form

Details of the project

1. Name of the project

Potential obstacles and opportunities for anxious adolescents: what are parent's perceptions of their children's transition from pre sixteen compulsory education?

2. Researcher's contact details

Louise Sawyerr

l.sawyerr@ncl.ac.uk

3. Researcher's supervisor's contact details

Dr Wilma Barrow

wilma.barrow@newcastle.ac.uk

4. Sponsoring institution

The University of Newcastle

5. Has project and ethical approval been obtained?

Yes, project approval and ethical approval has been obtained from the University of Newcastle's Postgraduate Research Students' Project Approval Committee and Ethics Committee

6. Funding source

This is non-funded research

7. How to file a complaint

Should you wish to make a complaint please contact the researcher, Louise Sawyerr or her supervisor, Dr Wilma Barrow who will provide you with further information about the University's complaints procedures.

Purpose/aims of the research

8. What is the aim of the research?

The aim of the research is to find out what constitutes successful transitions and how this can be achieved. The study will be an investigation into pre16 transitions for anxious pupils who receive their education within a hospital school setting.

What is involved in participating?

9. How much time will be required and what will the frequency be?

The interviews will be held over a 6-8 week period on a one-to-one basis with the researcher. Each interview will last for no longer than 1 hour and participants will not be expected to attend more than one interview. Participants will be invited to answer interview questions which will be recorded at the time and later transcribed. Taped interview audio recordings will be deleted once these have been transcribed. The researcher will either transcribe each interview herself, or she may decide to employ a professional audio typist. Participants will remain anonymous to the professional audio typist.

10. Will I receive any reward (financial or otherwise) or reimbursement for travel expenses?

No, participants will not be reimbursed or rewarded for their participation in the study as they will not incur any costs.

Benefits and risks

11. Will I experience any physical and/or psychological discomfort or embarrassment?

No. It is not anticipated that participation in the study will result in any psychological discomfort or embarrassment. Participants will not be subject to any harm and care will be taken to ensure the process is comfortable and that the wellbeing of participants will be monitored throughout.

Terms for withdrawal

12. Can I withdraw from the study?

Yes. Participants have the right to withdraw at any time without prejudice and without providing a reason. All paper, electronic and audio data will be destroyed in the event of a participant's withdrawal.

Usage of the data

13. How will my data be used during the research process?

Participant data will be collated and analysed by the researcher. It will be anonymised and treated as confidential. As mentioned previously, the researcher may choose to employ a professional audio typist to transcribe each interview.

14. How will my data be stored and archived?

Participant data will be stored and archived in line with the University of Newcastle's data protection policy. In line with the British Psychological Society's ethical research guidelines, participant data will not be retained for longer than is necessary, and not beyond the 5 year maximum period.

15. Will my data be reused?

Participant data will be written up as part of an academic report. The researcher may decide to submit this for publication in an academic journal. The data will be anonymised in advance.

16. Will other researchers in the institution have access to my data?

Yes. The researcher's University supervisor will have access to participant's data; however, it will be anonymised in advance. Each participant's anonymised interview transcript may also be requested by the researcher's external University moderators/examiners.

17. Will my data be confidential and anonymous?

Yes.

consent form

……

Potential obstacles and opportunities for young anxious adolescents: what are parents' perceptions of their children's transition from pre-sixteen compulsory education?

Please return this consent form by hand to Louise Sawyerr when we meet.

I give my consent for myself to participate in this research. Participation will involve the following:

- Myself taking part in a one-to-one interview with the researcher
- My interview being audio recorded and later transcribed
- My anonymised data being used to inform the researcher's academic research project
- My anonymised data to be disseminated and submitted to the local authority, the University of Newcastle, potentially another academic institutions, and possibly academic journals for publications

Name of child:

Name of parent:. . . . . .

Signature of parent: . . . . . Date:. . . . . .

Appendix 10: Interview schedule

Parents semi-structured interview guide

Research question: Potential obstacles and opportunities for anxious adolescents: what are parents' perceptions of their children's transition from pre-sixteen compulsory education?

Introductory comments

Thank you for agreeing to take part in my study and for consenting to be interviewed. I can assure you that you will remain completely anonymous and no records of the interview will be kept with your name of them. Can I first ask you some routine questions?

I am aware that your child attends the hospital school due to their severe anxieties.

Please can you confirm your relationship to the young person?

How old is your child?

What academic year are they in?

How long has your child been attending the hospital school?

Main topic headings

Success factors to transition

Does your child know what they might like to do when they leave the home and hospital school?

Prompt: work? further education? travel? relationships?

What support might they need to achieve their goals?

Prompt: Key people? Organisations? Family members? Peers? School? The necessary opportunities? The development of skills?

Has this support already been put into place?

Prompt: Who is involved? What are individuals' roles and responsibilities? When did the process start? How long does it take? How is the process being monitored, reviewed and evaluated? Access to services? Resources?

Can you tell me about how your child feels about their forthcoming transition out of the home and hospital school?

Prompt: What are they looking forward to? What are they worried about? Do the feel prepared?

Can you tell me about how you feel about your child's forthcoming transition out of the home and hospital school?

Prompt: What are you looking forward to? What are you worried about?

What would you like them to achieve?

How might your needs as a parent be met?

When do you think transition planning should start?

Do you feel that your child's transitions needs are being adequately identified and met?

Prompt: What aspects have you found to have worked well? How have you know that these aspects have worked well? What strategies have been used in support of your child?

Barriers to transition

What factors might constitute a barrier to your child's transition from the hospital school into the adult world?

Prompt: When do you anticipate that you might encounter these barriers? How might these barriers be overcome? What strategies might or are currently being used? Who has or might help overcome these barriers?

Areas for improvement

How do you think that current transition process for your child might be improved?

Prompt: Who would be involved? How would they be involved? How would you know that an improvement had been made? Who would notice? How would the improvement be sustained? Who would be accountable? Which services would be involved?

Final closing question

What is your child most looking forward to in relation to your child's transition from the hospital school?

Prompt: a shift in relationships, more adult to adult? The young person achieving the goals? The young person becoming more independent?

What are you most looking forward to in relation to your child's transition from the hospital school?

Prompt: greater independence? access to new opportunities, such as work of further education? their ability to meet new people?

Closing comments

Can I thank you once again for helping me and for giving up your time. Finally, can I ask you if you think there is any aspect of your child's pre hospital school transition that has not been covered in this interview? Please do not hesitate to contact me on the details provided in your information letter should you have any questions in the future.

Appendix 11: Audit trail, example pages of interview transcription

Example pages of interview transcription			
Line reference (P2= parent 2 followed by line number or transcript)	Emergent Themes	Original Transcript (Italic font: researcher/ plain font: parent)	(yellow- descriptive comments green- linguistic comments grey- conceptual comments)
P2 97		*If she does go to college she would be expected to...*	
P2 98 P2 99 P2 100 P2 101	Ability to get to college	They do full days don't they...? I know it's not every day but it would be getting her there and stuff like that because she won't go anywhere on her own and I don't suppose she would want me particularly to be taking her but I don't know... everything just seems to be a bit of a problem at the minute.	It will be hard for the young person to get to college without support from parent
P2 102	The need for parental support verses young person's need or desire for greater independence	*Mmm....*	Use of the words: "everything just seems to be a bit of a problem at the moment"
P2 103		There are a lot of hurdles to cross...	Is this a tricky dichotomy; the adolescent's desire for greater independence verses their inability to act without additional parental support?
P2 104 P2 105 P2 106		*In terms of her if she finds it difficult to get into college you know it would be getting the bus or walking home and that might be quite difficult for her just physically getting there.*	How does this link with theories about self-determination?
P2 107		Just physically getting to the building yeah.	
P2 108		*Right so that is a barrier in itself?*	Adolescent will not go out without parent. Young person's day to day routines are rigid.
P2 109 P2 110 P2 111	Ability to function on a day-day basis and to adapt	Yeah cos she doesn't go anywhere on her own, the only place she really goes is a Thursday with me to shop... shopping for her stuff that she wants and she might have a trip to "x" it's very organised where she wants to go and she won't	Note use of the words: she might have a trip to "x" it's very

P2 112 P2 113 P2 114 P2 115 P2 116 P2 117 P2 118 P2 119 P2 120 P2 121	to changes to set routines Ability to mix with peers Self-esteem and other's perception of self, either real or imagined	go after three o'clock when the kids come out. *Because it's...* She doesn't want to see them and with the six weeks holidays coming up she will probably not venture out of the house for six weeks if she gets away with it. *Right because there will be other young people out and about and it would too much for her to mix with them and just see them?* Yeah, she seems to think they are laughing at her for some reason, we could be in a shop and if somebody walks past and they are talking to each other and they laugh she immediately says they are laughing at her, very very low self-esteem.	organised Adolescent avoids other young people and is unlikely to leave the house over the six weeks holiday period without be prompted. How might this link with theories about labelling. Is the young person worried about being labelled or perceived in negative ways? Adolescent perceives that others are laughing at her. Adolescent has low self-esteem according to their parent Use of the words: very very low self esteem Does this warrant an investigation into the psychology of self-esteem, stereotypes and self-concepts?

Appendix 12: Completed WoE guidance framework

WoE framework guidance (The Evidence for Policy and Practice Information and Co-ordinating Centre, 2009)						
Study	(Barrett et al., 2005)		(Barrett & Pahl, 2006)		(Essau et al., 2012)	
Guidance point	**Positive factors**	**Areas for critical consideration**	**Positive factors**	**Areas for critical consideration**	**Positive factors**	**Areas for critical consideration**
N.1 Are there ethical concerns about the way the study was done? Consider consent, funding, privacy, etc.	Parents were provided with information letters and consent forms for the participants to "opt in" to the study	Researchers read aloud the pre-test anxiety questionnaire item by item to a whole class of participants. Participants were informed that there were no right or wrong answers. However, research assistants circulated the class to ensure children were completing the questionnaire correctly and answering questions. This raised the ethical considerations, did children feel under pressure to perform or to answer questions, did children feel obliged to answer questions in accordance to the perceived wishes of the researchers, did children feel able to withdraw from the study….what about power imbalances?	Parents were provided with information letters and consent forms for the children to "opt in" to the study	Researchers read and helped pupils to answer questions. -Did participants feel able to decline help or to opt out? Ethical matters are not given specific attention or consideration	Participants were not provided with incentives to participate	Ethical factors were not explicitly considered. It is difficult to infer their ethical position or to evaluate their practice with reference to "ethics"

WoE framework guidance (The Evidence for Policy and Practice Information and Co-ordinating Centre, 2009)						
Study	(Barrett et al., 2005) (continued)		(Barrett & Pahl, 2006) (continued)		(Essau et al., 2012) (continued)	
Guidance point	**Positive factors**	**Areas for critical consideration**	**Positive factors**	**Areas for critical consideration**	**Positive factors**	**Areas for critical consideration**
N.2 Were students and/or parents appropriately involved in the design or conduct of the study? Consider your answer to the appropriate question in module B.1	Informed parental consent was sought in advance of the study Parents were taught intervention re-enforcement skills to use in support of children at home. These included, praise and tangible awards, communication and problem solving skills and challenging negative thoughts skills.	The purpose or aims of the intervention were not explained to children in advance Group parenting booster workshop were poorly attended	Parents were provided with an information letter and consent form Parents were invited to attend four reinforcement evening parents' sessions	As a follow-up study, participants were recruited from a 2003 study conducted by the same authors. However, this study did not make attempts to assess if young people were still "at risk" of anxiety	Participants were informed that they would be taught specific skills that they would need to better cope with anxiety provoking situations	-
N.3 Is there sufficient justification for why the study was done the way it was? Consider answers to questions B1, B2, B3, B4	The authors make their research aims explicit, -For example to compare self-reported anxiety and depression between an intervention and control condition at pre and post-test and follow-up points.. -Hence, appropriate anxiety and depression inventories were chosen -Younger children were given the children's FRIENDS workbook. Adolescents, the youth workbook	The authors do not operationalise the concept of anxiety Hence, it is unclear as to what the researchers perceive themselves to be measuring and the reason why	The authors explain their aim, to evaluate the longer-term effectiveness of the FRIENDS programme in the reduction of anxiety and depression. A longitudinal follow-up study. Hence, follow-up measures were taken and 4 and 36 month follow-up points	-	The authors are clear about their research aims, to examine the effectiveness of the FRIENDS programme not only in reducing anxiety symptoms but also in its impact in on the specific correlates of anxiety symptoms, such as perfectionism A pilot study was conducted by the same authors in 2004. Subsequently, the authors adapted one of the relaxation games based on feedback gained from the pilot	Yes, research aims are clear, process aligns with research process

WoE framework guidance (The Evidence for Policy and Practice Information and Co-ordinating Centre, 2009)						
Study	(Barrett et al., 2005) (continued)		(Barrett & Pahl, 2006) (continued)		(Essau et al., 2012) (continued)	
Guidance point	**Positive factors**	**Areas for critical consideration**	**Positive factors**	**Areas for critical consideration**	**Positive factors**	**Areas for critical consideration**
N.4 Was the choice of research design appropriate for addressing the research question(s) posed?	Yes, see above. Appropriate measures and steps were used to investigate their research questions	-	A longitudinal design, appropriate to the researcher's aims. Research design attends to the research question	-	Control and intervention group design fit for purpose	However, a distinction was not made between the content of the control groups and intervention groups sessions
N.5 Have sufficient attempts been made to establish the repeatability or reliability of data collection methods or tools? Consider your answers to previous questions: Do the authors describe any ways they have addressed the reliability or repeatability of their data collection tools and methods (K7)	Attempts were made to use commonly used assessment tools such as the Spence Anxiety Scale for Children	Attempts were not made to explain how children were classified as "at risk" of anxiety. High, medium and low classifications were not explained	Attempts were made to use commonly used assessment tools such as the Spence Anxiety Scale for Children and Revised Children's Manifest Scale -SPSS data analysis methods could be reproduced	Authors do not explain how the intervention was "developmentally enhanced" References are made to the author's prior research, which makes this study difficult to replicate as a stand-alone piece of work	The authors provide a detailed explanation about how programme facilitators were trained to deliver the intervention Self-report measures are clearly explained	-
N.6 Have sufficient attempts been made to establish the validity or trustworthiness of data collection tools and methods? Consider your answers to previous questions: Do the authors describe any ways they have addressed the validity or trustworthiness of their data collection tools/ methods (K6)	See above. Some reasonable attempts were made	The authors do not make explicit if participants' information was anonymised prior to data analysis.	Questionnaires were presented in counterbalanced order within the assessment package, with each school receiving a different ordering of questionnaires across data collection points	-	Internal fidelity checklist were administered The first author reviewed and debriefed with trainers at the end each program session	-
N.7 Have sufficient attempts been made to establish the repeatability or reliability of data analysis? Consider your answer to the previous question: Do the authors describe any ways they have addressed the repeatability or reliability of data analysis? (L7)	The authors explain their use of an ANOVA and SPSS method of data analysis	See above	-	References are made to the author's prior research, which makes this study difficult to assess and repeat as a stand-alone piece of work. ANOVA and SPSS data analysis can be replicated and may allow for results to	The authors clearly explain the length, method, timing, content…of sessions which may increase the study's reliability and ability to be replicated …be generalised	

WoE framework guidance (The Evidence for Policy and Practice Information and Co-ordinating Centre, 2009)						
Study	(Barrett et al., 2005) (continued)		(Barrett & Pahl, 2006) (continued)		(Essau et al., 2012) (continued)	
Guidance point	**Positive factors**	**Areas for critical consideration**	**Positive factors**	**Areas for critical consideration**	**Areas for critical consideration**	**Positive factors**
N.8 Have sufficient attempts been made to establish the validity or trustworthiness of data analysis? Consider your answer to the previous question. Do the authors describe any ways they have addressed the validity or trustworthiness of data analysis? (L8, L9, L10, L11)	Attempts were made to assess the intervention's internal validity with use of a facilitator's check list	Attempts were not made to cross check data with the researcher's supervisor	Attempts were made to assess the intervention's internal validity with use of a facilitator's check list	-	Yes. See above Correlation tests were carried out as a method of data analysis.	
N.9 To what extent are the research design and methods employed able to rule out any other sources of error/bias which would lead to alternative explanations for the findings of the study? e.g. (1) In an evaluation, was the process by which participants were allocated to, or otherwise received the factor being evaluated, concealed and not predictable in advance? If not, were sufficient substitute procedures employed with adequate rigour to rule out any alternative explanations of the findings which arise as a result? e.g. (2) Was the attrition rate low and, if applicable, similar between different groups?	The attrition and missing data rates were made explicit	How the control condition and intervention condition is unclear. Attempts were not made clear to explain the focus of the control group's work The authors did not explain reasons for attrition or missing data	The attrition and missing data rates were made explicit Reasons were made clear, absenteeism on the day of the assessment from class due to extracurricular activities (for example sports and music activities)	How the control condition and intervention condition is unclear. Attempts were not made clear to explain the focus of the control groups work	See above	-
N.10 How generalisable are the study results?	A large sample size adds to the generalisability of the study's result	The results are specific across age and 'at risk' as understood by the researchers	A large sample size adds to the generalisability of the study's result	Results are specific to gender and at risk groups across time, although "at risk" of anxiety is not made explicit	A large sample size adds to the generalisability of the study's result	Results are specific to gender and perfectionism

WoE framework guidance (The Evidence for Policy and Practice Information and Co-ordinating Centre, 2009)						
Study	(Barrett et al., 2005) (continued)		(Barrett & Pahl, 2006) (continued)		(Essau et al., 2012) (continued)	
Guidance point	**Positive factors**	**Areas for critical consideration**	**Positive factors**	**Areas for critical consideration**	**Positive factors**	**Areas for critical consideration**
N.11 In light of the above, do the reviewers differ from the authors over the findings or conclusions of the study? Please state what any difference is.	-	-	-	-	-	-
N.12 Have sufficient attempts been made to justify the conclusions drawn from the findings, so that the conclusions are trustworthy?	Findings…. FRIENDS programme effective in reducing anxiety The intervention is more effective for younger children at moderate to high risk (in comparison to older children). Early prevention is better The intervention has some 12 months follow-up benefits	The authors acknowledge that the results must be taken with caution due to high rate of at risk children absent at 12 month follow up points Acknowledgement is given to the subjective nature of the anxiety self-report questionnaires	Results indicate, intervention reductions in anxiety as reported in the author's earlier 2003 study remained for pupils in year 6 Girls reported lower anxiety scores post-intervention scores in comparison to boys at 12 and 24 month follow-up points, but not at the 36 month point	Authors refer to earlier research findings which makes it difficult to draw conclusions about the present study	Children's social anxiety scores were presented separately to their other anxiety and depression scores	-
N.13 Weight of evidence A: Taking account of all quality assessment issues, can the study findings be trusted in answering the study question(s)? In some studies it is difficult to distinguish between the findings of the study and the conclusions. In those cases, please code the trustworthiness of these combined results/conclusions.	**low/medium**		**low/medium**		**medium/high**	

N.14 Weight of evidence B: Appropriateness of research design and analysis for addressing the question, or sub-questions, of this specific systematic review.	**medium/high**	**medium/high**	**high**
N.15 Weight of evidence C: Relevance of particular focus of the study (including conceptual focus, context, sample and measures) for addressing the question of this specific systematic review	**medium**	**medium**	**medium/high**
N.16 Weight of evidence D: Overall weight of evidence Taking into account quality of execution, appropriateness of design and relevance of focus, what is the overall weight of evidence this study provides to answer the question of this specific systematic review?	**medium**	**medium**	**medium/high**

WoE framework guidance (The Evidence for Policy and Practice Information and Co-ordinating Centre, 2009)						
Study	(Ginsburg & Drake, 2002)		(Miller et al., 2010)		(Miller et al., 2011) (randomised control trial 1)	
Guidance point	**Positive factors**	**Areas for critical consideration**	**Positive factors**	**Areas for critical consideration**	**Positive factors**	**Areas for critical consideration**
N.1 Are there ethical concerns about the way the study was done? Consider consent, funding, privacy, etc.	Informed consent was sought from parents	The authors adapted the CBT training manual to reflect experiences the sample and wider community were likely to encounter. These experiences included, theft, crime, violence, dating, drugs….Is this not perpetuating stereotypes about Black adolescents? -Sessions were audio-taped. Authors do not state if participants' and parental consent was sought	Parents were given information and consent forms	An opt-out study design raises ethical considerations?	-	Some sessions were audio taped. Was consent sought? -Participants were rewarded with weekly snacks to incentivise them to participate -Facilitators reminded participants that they were from the University as a prompt to participate in sessions
N.2 Were students and/or parents appropriately involved in the design or conduct of the study? Consider your answer to the appropriate question in module B.1	Informed consent was sought from parents	Participants were asked to fill-in reflection diaries	Participants were asked to reflect upon and to refresh their knowledge/skills at the start of each session	-	Teachers were given the researcher's contact details should they need further support or clarification	Participants were not involved in the study design
N.3 Is there sufficient justification for why the study was done the way it was? Consider answers to questions B1, B2, B3, B4	The authors explain that anxious adolescents were the unit of study as they are currently under-represented in paediatric anxiety literature -An explanation is given about why school-based interventions were chosen. The setting is real life, as opposed to a clinical setting	…. many of the anxiety provoking situations adolescents face are within the school environment etc.	The authors explain why teachers were chosen to carry out the intervention The authors explain why school-based settings were chosen	-	Yes. Researchers explain their aim to investigate reductions of anxiety over as screened by teachers, parents and self-report	

WoE framework guidance (The Evidence for Policy and Practice Information and Co-ordinating Centre, 2009)						
Study	(Ginsburg & Drake, 2002) (continued)		(Miller et al., 2010) (continued)		(Miller et al., 2011) (randomised control trial 1) (continued)	
Guidance point	**Positive factor**	**Areas for critical consideration**	**Positive factor**	**Areas for critical consideration**	**Positive factor**	**Areas for critical consideration**
N.4 Was the choice of research design appropriate for addressing the research question(s) posed?	Control vs intervention group design, fit for purpose	A small sample size limits study's generalisability	Yes appropriate control and intervention group design	-	Yes, two randomised control trials were carried out with measures of anxiety taken over time	-
N.5 Have sufficient attempts been made to establish the repeatability or reliability of data collection methods or tools? Consider your answers to previous questions: Do the authors describe any ways they have addressed the reliability or repeatability of their data collection tools and methods (K7)	The treatment manual is available from the authors	-	Yes data collection methods and techniques have been explained	-	-	Little attention was given to the stages of the research process, making this study this study difficult to replicate
N.6 Have sufficient attempts been made to establish the validity or trustworthiness of data collection tools and methods? Consider your answers to previous questions: Do the authors describe any ways they have addressed the validity or trustworthiness of their data collection tools/ methods (K6)	Assessment tools and measures are described I detail Attempts were made to explain how the tests were administered	-	Yes, research tools, procedures and follow-up mechanisms are explained The authors do not critically evaluate the TWD programme	Internal checklists were given to teachers to complete	-	Research tools and methodologies are not explicitly critiqued
N.7 Have sufficient attempts been made to establish the repeatability or reliability of data analysis? Consider your answer to the previous question Do the authors describe any ways they have addressed the repeatability or reliability of data analysis? (L7)	Assessment tools and measures are described I detail Attempts were made to explain how the tests were administered	-	-	The authors do not offer any critical reflections about their data analysis	Authors explain their data analysis formulas Their 2-piece linear growth model might be replicated	-

WoE framework guidance (The Evidence for Policy and Practice Information and Co-ordinating Centre, 2009)						
Study	(Ginsburg & Drake, 2002) (continued)		(Miller et al., 2010) (continued)		(Miller et al., 2011) (randomised control trial 1) (continued)	
Guidance point	**Positive factors**	**Areas for critical consideration**	**Positive factors**	**Areas for critical consideration**	**Positive factors**	**Areas for critical consideration**
N.8 Have sufficient attempts been made to establish the validity or trustworthiness of data analysis? Consider your answer to the previous question: Do the authors describe any ways they have addressed the validity or trustworthiness of data analysis? (L8, L9, L10, L11)	ANOVA results are presented	Authors do not explain why an ANOVA was used as a data analysis tool	Internal checklists were given to teachers	A distinction was not made between the content of the control groups and content of the intervention groups sessions	Authors do not refer to this matter explicitly	-
N.9 To what extent are the research design and methods employed able to rule out any other sources of error/bias which would lead to alternative explanations for the findings of the study? e.g. (1) In an evaluation, was the process by which participants were allocated to, or otherwise received the factor being evaluated, concealed and not predictable in advance? If not, were sufficient substitute procedures employed with adequate rigour to rule out any alternative explanations of the findings which arise as a result? e.g. (2) Was the attrition rate low and, if applicable, similar between different groups?	-	A high attrition rate 3 participants dropped out of a sample of 12.	Participants are asked to return completed assessment material in a sealed bag to teachers	-	Authors do not discuss attrition rates but do explain that missing data was not included in their data analysis	-
N.10 How generalisable are the study results?	Small sample size	Not generalisable	Reasonably large sample size	Difficult to determine how the authors define “at risk”	-	Sample size makes this study less generalisable -Some missing data
N.11 In light of the above, do the reviewers differ from the authors over the findings or conclusions of the study? Please state what any difference is.	-	-	-	-	-	-

WoE framework guidance (The Evidence for Policy and Practice Information and Co-ordinating Centre, 2009)						
Study	(Ginsburg & Drake, 2002) (continued)		(Miller et al., 2010) (continued)		(Miller et al., 2011) (randomised control trial 1) (continued)	
Guidance point	**Positive factors**	**Areas for critical consideration**	**Positive factors**	**Areas for critical consideration**	**Points for consideration**	**Areas for critical consideration**
N.12 Have sufficient attempts been made to justify the conclusions drawn from the findings, so that the conclusions are trustworthy?	Yes. The authors acknowledge the small sample size and high attrition rate	-	Yes the authors acknowledge the limitations of their work	-	Reductions in anxiety were higher in girls than in boys	Authors recognise limitations of their research, including heavy reliance on self-report scores
N.13 Weight of evidence A: Taking account of all quality assessment issues, can the study findings be trusted in answering the study question(s)? In some studies it is difficult to distinguish between the findings of the study and the conclusions. In those cases, please code the trustworthiness of these combined results/conclusions.	**low/medium**		**low/medium**		**high**	
N.14 Weight of evidence B: Appropriateness of research design and analysis for addressing the question, or sub-questions, of this specific systematic review.	**medium/high**		**medium/high**		**low/medium**	
N.15 Weight of evidence C: Relevance of particular focus of the study (including conceptual focus, context, sample and measures) for addressing the question of this specific systematic review	**medium**		**medium**		**medium**	
N.16 Weight of evidence D: Overall weight of evidence Taking into account quality of execution, appropriateness of design and relevance of focus, what is the overall weight of evidence this study provides to answer the question of this specific systematic review?	**medium**		**medium**		**medium/high**	

WoE framework guidance (The Evidence for Policy and Practice Information and Co-ordinating Centre, 2009)						
Study	(Miller et al., 2011a) (Randomised control study 2)		(C. C. Mifsud & R. M. R. M. Rapee, 2005)		(Roberts et al., 2010)	
Guidance points	**Positive factors**	**Areas for critical consideration**	**Positive factors**	**Areas for critical consideration**	**Positive factors**	**Areas for critical consideration**
N.1 Are there ethical concerns about the way the study was done? Consider consent, funding, privacy, etc.	The University Review board approved the study Parental consent was sought English Language proficiency levels were sought	Some sessions were audio taped. Was consent sought? Participants were rewarded with weekly snacks to incentivise them to participant Facilitators reminded participants that they were from the University as a prompt to participate in sessions	Parents were information and consent forms	Ethical issues were not considered explicitly	Ethical approval was sought in advance of the work Parent information session were offered before consent was gained	Opt-out study design raises ethical issues
N.2 Were students and/or parents appropriately involved in the design or conduct of the study? Consider your answer to the appropriate question in module B.1	Teachers were given the researcher's contact details should they need further support or clarification	Participants were not involved in the study design	-	Parents were offered a supporting parenting series of sessions	-	Participants were not involved the study design
N.3 Is there sufficient justification for why the study was done the way it was? Consider answers to questions B1, B2, B3, B4	Yes. Researchers explain their aim of investigate reductions of anxiety over as screened by teachers, parents and self-report	-	Yes tools and methods were explained and as to how these addressed the research question	-	Yes, authors wanted to assess the effectiveness of the AOP programme. Tools were selected appropriately	-
N.4 Was the choice of research design appropriate for addressing the research question(s) posed?	Yes, two randomised control trials were carried out with measures of anxiety taken over time	-	Yes, the research question was addressed with an appropriate pre-test and post-test design with use of control and non-control group	-	Yes schools were chosen as the unit of analysis	-

WoE framework guidance (The Evidence for Policy and Practice Information and Co-ordinating Centre, 2009)						
Study	(Miller et al., 2011a) (Randomised control study 2) (continued)		(C. C. Mifsud & R. M. R. M. Rapee, 2005) (continued)		(Roberts et al., 2010) (continued)	
Guidance point	**Positive factors**	**Areas for critical consideration**	**Positive factors**	**Areas for critical consideration**	**Positive factors**	**Areas for critical consideration**
N.5 Have sufficient attempts been made to establish the repeatability or reliability of data collection methods or tools? Consider your answers to previous questions: Do the authors describe any ways they have addressed the reliability or repeatability of their data collection tools and methods (K7)	-	Little attention was given to the stages of the research process, making this study this study difficult to replicate	Yes a step-by-step figure is presented. This highlights the research stages	-	The control groups, health programme was described. Intervention group programme described	Pictorial representation of research process might have made research process clearer Health programme similar to the intervention group's programme
N.6 Have sufficient attempts been made to establish the validity or trustworthiness of data collection tools and methods? Consider your answers to previous questions: Do the authors describe any ways they have addressed the validity or trustworthiness of their data collection tools/ methods (K6)	Participants admit that not all parents consented, this limited the study's sample size	Research tools and methodologies are not explicitly critiqued	-	Authors do not explicitly state how they have addressed issues of validity	Internal checklists were administered Observations of sessions were conducted by independent observers	-
N.7 Have sufficient attempts been made to establish the repeatability or reliability of data analysis? Consider your answer to the previous question: Do the authors describe any ways they have addressed the repeatability or reliability of data analysis? (L7)	Authors explain their data analysis formulas Their 2-piece linear growth model might be replicated		Yes, an explicit process diagram is provided	-	Yes, research process made clear	
N.8 Have sufficient attempts been made to establish the validity or trustworthiness of data analysis? Consider your answer to the previous question: Do the authors describe any ways they have addressed the validity or trustworthiness of data analysis? (L8, L9, L10, L11)	Yes, research design made explicit		Yes, an explicit process diagram is provided	However, authors do not internally validate their results with any audit or review processes	Yes, research design made explicit	-

WoE framework guidance (The Evidence for Policy and Practice Information and Co-ordinating Centre, 2009)						
Study	(Miller et al., 2011a) (Randomised control study 2) (continued)		(C. C. Mifsud & R. M. R. M. Rapee, 2005) (continued)		(Roberts et al., 2010) (continued)	
Guidance point	**Positive factors**	**Areas for critical consideration**	**Positive factors**	**Areas for critical consideration**	**Positive factors**	**Areas for critical consideration**
N.9 To what extent are the research design and methods employed able to rule out any other sources of error/bias which would lead to alternative explanations for the findings of the study? e.g. (1) In an evaluation, was the process by which participants were allocated to, or otherwise received the factor being evaluated, concealed and not predictable in advance? If not, were sufficient substitute procedures employed with adequate rigour to rule out any alternative explanations of the findings which arise as a result? e.g. (2) Was the attrition rate low and, if applicable, similar between different groups?	Authors briefly mention attrition rates		-	Authors do not mention attrition rates	-	Authors do not discuss attrition rates
N.10 How generalisable are the study results?	Incomplete data limits the generalisability of this study	-	Yes large sample size		Large samples size makes this study more generalisable	-
N.11 In light of the above, do the reviewers differ from the authors over the findings or conclusions of the study? Please state what any difference is.	-	-	-		-	-
N.12 Have sufficient attempts been made to justify the conclusions drawn from the findings, so that the conclusions are trustworthy?	Yes strengths and limitations of review are acknowledged	-	Yes strengths and limitations of review are acknowledged	-	Teachers and participants filed in end of project evaluation forms which increases trustworthiness of results	-

WoE framework guidance (The Evidence for Policy and Practice Information and Co-ordinating Centre, 2009)						
Study	(Miller et al., 2011a) (Randomised control study 2) (continued)		(C. C. Mifsud & R. M. R. M. Rapee, 2005) (continued)		(Roberts et al., 2010) (continued)	
Guidance point	**Positive factors**	**Points for critical consideration**	**Positive factors**	**Points for critical consideration**	**Positive factors**	**Points for critical consideration**
N.13 Weight of evidence A: Taking account of all quality assessment issues, can the study findings be trusted in answering the study question(s)? In some studies it is difficult to distinguish between the findings of the study and the conclusions. In those cases, please code the trustworthiness of these combined results/conclusions.	**low/medium**		**low/medium**		**low/medium**	
N.14 Weight of evidence B: Appropriateness of research design and analysis for addressing the question, or sub-questions, of this specific systematic review.	**medium/high**		**medium/high**		**medium/high**	
N.15 Weight of evidence C: Relevance of particular focus of the study (including conceptual focus, context, sample and measures) for addressing the question of this specific systematic review	**high**		**medium**		**medium/high**	
N.16 Weight of evidence D: Overall weight of evidence Taking into account quality of execution, appropriateness of design and relevance of focus, what is the overall weight of evidence this study provides to answer the question of this specific systematic review?	**medium**		**medium**		**medium**	

WoE framework guidance (The Evidence for Policy and Practice Information and Co-ordinating Centre, 2009)				
Study	**(Miller et al., 2011)**			
Guidance point	**Positive factors**	**Areas for critical consideration**		
N.1 Are there ethical concerns about the way the study was done? Consider consent, funding, privacy, etc.	Ethical approval was sought in advance	Does culturally enriching the intervention perpetuate stereotypes? Parts of the intervention were read aloud to participants		
N.2 Were students and/or parents appropriately involved in the design or conduct of the study? Consider your answer to the appropriate question in module B.1	Authors provide a step by step research process model	Participants were not involved in the study design		
N.3 Is there sufficient justification for why the study was done the way it was? Consider answers to questions B1, B2, B3, B4	Yes, the authors explain why the programme was culturally enriched.	However, their interpretation and revision of the manual was not piloted or critically reviewed in advance		
N.4 Was the choice of research design appropriate for addressing the research question(s) posed?	Yes appropriate control vs intervention group Anxiety measures were taken at x3 follow-up points	-		
N.5 Have sufficient attempts been made to establish the repeatability or reliability of data collection methods or tools? Consider your answers to previous questions: Do the authors describe any ways they have addressed the reliability or repeatability of their data collection tools and methods (K7)	Yes, the authors provide a step by step research process guidance framework Research tools are explained and warranted	-		

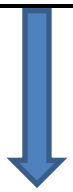
WoE framework guidance (The Evidence for Policy and Practice Information and Co-ordinating Centre, 2009)				
Study	**(Miller et al., 2011)**			
Guidance points	**Positive factors**	**Areas for critical consideration**		
N.6 Have sufficient attempts been made to establish the validity or trustworthiness of data collection tools and methods? Consider your answers to previous questions: Do the authors describe any ways they have addressed the validity or trustworthiness of their data collection tools/ methods (K6)	Yes internal checklists were given to facilitators	-		
N.7 Have sufficient attempts been made to establish the repeatability or reliability of data analysis? Consider your answer to the previous question: Do the authors describe any ways they have addressed the repeatability or reliability of data analysis? (L7)	Yes a research process diagram is given	-		
N.8 Have sufficient attempts been made to establish the validity or trustworthiness of data analysis? Consider your answer to the previous question: Do the authors describe any ways they have addressed the validity or trustworthiness of data analysis? (L8, L9, L10, L11)	Yes	-		

WoE framework guidance (The Evidence for Policy and Practice Information and Co-ordinating Centre, 2009)				
Study	Miller, Laye-Gindhu, Bennett, et al., 2011)			
Guidance point	**Positive factors**	**Areas for critical consideration**		
N.9 To what extent are the research design and methods employed able to rule out any other sources of error/bias which would lead to alternative explanations for the findings of the study? e.g. (1) In an evaluation, was the process by which participants were allocated to, or otherwise received the factor being evaluated, concealed and not predictable in advance? If not, were sufficient substitute procedures employed with adequate rigour to rule out any alternative explanations of the findings which arise as a result? e.g. (2) Was the attrition rate low and, if applicable, similar between different groups?	The researchers discuss their attrition rates	Attrition rates affected the sample and overall data set		
N.10 How generalisable are the study results?	Relatively robust apart from levels of attrition	-		
N.11 In light of the above, do the reviewers differ from the authors over the findings or conclusions of the study? Please state what any difference is.	-	-		
N.12 Have sufficient attempts been made to justify the conclusions drawn from the findings, so that the conclusions are trustworthy?	Yes, authors acknowledge their strengths and limitations	-		

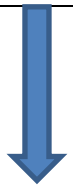
WoE framework guidance (The Evidence for Policy and Practice Information and Co-ordinating Centre, 2009)				
Study	Miller, Laye-Gindhu, Bennett, et al., 2011)			
Guidance point	**Positive factors**	**Areas for critical consideration**		
N.13 Weight of evidence A: Taking account of all quality assessment issues, can the study findings be trusted in answering the study question(s)? **In some studies it is difficult to distinguish between the findings of the study and the conclusions. In those cases, please code the trustworthiness of these combined results/conclusions.**	**high**			
N.14 Weight of evidence B: Appropriateness of research design and analysis for addressing the question, or sub-questions, of this specific systematic review.	**medium/high**			
N.15 Weight of evidence C: Relevance of particular focus of the study (including conceptual focus, context, sample and measures) for addressing the question of this specific systematic review	**medium**			
N.16 Weight of evidence D: Overall weight of evidence **Taking into account quality of execution, appropriateness of design and relevance of focus, what is the overall weight of evidence this study provides to answer the question of this specific systematic review?**	**medium/high**			

Appendix 13: Returning to the stages of the systematic literature review

Database search
literature dated 2004-2014
search dates 17/09/2014 – 13/10/2014



	Database search terms
	participants terms
	parent* carer*
	setting terms
	school*/educat*/class*/school-age*/secondary school*/high school*/work*/college*/further education*/training*/job*/employment*/
	hospital*/paedi*/health*/service*
	mediating factor terms
	social*anxi*/social anxiety*
	mediating factor terms
	transition*
	subject terms
	child*/adolesc*/ young pe*/teenage*/youth*/ pupil*/ paedi*



	Step 1: Search for literature dated 2007-2012
database searched	ProQuest
date of search	studies located
17/09/2014	1. (Bhakta et al., 2000) 2. Clarizia, 2009 #991} 3. (K. Roth & Columna, 2011) 4. (Salmela-aro & Tuominen-soini, 2010)

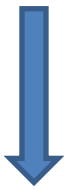
18/09/2014	5. (Lang, 2010) 6. (J. Graham, 2005) 7. (Yates, 2005) 8. (Karin Du et al., 2012) 9. (Kochhar-Bryant & Margo Vreeburg, 2006) 10. (J. R. Graham et al., 2014)

database searched	EBSCO
date of search	studies located
20/09/2014	none

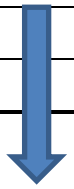
database searched	Ovid
date of search	studies located
21/09/2014	none

database searched	Scopus
date of search	studies located
25/09/2014	none

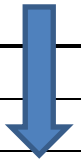
database searched	Web of knowledge
date of search	studies located
27/09/2014	11.(McNamara et al., 2014) 12. (Murcott, 2014)



database searched	First search
date of search	studies located
28/09/2014	none



database searched	Medline
database	studies located
29/09/2014	none



Hand searches	
date of search	Parenting Science and Practice
30/09/2014	studies located
	none
date of search	Journal of Adolescence
30/09/2014	studies located
	none
date of search	Journal of Youth and Adolescence
30/09/2014	studies located
	13. (Salmela-Aro & Tynkkynen, 2010)
date of search	Journal of Anxiety Disorders
01/10/2014	studies located
	none
date of search	Educational Psychology in Practice
02/10/2014	studies located
	none
date of search	Journal of Applied School Psychology
03/10/2013	studies located
	none
	Journal of Depression and Anxiety
	studies located
date of search	none
13/10/2014	Social Psychology of Education : An International Journal

	studies located
	14. (Elffers & Oort, 2013)

Total number of studies located: 14