Exploring Behavioural Activation as a treatment for low mood within CAMHS: an IPA study of adolescent experiences.

Abbreviated title (running head): Adolescent Experiences of Behavioural Activation Therapy

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ABSTRACT

Background

Low mood is the most commonly diagnosed mental health condition affecting adolescents, and remains complex to treat due to multi-systemic risk and maintaining factors. Behavioural Activation (BA) is a brief therapy demonstrating promising treatment outcomes, although limited qualitative accounts exist of how they experience this.

Objective

This is one of the first studies undertaken in Child and Adolescent Mental Health Services (CAMHS) to explore the perspectives of young people with low mood who have received BA therapy.

Method

Interpretative phenomenological analysis (IPA) was conducted from one-to-one interviews with nine adolescents who received BA; generating an idiographic account of their experiences.

Results

Three superordinate themes emerged: how the format of BA can promote the integration of coping skills into one's life; how interpersonal connections and therapeutic relationships may improve intervention outcomes; and how BA principles could be internalised as part of a young person's day-to-day life. Participants valued the structure and flexibility of the manualised approach, forming an alliance with the therapist, and enhancing interpersonal relationships.

Conclusions

This study details how BA can enhance resiliency skills for young people experiencing low mood, and illustrates some of the change process at inter- and intrapersonal levels; which should guide further youth-led research.

1. BACKGROUND

Prevalence rates of depression amongst young people are steadily rising in the United Kingdom (Fink et al., 2015). Overall rates are suggested to be between 1-6% within the school-aged population (Roberts, 2013; Finning et al., 2019). Cognitive Behavioural Therapy (CBT) is the recommended treatment for low mood and depression within young people, along with Interpersonal Therapy (IPT) and Family Therapy (NICE, 2016). These interventions have demonstrated substantial effectiveness in reducing low mood (NICE, 2016). However, the delivery of such psychological therapies can pose numerous systemic challenges. Firstly, there is growing demand for specialist mental health services for young people within a system already under-resourced. This situation has been compounded during the COVID-19 pandemic (Fegert et al., 2020). Consequently, waiting lists and capacity pressures have increased (Richardson, Stallard, & Velleman, 2010). Secondly, the delivery of recommended psychological treatments (NICE, 2019) can be both costly and limited in availability (Roberts, 2013); particularly as senior clinicians are often required to facilitate their delivery (Goodyer et al., 2017). These systemic complexities mean there are many young people experiencing pervasive periods of low mood (Polanczyk et al., 2015) who may not be supported in a timely manner. Coupled with the demotivated mindset of young people experiencing low mood, they often don't access or engage with services (Keeley et al., 2016), leading to infrequent contact with mental health services (Frith, 2016). This makes it harder to assess, diagnose and offer appropriate intervention (Watnick et al., 2005). As such, there is a need for brief, engaging interventions that can be effectively delivered by a variety of professionals within the health service.

While diagnostic and service accessibility pose a challenge for people living with low mood, this is particularly pertinent for children and adolescents. Untreated periods of low mood can have a detrimental impact on young people's familial and peer relationships, increasing the likelihood of other risks and impairing social and academic functioning (NICE, 2016); affecting developmental potential (Birmaher & Brent, 2007). With this in mind, it is important that young people experiencing low mood are identified early and receive appropriate intervention; preventing further developmental difficulties and co-morbidity in the future (NICE, 2016).

The loss of interest and pleasure is a core component of low mood (APA, 2013). It has been suggested that increasing engagement in pleasurable activities could be a helpful way of

managing such difficulties (Lewinsohn, 1974). Behavioural Activation (BA) is a well-established, brief psychotherapeutic intervention which intends to 'activate' and establish positive behavioural habits (Lewinsohn, 1974; Martin & Oliver, 2019). It does this by enabling the individual to experience positive reinforcement through feelings of pleasure and accomplishment in relation to tasks (Soucy et al., 2017). These task orientated successes have been shown to be an effective intervention in ameliorating low mood symptoms across various clinical samples (Cuijpers, Van Straten & Wamersam, 2007; Ekers, Richards & Gilbody, 2008; Mazzuchelli, Kane & Rees, 2009; Richards et al., 2017). In conjunction, when comparing the efficacy of BA and other pharmacological and psychotherapeutic interventions, it was evidenced that delivering BA in a low intensity format (guided self-help) is as effective (Lewinsohn, 1974; Chartier & Provencher, 2013; Martin & Oliver, 2019).

Moreover, adaptations have been made to BA to improve accessibility for adolescents, with Pass et al (2018) evidencing a large pre-post effect size following BA, with 65% of their sample requiring no further psychological intervention, as well as reporting high levels of acceptability and satisfaction with the therapy. Lewis-Smith et al (2021) provided further backing for BA through an adolescent qualitative study within a school, evidencing participants found identifying values and related valued activities to be helpful, alongside therapist support; however therapy duration and maintaining wellbeing improvements proved challenging. Whilst qualitative research exploring the therapeutic experience of adolescents undertaking BA as a stand-alone treatment option exists, this is limited when contextualised within a clinical setting, and delivered by a non-specialist clinician in a manualised low intensity format (Pass et al., 2018; Martin & Oliver, 2019).

Given the increasing prevalence of depression and low mood within the child and adolescent population, it is imperative further research considers the efficacy of BA as a treatment option. Following involvement in a quantitative feasibility study (Dubicka et al., 2020), the authors completed semi-structured interviews with nine young people experiencing low mood. The interviews aimed to explore individual experience and mechanisms of change, contributing as yet unheard perspectives to the literature and evidence base. Enhancing our understanding of how BA may be a beneficial intervention for young people with low mood could inform future provision and service design in a manner that addresses existing barriers to positive service engagement.

2. METHODOLOGY

2.1 Design

In order to explore the ideographic individual experiences of the participants, interpretative phenomenological analysis (IPA) was selected as the most appropriate methodology. One-to-one in depth interviews with nine participants were conducted in two Community CAMHS settings. The BA intervention was delivered by Assistant Psychologists and used a structured manual consisting of eight weekly sessions. Each session used a specific focus (see Table 1) to 'activate' positive behaviours, which may help to mitigate low mood.

Session Number	Session focus
1	Goals, education and recording
2	Introduction to valued living
3	Values clarification
4	Activity planning and barriers
5	Rewards and getting support
6	Avoidance patterns
7	Problem solving
8	Staying well and review

Table 1: BA session focus

2.2 Ethical considerations

Ethical approval for the study was granted by the Health Research Authority (HRA) 19/NW/0042. In order to protect the anonymity of participants, each young person was given a unique study ID known only by the research team. This was used for all study documentation, and pseudonyms were used in the final write up.

2.3 Participants

Many young people experience periods of low mood of sufficient severity and duration as to have a substantial negative impact upon one's quality of life; requiring referral to CAMHS for assessment and treatment. Whilst the initial screening may identify low mood as the primary mental health difficulty, if no urgent risk factors are present, the referral is placed on a waiting list for an average of two months (Crenna-Jennings & Hutchinson, 2020) before receiving treatment; including diagnostic assessment.

Due to its accessibility and relatively short timescale, the BA intervention within the current study is intended to be delivered to young people situated on this waiting list, as the first

intervention of a stepped care approach. As such, whilst they may present significant low mood, there is often no formal diagnosis of depression.

The current study used purposeful sampling to recruit nine young people from two CAMHS sites who met the eligibility criteria: presented low mood following initial screening; received BA therapy whilst situated on the post-screening and pre-treatment waiting list; were aged 12-17 years of age. Participant demographic information is shown in Table 2.

Pseudonym	Gender	Age	Ethnicity	Presenting mental health difficulty
Emily	F	15	White British	Low mood, anxiety
Natalie	F	13	White British	Low mood
Hayley	F	15	White British	Low mood, anxiety
Charlotte	F	15	White British	Low mood
Abbie	F	14	White British	Low mood
Harry	M	12	White British	Low mood, anxiety, possible ASD
Liam	M	15	Asian British (Pakistani)	Low mood anxiety, possible ASD
Salim	M	14	White British	Low mood, anxiety, ASD
Elliot	M	15	White British	Low mood

Table 2: Participant demographic data

2.4 Recruitment and research procedure

The researchers liaised with CAMHS staff to identify potential participants who were then provided a participant information sheet and opportunity to discuss the study with the researchers. The process for obtaining informed consent was in line with HRA Guidance. Following written informed assent from the young person and parental consent, a face to face semi-structured interview was conducted by the first two authors. Interviews lasted 24-33 minutes and were informed by the conversational and experiential principles of IPA, with the participant leading the content of the interview, guided by the open interview questions. Transcripts were transcribed verbatim, anonymised and then analysed using IPA. The following the IPA procedure, as proposed by Smith and Shinebourne (2012), was used:

1. Familiarisation of data: transcripts were read multiple times.

2. Initial exploratory commentary: researcher recorded initial thoughts and observations.
3. Creating emergent themes, based on original text and initial observations. This included: motivation to engage in BA; flexibility within or across sessions; encouraging deeper communication.
4. Developing subordinate themes: identifying connections between similar emergent themes and grouping them together. This included: structure of BA therapy; the relationship between client and therapist; psycho-education.
5. Establishing superordinate themes: identifying connections between similar subordinate themes and grouping them together.
6. Defining superordinate themes to ensure they captured the essence of participant narrative. This included:
    i) How the format of BA can effectively promote its integration into one's life,
    ii) Cultivating interpersonal connections to improve BA outcomes,
    iii) Development of one's self pre and post BA therapy.

2.5 Data analysis

IPA is an interpretative endeavour that seeks to explore and make sense of one's lived experience through cognitive and emotional reactions to a phenomenon (Smith & Shinebourne, 2012). IPA maintains a focus on understanding individual's lived experiences, rather than the experience being understood in the context of pre-existing, theoretical preconceptions (Smith & Shinebourne, 2012). An idiographic focus guided the discovery, and through a realist epistemological position, initial emergent themes were established based on participant narratives. Emergent themes formed subordinate themes. The subordinate themes aimed to accurately reflect participant's experiences during their BA intervention, which collectively led to the three superordinate themes. It is important to recognise that autobiographical accounts are often based on perception rather that factual information. As such, it is recognised through the critical realist epistemological position taken that these experiences were subjective as the interpreted reality of each participant, which collectively were synthesised to form the collective hermeneutic interpretation of the superordinate themes.

3. RESULTS

Findings indicate participants value the structured child-centred format of BA. An appreciation of the structure and child-focused approach facilitated increased engagement with the therapy and mood improvements. Such outcomes were encouraged through the development of

occupational skills, improved interpersonal relationships and the cultivation of greater social support. This process is illustrated in Figure 1.

3.1 Theme 1: How the format of BA encourages improved integration into client's life.

Within BA, the therapist is tasked with finding a balance between a flexible and structured delivery; facilitating improved therapeutic engagement as well as serving as a protective factor for managing low mood between sessions. Such a balance both motivates and enables young people to embed newly acquired BA skills within their current lifestyle; aiding the recovery process. This theme discusses how participants experienced and interpreted this aspect of the intervention.

3.1.1 *Structure of BA therapy*

As an eight-session manual-based format, the intervention was generally well received, with Harry stating *'I like that they're planned out because sometimes things can get very chaotic'.* Participants reported being able to communicate effectively due to the focus of sessions; '*it was good because I kind of felt like having it set out in a little booklet, I didn't have to think of things to say, which I find very hard to do' (Hayley).*

Through supporting and guiding client dialogue in this way, the BA structure may lessen the anxiety associated with therapy; encouraging deeper communication that provides greater insight into client's mental state. Additionally, participants appreciated the consistency of structure across sessions, which helped them apply the BA ethos to their own lives. For example; '*they all followed on from each other, yet they're almost different chapters, like finding out what's important to you and then doing that chapter makes you think, but then when you take the booklet away and read it again, it makes you think more' (Abbie).* In this way, the manualised structure facilitated consolidated learning and reflection in-between the delivery of sessions, increasing the likely acquisition of new skills and positive lifestyle habits that aim to improve mood. However, whilst the format was generally deemed beneficial, some remarked it could feel too rigid, and not provide sufficient opportunity to deviate away from the manual if the client wanted to discuss other areas:

> *The only bit I don't like is that they're all really thoroughly planned out … if the booklet says what the agenda is today it is the entire session, I know that half-way through we will be going through an activity log.*
>
> (*Harry*)

This shortcoming may evoke demotivation and disengagement if the client feels their concerns are not being acknowledged, and their role within the therapy becomes overly passive. Moreover, participants valued having a physical booklet, with this tangible reminder of BA allowing independent application of associated skills to regulate their mood throughout the week, which alongside weekly sessions, became a protective factor against mood deterioration.

> *If you've had a really bad week just make it to Wednesday, less than a week to see [therapist] and you can sort your problems out … you can speak to him and stuff, and it's only four days, four days and then I get to see [therapist], you can manage, it's like a goal.*
>
> *(Charlotte)*

> *Instead of maybe remembering something like that when you're feeling quite low, you might struggle, it might have exited your mind, so to have something in your hands to read again, that really did help.*
>
> *(Abbie)*

The multi-faceted format of BA can promote psychological support to clients and influence their thinking in-between sessions to consolidate resilience and emotional regulation skills that may mitigate low mood. Supported by Elliot, *'It was more than just being good to have somebody to talk to every week, the fact it focussed on a particular area and how you can improve in that area'.* Such targeted focus encourages greater application and integration to one's life, as well as improved skill acquisition; collectively contributing to alleviate low mood symptoms.

3.1.2 *Links between BA therapy and the client's life.*

Within BA, the 'activation' of adaptive behaviours is precipitated through an explicit values focus in early sessions, whereby the client identifies what is most important to them, and why. Participants appreciated this personal focus directing the therapy, and the sense of control over their treatment it provided. Recording this information in the booklets helped highlight:

> *… what you don't really think about and what's very important to you, and it was just helpful to like put them into sections of what's not important to me … just seeing it in front of you helped me visualise and understand, sort of sort out in my own head what do I need to focus on and what isn't necessary.*
>
> *(Elliot)*

Due to the entrenched negative thought patterns and demotivated attitudes associated with low mood, individuals can struggle to maintain focus and engage with positive treatment strategies (Keeley et al., 2016). BA's manualised format aims to remedy this, with the booklet serving as a visual aid that provides easy access to session content and allows swift identification of positive behavioural actions; which may help manage low mood, especially during periods of heightened emotional distress. Additionally, a structured visual aid encourages improved accessibility; supporting BA's ability to be delivered by multiple therapeutic roles, across a wide range of client groups with varying needs. Such increased accessibility and client engagement is complemented through the recognition of client values and the pairing of this with related activities, in order to install a strong motivator to increase activity engagement that may promote mood improvement. Activity scheduling further encourages this, a feature well received by participants:

> *I did cooking and music, but I wasn't playing it as often, but now because of the booklets I started planning to do them more … we started planning things that got me to go outside more because of my social anxiety, … I just got on with my activities and they became a part of my daily routine.*
>
> *(Natalie)*

Aligning client values and activities in a scheduled way encourages active participation in the therapy; fostering a sense of personalisation that likely has a positive impact on motivation towards behavioural change. This stimulates client ownership over their treatment and installs a practical technique they can independently apply to increase activity engagement; developing autonomy and reducing the need for professional clinical input that may precipitate timely discharge. Whilst participants found activity scheduling helpful, some expressed concerns regarding the daily diary, particularly if they had adverse experiences; '*with the diary, if I've had a bad day I just want to forget it, and if I have to fill in that day, it's like a reminder of the bad day I've had' (Harry)*. If clients cannot tolerate such reflection, it may stimulate negative

emotions and undesirable behaviours, impeding BA's aspirations and potentially inducing disengagement from therapy.

Finally, participant narrative suggested BA felt tailored to them; '*it was more focussing on what's important to me and how I can start doing more of what's important to me' (Elliot).* Varying session focus may help this, as some felt more relevant to certain participants; '*the avoidance session was beneficial because that's one of my main problems' (Elliot).* This relevance to individual clients further contributes to their motivation to engage with BA, as session content feels more meaningful and applicable to their situation.

3.2 Theme 2: Cultivating interpersonal connections to improve Behavioural Activation outcomes

The importance of client's experiencing a sense of safety within a therapeutic relationship which allows space to express their true thoughts and feelings, while collaboratively exploring and acknowledging ones values. This facilitates both continued motivation to engage with BA and encourages improved connections with support networks outside of therapy; helping to maintain client wellbeing.

3.2.1 *Therapist tailoring the structure of BA therapy in relation to client needs.*

The format of BA allows slight deviation from the fixed structure to create a more open therapeutic space, in response to client needs; *'[therapist] did try to adapt it to suit my needs' (Salim).* Such a process is managed by the therapist, who ensures deviation is meaningful, beneficial and boundaried, ensuring the therapy remains contextualised within the BA model. This feature was highly valued by participants:

> *Sometimes I kind of used the session to just talk about how I was feeling and like cos we were saying we didn't have to go straight by the book ... sometimes we kind of just used it to talk about things that had stressed me out or made me feel down.*
>
> *(Hayley)*

This deviation could occur within a session, or it may be appropriate for the therapist to adjust the session order to reflect individual client situations, as for Hayley; '*We did it like in different orders, because I think [therapist] felt one was more relevant to the time than the other'.* Such flexibility allows clients to feel validated and listened to, as their unique concerns and emotional needs are acknowledged. This improves the client-therapist relationship as it becomes one of increased equality, empowering the client to have an active role within the

therapy. Whilst this degree of flexibility was highly valued, the manualised structure of BA provides a specific shared framework both client and therapist work towards; encouraging a more collaborative working relationship.

However, participants suggested more flexibility would be beneficial; 'S*ometimes I sort of wished I had more time to just go like you know off script because some days I kind of felt like stuff in the book wasn't exactly what I wanted to talk about on that day, some days I felt like it was, some days I felt it wasn't' (Hayley).* If clients feel the therapy is overly rigid, it may disempower and demotivate them, potentially leading to relationship ruptures and disengagement.

3.2.2 *The relationship between client and therapist.*

The flexibility merged with the therapist's professional approach and personality to underpin and promote a positive client-therapist relationship. Such connection is important for desirable recovery outcomes, with participants suggesting their opinion of BA was influenced by their perceptions of the therapist. They emphasised the importance of an informal therapist who genuinely cares:

> *I could tell her [therapist] a problem about my week and she focussed on it, and it wasn't just because of the booklet it was because she actually wanted to help me'.*
>
> *(Harry)*

> *'I felt it [therapeutic relationship] was better because it was more laid back, which I liked … it wasn't just [therapist] asking me questions, me answering … it was more of a conversation'.*
>
> *(Hayley)*

This highlights how a positive client-therapist relationship can establish a comfortable space that may reduce possible client anxiety and foster deeper communication. In addition, participants valued speaking openly without receiving judgement, as evidenced by Hayley; '*Even if I said something wrong I wouldn't be judged for it … cos I feel like a lot of my life I've been kind of judged for who I might be or things I like, so just going in having someone I know wouldn't judge me for things I say was better'.* Individuals experiencing mental health difficulties often feel they cannot talk to anyone due to perceived or genuine judgement, so a BA session may provide the only opportunity to discuss their mental state. This can be very cathartic, especially when coupled with a collaborative approach to address such difficulties:

> '*I could relieve everything, get everything off my chest … say what I needed to say, but then he'd also try and help … instead of him doing what he thinks is best for me, but listening to me and doing what we both think is best for me'.*
>
> *(Charlotte).*

Such an open, non-judgemental environment facilitated deep and personal communication which provided richer insight to client's mental state, as well as contributing to strengthening the therapeutic relationship.

3.2.3 *Wider stakeholders and relationships in client's life.*

Cultivating a therapeutic relationship within BA provides opportunity to model and develop effective relationship building skills, supported by identifying activities that are positive due to interactions with others. This is valuable considering clients place within an interpersonal network of family and friends; '*I feel like a lot of my support comes from the people around me and you could see in places that if there was a low closeness to others rating, the enjoyment rating was lower as well' (Elliot).* Recognising and strengthening these connections may promote positive mental wellbeing by improving this support system and encouraging activity engagement with others. This relational development occurs through acknowledging and addressing areas of improvement within client perceptions and personality characteristics:

> '*At home I was very snappy … it's definitely changed because I think I have opened up a lot to my mum … it's kind of made me better towards her'.*
>
> *(Hayley)*

> *I used to be very critical of myself … I used to just look at myself and think what is that, but now I definitely feel a lot better knowing I have a good network of friends that I can talk to. I don't have much paranoia and my depression levels have definitely gone down.*
>
> *(Hayley)*

This exemplifies how improved interpersonal connections can serve as a protective factor to low mood, and encourage positive thought patterns that advance this. However, it may require the client to sufficiently adjust their thinking and behaviour to enable positive relationship building. Additionally, mental health stigma within peer social groups may threaten relational development, as well as engagement with therapy; '*I was in a different friend group to what I'm in now and I was picked on for my mental health and so like I couldn't have gone through*

this [therapy] because I would have been embarrassed' (Charlotte). This highlights the prominence and influence of social dynamics within an adolescent's life.

3.3 Theme 3: Development of one's self pre and post BA therapy

Developing emotional, reflective and practical skills, and how these can be applied to promote the identification and realignment of one's values, increase occupational and social engagement, and counter low mood.

3.3.1 *Application of BA techniques in one's life*

BA therapy aims to alleviate low mood through developing positive habits that embed into one's life:

> *When I used to not do anything, I'd get really bored and I became more tired because I wasn't doing anything and that's what made me feel low. I never went outside either because I didn't like it, it was just the fear of people coming up to me and stuff, and now I do more activities like going swimming and I feel better.*
>
> *(Natalie)*

This evidences how BA helps clients acknowledge the unhelpful behaviours and thought patterns that maintain low mood, which can then prompt behavioural change to improve this. Participants appeared largely able to grasp this concept; '*I'm more proactive now instead of just sitting around and expecting things to change around me, I've started doing things to make a change for the better' (Elliot).* Through developing positive thought patterns clients were equipped with a strong motivational drive that stimulated activity engagement, and established a robust protective factor to help manage low mood.

Moreover, increased activity engagement is encouraged through a focus on client values and coupling this with activities they genuinely want to do, although this may conflict with current activities: '*[I've stopped doing] the clubs I really hate and do new things. I've joined a new club which is a board game club' (Harry).* This suggests participants found BA helpful in realigning their activities with their values; supporting them to overcome associated barriers; '*Sometimes it feels like I don't wanna do it but when I actually do it, it's kind of different. It feels better when I do it and I feel enjoyment when I'm actually good at it' (Harry).* Whilst there may be motivational challenges, through activity scheduling and increased reflective practice, participants recognised the benefits of overcoming such barriers, leading to increased activity engagement and mood improvement.

3.3.2 *Psycho-education*

A key driver of such cognitive and behavioural change is the psycho-educational aspect of BA. Supported by reflexive practice, this aims to increase client's understanding of their mental health; recognition of internal and external triggers to mood deterioration; and develop emotional intelligence and low mood mitigation strategies.

> *It's easier to understand what happens when I'm dipping than why I dip; sometimes it's not just negative comments, it can be like a disappointment which then develops into something else … usually when I feel myself going into a low mood I go quiet and don't interact with other people … that's why it's important to not let yourself go quiet, start talking to people, take your mind off it, do other things.*
>
> *(Elliot)*

This exemplifies the challenge and complexity of understanding mood fluctuations, and the importance of clients recognising this in order to apply emotional management techniques that may prevent further mood deterioration. Therefore, developing this skill within BA is essential, particularly concerning adolescents who typically experience heightened and changeable emotions, and are more likely engage in harmful behaviours. Subsequently, BA teaches 'The Depression Trap' to develop understanding of low mood; a concept participants found beneficial and one that also encouraged motivation to engage with BA therapy and make behavioural changes:

> *There is a depression cycle, like if you do less you feel guilty which makes you feel more low and then because you feel low you don't wanna do anything and it repeats. Learning this helps because I didn't really understand why I was feeling that way.*
>
> *(Natalie)*

> *Once you get stuck in [The Depression Trap] it's hard to get out and you have to understand that you need to start doing things otherwise it's only going to get worse and you'll get stuck, but once you break out of it you start doing more, you can be active.*
>
> *(Elliot)*

Developing client understanding of the cognitive, emotional and behavioural factors influencing low mood exemplified how interlinked these components are, and their impact on

each other. Understanding this multi-dimensional process allows clients to better apply BA's central premise of increasingly undertaking adaptive activities which help to reduce low mood. Elliot exemplified this by compared themselves before and after; *'I asked myself what's made that change and I think it was just understanding myself better and knowing what things I do to enjoy my time'.* Whilst depressive symptoms pose a challenge, positive outcomes can occur through understanding the concept of BA, identifying one's values and intrinsic motivators, and using this to engage in related meaningful activities.

4. DISCUSSION

This innovative study provides one of the first phenomenological first-person accounts from young people accessing BA. Findings indicate the course and session structure was beneficial, providing the therapist could also offer responsive flexibility. The child-focused format and development of a positive therapeutic relationship was also important. The workbook facilitated reflexivity and consolidation between sessions, which nurtured skill development and wider social relationships. Skill development and enhanced relationships within a child's social milieu maintained the positive outcomes young people reported (Figure 1). These findings illustrate novel mechanisms of the therapeutic process and how behaviour change can influence and strengthen supportive relationships. To bring this change about requires the young person to appraise the therapist is present, non-judgemental and provides regular structure and authority. This is achieved via regular sessions and measured, creative persistence with activity scheduling. The manualised yet flexible approach to BA appeared to help most participants engage in the process.

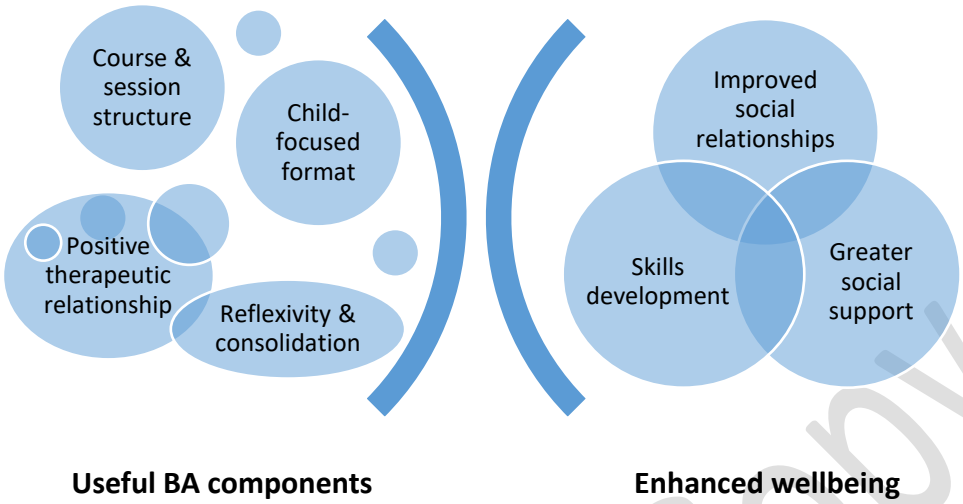

Figure 1: BA components and outcomes

On-going low mood poses serious health concerns for young people and can have detrimental, long-term implications on their academic and social functioning (National Institute of Mental Health, 1999), potentially leading to premature death (Thapar, Collishaw, Pine & Thapar, 2012). This highlights the importance of young people accessing evidence-based treatment interventions in a timely manner to prevent such detrimental outcomes. Despite this, there is a multitude of systemic complexities which can make access to appropriate interventions in a timely manner challenging. It is imperative that this is considered with a sense of urgency to prevent further health risks within the adolescent population.

BA could offer a potential opportunity to overcome such access and engagement challenges, with the current study highlighting participates highly value it's structured format and focus on cultivating therapeutic relationships. Therapist characteristics beneficial for enhancing this positive alliance when delivering manualised therapies include authenticity, measured self-disclosure, recognising the importance of values, and defining the client's own values, rather than using the values of the therapist or others in driving goal focused activities (Cassar et al., 2016). A focus on the young person's needs, abilities and desires nurtures the activity scheduling and accomplishment, promoting achievement, self-esteem and belief in the process. Moreover, the current study highlights that Assistant Psychologists are able to adhere to these characteristics and hold young people's values in mind when delivering the intervention. This

enables them to offer high quality, effective BA as a stand-alone intervention, which could have wider implications for mental health services for several reasons. Firstly, it provides a cost effective alternative to the current evidence-based interventions (CBT, IPA and family therapy) as BA does not require extensive, specialist training (Pass et al., 2018). Secondly, the ability for these evidence-based treatments to be delivered is often reliant on clinician capacity; often limited by the number of senior and specialist clinicians trained in delivering current evidence-based interventions (Richardson et al., 2010; Roberts, 2013; Goodyer et al., 2017). As BA offers a manualised approach, fidelity to the model can still be upheld and delivered via a wider range of clinicians, including those of Assistant Psychologist level or similar (Pass et al., 2018) which could help young people to access effective treatment in a timely manner. This may also improve health economics and reduce the detrimental, long-term impacts of low mood.

Despite the current study providing a novel insight into adolescent's experience of BA, qualitative research within this area remains limited. Furthermore, this study was opportunistic in sample selection and two of the qualitative researchers were also BA therapists. Given the prevalence of low mood and depression within young people and the serious health concerns it poses, it would be useful to complete further research with a randomly selected group of young people, better reflecting the ethnic diversity of the UK's youth population, including those whom discontinue BA prematurely. Nonetheless, this study offers unique qualitative data to guide and inform future research around this exciting and promising intervention.

5. CONCLUSION

Qualitative accounts of young people's experiences of BA illustrate further research is needed around implementation, treatment integrity, and mechanisms of change. A focus on attitudes to therapy is needed, particularly early in treatment when overt and more passive withdrawal needs attention to establish a therapeutic alliance (O'Keeffe et al., 2020). It may also be important to establish the readiness of parents to support their child through the process. External barriers to change are also important to explore, which is why future studies should gather in-depth individual and systemic contextual data about participants. A key finding of the current study is that providing skills training to young people and positive therapeutic relationships can positively and dynamically influence their personal resilience and wider relationships. This aspect of the BA intervention is particularly encouraging, and further study could be beneficial in terms of understanding this particular therapeutic mechanism. The

mechanisms of change and therapeutic processes in the current study provide a new foundation upon which to explore these important factors further.

6. CONTRIBUTORSHIP

Naomi Shenton and Tomos Redmond collected and analysed the interview data, and co-wrote the paper. Dr. Leo Kroll and Dr. Sarah Parry provided clinical and academic support respectively, and co-wrote the paper.

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8. DECLARATION OF CONFLICTING INTERESTS

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