AN EVALUATION OF ONLINE METHOD OF LEVELS THERAPY WITH YOUNG PEOPLE

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ABSTRACT

Background: Adolescence is an influential stage in a person's life, where they may experience significant psychological distress. Multiple youth-led reports and a youth-consulted framework (THRIVE) emphasise the importance of challenging the current diagnostic system and promoting accessible client and needs-led psychological support. Method of Levels (MoL) is a transdiagnostic, client- and needs-led therapy which appears to align with these reports and principles. Studies have not yet explored the utility of MoL with young people in 'late adolescence' (ages 16-19), or evaluated the delivery of MoL in an online videoconferencing setting.

Aims: This study aimed to explore the patterns of attendance, effectiveness, and participant experiences (i.e. acceptability, accessibility and helpfulness) of online MoL with young people in 'late adolescence.'

Methods: This study adopted a quantitative, within-subjects pretest-posttest design. Late adolescents aged 16-19 (N=25) were recruited and offered to engage with online MoL. Participants completed self-report questionnaires pre-intervention, at completion of therapy and at a one-week and four-week follow-ups. Open-text feedback questions were used to explore perceptions of the participant-led practices of online MoL. Descriptive statistics described the patterns of attendance and a Repeated Measures ANOVA tested for changes in the symptom-, process- and life-functioning-based measures. The reliable change index determined the reliability of changes in symptom-based measures. Descriptive statistics of feedback on the acceptability, accessibility, and helpfulness of online MoL were examined.

Results: Mean attendance was between 3-4 online MoL sessions. Scores on 'goal conflict reorganisation' (ROC) followed significant linear and quadratic trends over time. A statistically significant cubic trend was found for life-functioning (ORS) scores across time. The reliable change scores between pre-intervention and 1-week-follow-up suggested a moderate to high practical significance for both symptom-based measures (GAD-7 and PHQ-9). Participants reported various patient-led aspects of MoL as acceptable, accessible and helpful (e.g. control over session direction, self-scheduling, online sessions).

Discussion: Online MoL appears to be a useful intervention for older adolescents, and may provide a more efficient, accessible and helpful alternative to current disorder-focused approaches. The occurrence of changes in process- and life-functioning based measures (without significant changes in symptom-based measures) also supports discourse around shifting the current diagnostic approach to psychological distress, and calls into question how change in psychological distress is meaningfully measured in mental health.

Keywords: Transdiagnostic, Method of Levels, MoL, adolescents, young people

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1. INTRODUCTION

1.1. Chapter Overview

This chapter begins with definitions of the key terminology used, which reflects the position of the researcher. This is followed by a summary of the subject of psychological wellbeing in young people in the United Kingdom (U.K.), specifically the policies and service approaches offered and their impact on the ongoing mental wellbeing of U.K. youth. The chapter describes the need for a complete overhaul of the approach to supporting young people who experience psychological distress, in line with numerous professional and service-user reports for a needs-led rather than diagnosis-led approach. It then discusses, the possibility of a transdiagnostic approach, such as Method of Levels (MoL as potentially addressing this needs-led approach from a therapeutic perspective. Following this, it explores the possibility of utilising digital technology to provide a more accessible method of delivering therapeutic mental healthcare and proposes the utility of online MoL within this. Finally, a scoping review of the current literature is presented to underline gaps and outline a rationale for the study's aims and research questions.

1.2. Definitions and Terminology

1.2.1. Psychological Wellbeing and Distress

The current categorical nature of the diagnostic system is limited in its capacity to reliably explain human wellbeing and distress (Bentall & Beck, 2003; Kinderman et al., 2013). There is extensive evidence from decades of research to suggest that mental health exists along continua, not distinct categories (Haslam et al., 2012; Waszczuk et al., 2017). One such description of these continua is The Two Continua Model (Keyes, 2005), which is based on large scale research data from across Europe and the US. It describes psychological wellbeing (or 'mental health') and distress as two distinct but interconnected constructs, each of which exist on a spectrum from low to high. An individual can fluidly move around these continua, depending on the level of both wellbeing and distress they experience (Payton, 2009).

1.2.1.1. *Psychological Distress:* In line with this conceptualisation (Keyes, 2005), distress will not be thought of in terms of clinical (or non-clinical) classifications, and the terminology used below aligns with the non-pathologising position taken towards mental health. As much of the recent literature on mental health uses diagnostic or pathology-based language, where references are made to such literature, this language will appear in quotation marks.

1.2.1.2. *Psychological Wellbeing and Mental Health*: Some medical models previously considered mental health as the 'absence' of illness or disorder (Ozarin, 1970), but mental health is, in fact, a complete state of wellbeing (CDC, 2021; Faculty of Public Health, 2022; Keyes, 2005). 'Mental health' is a commonly used term in the public arena which encompasses one's psychological, emotional and social wellbeing (Keyes, 2006, 2014). It covers how one might think, feel or behave. Individuals might experience periods of time where their psychological, emotional or social wellbeing (and, therefore, their mental health) are impacted, but that does not imply the presence of an 'illness.' Similarly, individuals who have been ascribed diagnostic labels are not permanently in a state of 'illness' (as medical models may suggest), but also experience periods where these three aspects of their wellbeing are positively influenced by events or circumstances. Forcing wellbeing into a categorical dichotomy can mischaracterise and pathologise the ever-shifting nature of mental health. This new way of understanding wellbeing encourages a shift away from a pathological, symptom-based approach towards a more holistic understanding of the quality of one's life (Connell et al., 2014).

This thesis will specifically use the terms 'mental health' or 'psychological wellbeing' to encompass the dynamic quality of the mental health spectrum. The terms 'psychological wellbeing' and 'mental health' are often used interchangeably in mental health research, and will similarly be used interchangeably in this thesis.

1.2.2. Young People

There are a variety of ways to describe "the phase of life between childhood and adulthood," known as 'adolescence' (World Health Organization, 2021a). Global cultures may understand this process differently, but this transformation is frequently recognised across cultures in some form. Western approaches describe adolescence as a sequence of transformative events, often influenced by biological, psychological, social, historical and cultural factors, meaning it is a flexible concept that adapts both its definition between and within cultures and circumstances (Crockett, 1997; Curtis, 2015; Graber & Brooks-Gunn, 1996).

Some research notes that adolescence can extend up until around age 24 or 25 (National Academies of Sciences, Engineering, and Medicine et al., 2019; Sawyer et al., 2012). The World Health Organisation (WHO) (World Health Organization, 2021a) as well as the U.K. government (Davies, 2013) define 'adolescents' as individuals aged 10-19 years. In research this is generally divided into distinct categories, including 'early adolescence' (age 10-14), 'late adolescence' (ages 15 or 16-19) and 'young adulthood' (ages 20-24) (Sawyer et al., 2012; World Health Organization, 2001).

However, much of the content and literature included in this thesis is based on Western concepts of adolescence, meaning that this is but one viewpoint amongst many perspectives on the topic. The research was conducted in the U.K., and although the 'British adolescent' experience is rich and diverse, the cultural context within which many British young people live is strongly influenced by Western ideas. Acknowledging this, the critical realist epistemological stance of this research guides the assumption that this is but one understanding of this age group, and that there may exist other relevant perspectives on this subject.

To discuss the research from a position of inclusivity, whilst acknowledging the cultural limitations that arise with the specific terminology mentioned previously, the term 'young people' (which can refer to people aged anywhere between 10-24 years (World Health Organization, 2001)) will be used throughout this thesis.

1.2.3. Transdiagnostic

In the context of mental health, the term 'transdiagnostic' implies the existence or application of a concept/mechanism across diagnostic categories. For instance, it could be used to describe underlying processes which occur across current 'disorder-specific classifications' or an intervention which can be applied across 'diagnostic categories' (Carey, 2008b; Dalgleish et al., 2020). It may seem contrary to use this term, given the stance of the researcher around mental health as existing on continua rather than in categories. However, this term is most widely used in the context of the current diagnostic system and the hope is that the current system for understanding mental health will eventually move towards an adiagnostic model, which would dispense of the categorical approach to mental health entirely. Instead, psychological wellbeing and distress could then be understood as existing on a fluid spectrum. This would mean that there would be no ‘clinical cut-offs’ to distress, but rather ‘volumes’ of distress, or degrees to which an event bothered or impacted an individual (Dalgleish et al., 2020; Mansell et al., 2012). However, to reflect the current state of the literature, and given the current pervasive nature of the diagnostic model, the term ‘transdiagnostic’ will be used throughout this thesis.

1.3. Mental Health and Young People

1.3.1. Context

In England in 2020, one in six (16.0%) 5-to-16-year-olds was recognised as having a “probable mental disorder” (Vizard et al., 2020). This is an increase from one in nine (10.8%) in 2017. These figures are also significantly higher for older adolescents (17-to-22-year-olds), with 27.2% of young women and 13.3% of young men being identified as having a “probable mental health disorder” (Vizard et al., 2020). Globally, figures show approximately one in seven 10-19-year-olds (14%) as having experienced a “mental health disorder” (World Health Organization, 2021b).

Psychological distress can be particularly significant in adolescence, as this is a stage when young people are not only going through hormonal and neuroanatomical changes due to puberty (Goddings et al., 2014), but also changes in their social environment. During their teenage years, Western adolescents seek greater independence, explore their identity and sexuality (whilst balancing the pressure to conform) and are exposed to social media at unprecedented rates (Borschmann & Patton, 2018; Kehoe et al., 2014; World Health Organization, 2021b). These changes, when accompanied by exposure to violence, parental psychological distress, socio-economic disadvantage or physical/psychological/sexual abuse can further increase psychological distress, and make accessing coping strategies more challenging (Blakemore, 2019).

1.3.2. Impact of Psychological Distress on Young People

Late adolescence is distinct from the earlier stages of adolescent development in that it is a point in a young person's life where they transition towards independence and adulthood (Sawyer et al., 2012). It is a stage where psychological distress occurs more frequently (Davies, 2014) in conjunction with the development of their self-identity and increased capacity for abstract thoughts and goal-setting (Sawyer et al., 2012).

Psychological distress can impact young people in several important areas of their life: social, academic and emotional domains.

Peer relationships are of heightened salience during adolescence (Long et al., 2020), and some research suggests that young people who experience psychological distress have significantly fewer friends (Scharfstein et al., 2011), or potentially withdraw from peers altogether (Pachucki et al., 2015; Schaefer et al., 2011). They can be rejected or victimised by peers (Kingery et al., 2010; Milledge et al., 2019), which could exacerbate already existing distress or become the cause of their distress.

A similar cycle occurs with young people and their parent/guardian relationships. Young people who experience more psychological distress may have more strained relationships with their parents/guardians (Maurizi et al., 2012), and where parent/guardian-child attachments experience challenges, young people find it more difficult to manage their psychological distress on their own (Crandall et al., 2020). Without peers or guardians to provide or model helpful coping strategies, young people are left with limited support to manage their distress.

Adolescence is also a key stage where academic achievement is linked with important life decisions. 96% of young people report that their schoolwork is impacted by their mental health (Mind UK, 2021b). With accounts of their experiences of distress being invalidated or disciplined, and reports of racism in school severely impacting their mental health (Mind UK, 2021b), young people are developing a mistrust for a system that is supposed to support them. Not only then are young people absenting from class, but some are even then excluded (Mind UK, 2021b). How are young people supposed to academically thrive if their psychological wellbeing is not being supported?

Finally, perhaps the most commonly reported area impacted by psychological distress, is young people’s emotional wellbeing. Recent statistics (Mind UK, 2021a) suggest that almost half the 17-19-year-old informants with a “diagnosable mental health disorder” had self-harmed or attempted suicide at some stage in their lives. Without adequate support, young people feel expected to navigate their distress alone, which may lead to inadequate coping strategies that last long into adulthood (Clarke & Lovewell, 2021). Young people are seeking out support to navigate their distress and identity from the adults around them, but may feel they are not surrounded by systems that provide them with what they need.

Young people in U.K. exist within a Westernised context that dictates much of their choices and rights throughout this developmental phase until they reach ‘adulthood.’ The systematic assertion of this adult authority coupled with oppressive White Western ‘British’ values then adds another obstacle to minoritised groups who are already struggling to navigate their identity within society. In a period of time where they are already trying to make sense of the world, these oppressive practices impact young people’s mental health and disempower them from seeking appropriate support.

Waiting until they reach ‘adulthood’ should not be idealised as the solution to empowering young people to seek additional mental health support. Multiple reports indicate that the transition from young people’s mental health services to adult mental health services in the U.K. has been imperfect (Khan, 2016). Young people can receive less or entirely lose much needed support at a time when they are more psychologically distressed and less likely to seek help (McGorry et al., 2013). Leaving young people to simply ‘age out’ of mental health services is a dangerous and unempathetic approach, which risks neglecting a significant proportion of the population. Early intervention to prevent this potential harm and help mediate the distress of young people is imperative on a national scale.

1.4. A Timeline of British Policies for Young People Seeking Mental Health Support

1.4.1. Past Policies

Since the announcement of the ‘No Health Without Mental Health’ Strategy (HM Government & Department of Health, 2011) almost a decade ago, the respective governments (in conjunction with NHS leadership) produced a series of documents and policies outlining their plans for mental health support in the U.K. The primary aims were to enhance the mental health service offer and to also ensure that the pathways to these services were more efficient and effective.

To tailor to the needs of young people, a five-year plan was created called ‘Future in Mind’ (Department of Health & NHS England, 2015). The report contained recommendations for transforming services around the themes like “Promoting resilience, prevention and early intervention” and “Improving access to effective support.” The ‘Five Year Forward View for Mental Health’ plan then outlined priority actions (Mental Health Taskforce, 2016), particularly focusing on early and efficient access to mental health support for at least 70,000 young people, a reduction in waiting times (and support whilst waiting), and confronting the inequalities faced when accessing care.

When the 2020/21 deadline was fast approaching, the NHS Long Term Plan (NHS England, 2019c) reported a 5.5% increase in mental health support services between 2015/16 and 2017/18 (NHS England, 2019b), and committed funding to support an additional 345,000 young people under 25 by 2023/24. However, with a National Audit Office (NAO) report (2018) concluding that the transformation could only be realistically “rolled out to 20-25% of the country by 2023” (Parkin & Long, 2021), the British public were reminded yet again of the inadequate prioritisation of young people’s mental health.

1.4.2. Current Provisions for Young People Seeking Mental Health Support

With a decade-long journey now reaching its proposed final phase, and a recent NHS Long Term Plan (NHS England, 2019c) seeking to further shift the deadlines for supporting young people (describing it more palatably as ‘determining a more realistic approach'), it is important to understand how mental health services currently support young people.

Following NICE guidelines pathways for various diagnoses, young people are offered manualised cognitive-behavioural therapy (CBT) at almost all tiers of service, and either family-based therapies or individual psychotherapy if their needs are not met by CBT (NICE, 2019, 2021).

NHS England (2019a) reported that their community services provided these interventions to over 420,000 young people with a "diagnosable mental health condition" in 2020/21, which is beyond their target of 35%. However, recent evaluations of these services seem to provide a more striking picture.

It was found that getting suitable and timely care can be a struggle for young people experiencing psychological distress (CQC, 2017). A consultation with young service users (CQC, 2018) found that the most challenging aspects of engagement with mental health services were "excessively restrictive eligibility criteria," "gaps in the availability of services" and "long waiting lists." Thirty-nine percent of specialist community CAMHS were rated as "requires improvement" and 2% were rated as "inadequate" when considering waiting times standards (CQC, 2017; Parkin & Long, 2021). Alongside this, child and adolescent dropout rates average around 45% (de Haan et al., 2013).

Clearly what is currently being offered to young people is insufficient and needs a radical re-evaluation. Young people have repeatedly asserted where the problems are in their mental health service provision, and yet their recommendations are being implemented "to varying degrees" (CQC, 2020). The restrictive gatekeeping of mental health support in schools and other charities (Lally, 2020), has meant that waiting times for CAMHS have increased and young people's mental health has worsened whilst on these long waiting lists (YoungMinds, 2018). The COVID-19 pandemic has only exacerbated these challenges, with the prevalence of 'high psychological distress' significantly increasing (Vizard et al., 2020) and reports that 7.4% of young people having attempted suicide by age 17 (Patalay & Fitzsimons, 2020). Young people can no longer rely on specialist services with long waiting lists and extensive changes need to be made .

1.5. Difficulties with the Current Classification of Psychological Distress experienced by Young People

The current system of mental health for young people relies on a model of tiers, which is based on diagnosis and severity. Current approaches to psychological therapy rely on diagnostic templates, which is problematic given the low validity of diagnoses as separate constructed entities (with distinctive severity categories) (Bentall & Beck, 2003; Boyle, 2014), and the low reliability of diagnosis (and severity) between clinicians (Bentall & Beck, 2003; Boyle, 2014). This stigmatising and flawed strategy not only drives the allocation of interventions based on diagnosis and severity, but also homogenises individuals within a diagnostic category as having the same needs (Boyle, 2007). In order to streamline interventions, evidence-based therapies are often manualised based on this homogenisation. Manualising these mental health interventions may mean they lack the flexibility in their engagement and delivery (Ehrenreich, 2021). This critique remains true of child and adolescent services (Hoagwood et al., 2001), with young people reporting that they find services with this approach to be “impersonal, frustrating and often confusing” (The Children’s Society, 2020).

Engaging with young people in a problem-specific manner might not appropriately reflect the reality of what they are experiencing, as up to 75% of young people with an “emotional disorder” diagnosis have concurrent “comorbid diagnosis” (Arcelus & Vostanis, 2005; Ehrenreich, 2021; Ford et al., 2003), some of which co-occur over time. As such, taking a problem-specific approach may not best fit the mental health needs of young people.

1.6. Moving Towards Personalising Mental Health Care for Young People

Diagnosis-based interventions have been criticised by young people for many years, with several reports emphasising a desire for flexible and personalised care where they are involved in the decision making (CQC, 2018). Staff reports also describe more effective care where young peoples' needs and preferences are met (CQC, 2018).

Beyond individual intervention, calls have been made to abandon the diagnosis-and-severity-led tiered model of care as a whole, as the high threshold criteria for certain tiers has been a significant barrier to receiving much needed care (Department of Health & NHS England, 2015). This also creates stigma around who is 'worthy' of timely mental health support, and the current system reflects the notion that only those who are 'at-risk' require care, whilst those who require early intervention may be overlooked (CQC, 2017).

The recent NHS Long Term Plan (NHS England, 2019c) supports this move away from tiered healthcare pathways and endorses a needs-led model for young people aged 0-25 (and their families) called the THRIVE framework (Wolpert et al., 2019). The THRIVE framework (Wolpert et al., 2019) is a set of principles designed to guide local systems (e.g. health, education, social care and other third sector organisations) on how to develop and/or reform their current mental health and wellbeing services so that they become more "coherent and resource-efficient" for local communities. Some of the THRIVE framework's many principles include having a common language, being needs-led and ensuring shared decision making and accessibility. This needs-led framework is understood as a system where "mental health needs are defined by children, young people and families alongside professionals through shared decision making. Needs are not based on severity, diagnosis or health care pathways" (Wolpert et al., 2019).

The THRIVE framework divides children, young people and families into four needs-based groups: (1) "Getting advice" (for signposting and advice), (2) "Getting Help" (for those who require goals-based support), (3) "Getting More Help" (where more intensive or specialist goals-based support is required) and (4) "Getting Risk Support" (where prior support has been insufficient, and a level of risk remains that requires support).

To truly steer away from ineffective diagnosis-led support and understand how best to implement a needs-led approach, mental health services need to rethink how they understand young people’s experiences of psychological distress. One such approach in the literature is the concept of a ‘transdiagnostic approach.’

1.7. A Transdiagnostic Approach

As explained in section 1.2.3., transdiagnostic theory seeks to dispense with current diagnostic accounts of psychological distress and reconceptualise mental health (Dalgleish et al., 2020). There are a number of limitations with the diagnostic paradigm that have been identified in the literature including, but not limited to, the high comorbidity rates between various diagnoses, heterogeneity within diagnostic labels and the lack of explanation for ‘anomalous’ symptoms (Dalgleish et al., 2020). As such, there is increasing support for a transdiagnostic approach which cuts across current diagnostic categories (or, in the case of adiagnostic approaches, dispenses with them altogether). Transcending taxonomic distinctions allows for new theories of mental health to emerge, thereby redefining what it means to provide interventions for psychological distress. In light of these limitations, the current research understands mental health as existing on a continuum rather than in discrete categories (Haslam et al., 2012; Keyes, 2005; Waszczuk et al., 2017) (see section 1.2.1.).

There have been a variety of attempts to explain the transdiagnostic processes underpinning psychological distress over time (e.g. early broadly transdiagnostic forms of psychoanalysis focusing on ‘neurotic conflicts’), and one strand of transdiagnostic research suggests that all psychological distress is, in fact, underpinned by a common cognitive and behavioural process or processes (Mansell et al., 2008; Patel et al., 2015). Within this strand, there have been a variety of attempts to name these underlying processes, such as ‘cognitive emotion regulation’ (Aldao & Nolen-Hoeksema, 2010), ‘emotion dysregulation’ (Shields et al., 2016) or ‘negative affect’ (Ellard et al., 2010). Over twenty different cognitive and behavioural processes have been identified as potentially transdiagnostic, but there is evidence to suggest that they may not significantly differ from one another and that they likely overlap (Mansell et al., 2012). Focusing on this overlap may provide a more parsimonious narrative of psychological distress. One such way of conceptualising this overlapping ‘core’ mechanism is through Perceptual Control Theory (PCT)

(Powers et al., 1960). Due to the vast amount of evidence in the literature, spanning decades of research (Mansell & Carey, 2015; Marken, 1986; Marken & Mansell, 2013; Powers, 1973; Vancouver, 2005), and the way in which it unites the various transdiagnostic processes, the current research focuses on PCT (Powers et al., 1960).

1.7.1. Perceptual Control Theory (PCT)

PCT is an empirical model of behaviour that suggests that control is key to understanding the behaviour of all living organisms (Powers et al., 1960). It centres around three elements: control, conflict and reorganisation.

1.7.1.1. *Control*: People are 'typically functioning' when they are in control of their desired goals, known as 'preferred states' (Mansell et al., 2012; Powers, 1973, 2005). This state of control is attained via a negative feedback loop: individuals explore and understand their current situation, compare them to what their ideal circumstances would look like ('preferred state') and adjust their behaviour to actualise this preferred state (Carey et al., 2015; Carey & Mullan, 2008).

Individuals are required to control various goals simultaneously, which are ordered in a perceptual hierarchy. Center (2006) proposed that there are 11 levels to this hierarchy, which are controlled by the human mind. The lowest levels are understood to be what a person becomes aware of or pays attention to in the present moment when changes in a person's goals are made (de Hullu, 2020). This includes, for example, the quality of a texture or arrangement of patterns on a football. As a person progresses up levels, they can then understand (and change) the linear causal relationship between actions or events, where higher up levels reflect more integrated experiences of causality rather than isolated ones (de Hullu, 2020). This can include recognising that someone is crying because they lost something, or recognising a sequence of musical notes as a particular song. At the highest levels, complex emotions tend to occur (e.g. love and hate) as a person experiences their sense of self and their consciousness (de Hullu, 2020). This can involve following a plan, having values (e.g. "Do not harm others") or having beliefs about ourselves and the world (e.g. "I am a good person."). By controlling and adjusting various levels of this hierarchy, people can then experience the world as they'd like it to be. This is considered key to feeling satisfied with day-to-day life (Carey et al., 2015).

1.7.1.2. *Conflict:* If one's current experience is incompatible with their 'preferred state' (i.e. ideal way they would like their circumstances to be), it is described as an 'error,' and the control system then seeks to reduce this (Carey et al., 2012). Conflict occurs when a person attempts to work towards multiple incompatible goals, meaning a 'preferred state' is unattainable. According to Carey et al. (2015), this leads to a loss of control, resulting in psychological distress. Some conflicts might be simple to resolve (e.g. choosing between ice cream flavours), but others (e.g. conflicts around a desired lifestyle) can lead to a sense of 'immobility.' People might frequently go back and forth between their options due to the potential consequences of each. One example (Carey et al., 2015) could be that someone might choose to isolate or distance themselves from others in order to feel safe, but may also desire the sense of connection and acceptance that comes with socialisation. Young people might want social approval from peers or parents, whilst another part of them seeks independence or autonomy. These types of conflicts might create an ongoing sense of psychological distress; constantly feeling stuck "between a rock and a hard place" or wanting to "have your cake and eat it too."

1.7.1.3. *Reorganisation:* Reorganisation is the flexible learning mechanism that supports individuals to resolve their conflicts. Individuals focus their awareness on this loss of control for an extended period of time (Tai, 2016). This provides the opportunity to randomly generate various solutions, until the best possible balance of goals is found, which minimises error and maximises control (Tai, 2016). As the system is neutral and non-judgmental, there is no 'right or wrong' to this reorganising system, and the process takes place in a 'trial and error' fashion (Mansell et al., 2012).

This framework could be a useful tool to understand psychological distress in young people (Marken & Mansell, 2013). Young people function best when important elements of their life are in their control, and when they are psychologically and physically well equipped to manage conflicts that occur (Churchman, Mansell, Al-Nufoury, et al., 2019). However, just as people aren't born with values and beliefs, neither are they born with strategies to manage their mood. They build on these as they develop and experience life. Young people go through developmental stages which shape how they interact with the world around them. The process of reorganisation, particularly in the context of managing conflict, is no different and is also fine-tuned over time. Consider, for a moment, a young person who is learning to ride a bike. If their ‘trial and error’ learning process is too slow, they may become frustrated and give up too quickly and they may not give themselves the time to learn which option is best to keep them upright and balanced in cycling. However, with the right supportive mentor and conditions, the young person might find the balance between persisting when things are difficult or slowing down to make effective changes.

In considering psychological distress, should reorganisation occur too slowly, a young person might experience frustration, low mood and potentially a ‘stuckness.’ However, if this process occurs too quickly, the young person might not allow themselves the opportunity to experience a change in their wellbeing before moving onto another strategy (some authors note that experiences of psychosis could be one such example of more rapid reorganisation (Carey et al., 2015; Mansell et al., 2012)). Powers (1973, 2005) argues that individuals have an optimum range for reorganisation. Just as we support young people to make important judgments in their academic learning, so too should young people be provided the framework for managing their psychological distress. Therapy might provide the optimum conditions for reorganisation, homeostatically supporting individuals experiencing psychological distress to adjust their awareness and consider solutions at different levels of the hierarchy which might resolve their conflict.

1.8. The Method of Levels (MoL)

1.8.1. MoL: A Transdiagnostic Intervention

Studies have shown that various psychological interventions appear to have equivalent outcomes (Stiles et al., 2008) and many contain similar and effective strategies across various “diagnostic categories” (Ehrenreich, 2021). This may indicate that there are key transdiagnostic therapeutic elements that facilitate successful therapy across experiences of psychological distress. One such transdiagnostic therapy that applies this logic is Method of Levels (MoL; Carey, 2006).

MoL is a transdiagnostic (and adiagnostic) psychological intervention informed by the principles of PCT and, as such, aims to facilitate the process of understanding one's goals and increasing conflict awareness, in order to regain flexible control through reorganisation (Carey, 2006). These goals are facilitated by 'moving up' or 'moving down' the levels of the perceptual hierarchy (see 1.7.1.) and making changes at these levels. 'Lower level' goals would include more practical aspects of 'how' an individual might like things to be or what actions could be taken (e.g. offering to help someone with their bags), whilst 'higher level' goals involve the more conceptual, like 'why' they might want things to be a particular way (e.g. having the value of 'being kind to others') (Tai, 2016).

MoL accomplishes this through the use of a curious questioning style, by focusing on the experiences of the client as they describe them and by avoiding the use of any interpretations, judgments, diagnoses, or advice (Carey, 2006). The therapist can fulfil this by following the two main objectives of MoL (Mansell et al., 2012):

(1) To support the client to focus on the difficulty causing them distress. This can be done by asking questions like: 'Could you tell me more about X?', 'What is it about X that bothers you?' or 'What is most important about X?'

(2) To direct the client's attention to any background thoughts (known as 'disruptions') in order to examine them further. Typically, this is understood to occur during a verbal or non-verbal pause/shift in the client's communication (e.g. change of tone, smile, sudden gestures). These pauses or shifts may point to the client becoming more aware of higher order goals. Examples of questions that support clients to verbalise this shift include: 'What were you thinking about when you paused just then?', or 'What made you just smile just then?' (Carey, 2008a; Carey et al., 2015). By shifting the client's consciousness to this higher level of perception through the discussion of these disruptions (i.e. 'going up levels'), they may become aware of the origins of their conflicts (Carey, 2006). Continued awareness of the origin of the conflict may then enable the reorganisation process (Tai, 2016).

MoL also has some additional distinct practices about how it engages with its clients. Following the principles of PCT, clients are characterised as ‘control systems’ who are ‘stuck,’ not as patients who are ‘sick’ (Carey, 2006). Alongside this, reorganisation is not a process that occurs within a predictable time frame or linearly (Carey, 2006). Therefore, clients are understood as knowing best when they require support, as well as when they have had sufficient care. As such, clients are sometimes encouraged to arrange their own therapy delivery, and MoL therapists are required to create a flexible booking schedule whereby clients can book appointments according to their need, rather than following a rigid attendance schedule (Carey, 2006). Clients are also able to determine the pace at which they want to take sessions, when they would like to end a session and when they feel they would like to end therapy altogether following an adequate number of sessions for them (Carey, 2006).

MoL prides itself not on purporting to be ‘distinct’ from other therapies, but instead describes itself as an intervention that is a distilled version of mechanisms common to CBT, successful therapy and natural recovery (Carey, 2006). It calls into question the notion of ‘disorder-specific’ techniques and of the therapist as the ‘expert,’ and argues that effective therapy is based on the aforementioned common underlying principles (Carey, 2009). In fact, MoL can be facilitated by anyone with the appropriate MoL training. However, a principle-based intervention such as MoL may differ when translating theory to practice.

1.8.2. The Evidence Base for MoL

A number of early reviews (Carey, 2008b) provide evidence for the feasibility of MoL with various adult populations, with significant changes in psychological distress.

A preliminary case study by Carey (2001), reported a significant reduction in scores on measures of low mood and anxiety following four appointments of MoL, a trend which continued even at a 10-week follow-up. This then led to a larger study (n=98) in NHS Scotland, which saw a significant decrease in measures of psychological distress in clients who attended between 1 and 23 MoL sessions (median = 4) (Carey, 2005).

Carey and Mullan (2008) saw a similar decreases in scores on measures of distress when MoL sessions were delivered to clients at an urban GP practice, and noticed there was no significant relationship between the amount of sessions attended and the proportion of change in scores of depression and anxiety (Carey & Mullan, 2008). The researchers then expanded their approach (Carey et al., 2009) to include individuals from primary and secondary care services (n=120). Although they similarly noticed a decrease in scores on measures of low mood, anxiety and distress following MoL, the amount of change in these scores was, this time, related to the number of sessions attended.

MoL's client-led booking system (Carey et al., 2013) has also been shown to be equally effective, but significantly more efficient compared to traditional appointment-booking methods in secondary care services, with low levels of DNAs or cancellations. Although client-led booking systems can be used with any intervention (and MoL can also be delivered without using a client-led booking approach), this method fits particularly well with the underlying MoL principles of being 'client-led' (Mansell et al., 2012).

With this early evidence of the success of MoL, further studies went on to explore its effectiveness through a number of feasibility studies.

Griffiths et al.'s (2019) study met targets for both recruitment (at least 36 participants) and retention (>80% participant retention) for the feasibility of MoL as an intervention for individuals experiencing first-episode psychosis. Participant feedback suggested that MoL was acceptable (measured by the fact that none of the participants left because MoL was 'not meeting their needs') and that participants receiving both MoL and 'treatment as usual' reported positive experiences. Participants reported that the most helpful aspects of the intervention were 'feeling in control over their therapy,' 'being able to discuss and consider a variety of different experiences of psychological distress,' and 'the process of understanding their distress from new perspectives.' These findings indicated that a larger scale pilot study could be run (R. Griffiths et al., 2019). Another feasibility study conducted in an acute inpatient mental health setting (Jenkins et al., 2020), found that participants similarly described MoL as both acceptable (i.e. they ‘gained something’ and found the sessions ‘meaningful’) and helpful (i.e. they appreciated the ‘opportunity to reflect’ and ‘generate new approaches to their problems’).

A recent time-limited feasibility study by Bird, Tai, Hamilton and Mansell (2020) (n=55) comparing MoL to ‘treatment as usual’ in a primary care service, showed promising results with a medium effect size (on measures of anxiety (d=.69) and low mood (d=.65)) for individuals who engaged with the MoL intervention.

It is important to acknowledge that these studies have all been conducted in adult populations. Evidence for the utility of MoL with young people has only emerged more recently (Churchman et al., 2021; Churchman, Mansell, & Tai, 2019). Churchman et al. (2019) found medium to large effect sizes regarding MoL’s effectiveness in improving the wellbeing of 16 young people (aged 11-16). In their follow-up interviews (Churchman, Mansell, Al-Nufoury, et al., 2019), participants valued being given control over booking sessions, the session focus, and ending therapy. These are distinctive features of MoL, and were a significant part of its acceptability.

Although still early in its research process, these positive findings are encouraging. This shows that MoL could be a very promising intervention for young people.

1.8.3. Potential Benefits of MoL for Young People

Utilising a transdiagnostic approach like MoL could be beneficial not only in terms of fulfilling the aims of service provision set by the NHS Long Term Plan (NHS England, 2019c), but could also finally provide a young-person-led intervention which fulfils their personal needs alongside the principles of the THRIVE framework (Wolpert et al., 2019) (a model endorsed by the proposed NHS Long Term Plan (NHS England, 2019c)) (see section 1.6.).

1.8.3.1. *Reducing Stigma:* Diagnostic categories have been criticised for creating “divisions between [what is considered] ‘normal’ and ‘abnormal’” and, therefore, “hinder[ing our] understanding of behaviour and experience” (Boyle, 2007). Young people already grapple with these fears of being stigmatised as ‘abnormal’ and ostracised due to mental health diagnoses, and it can prevent them from accessing much needed care (CQC, 2017). So the THRIVE framework (Wolpert et al., 2019) highlights the importance of a needs-led (not diagnosis-led) approach whereby young people define what their mental health needs are and where they need support (Wolpert et al., 2019). MoL aligns well with this principle as it does not take the expert position and assume what young people need or how they define their psychological distress (Carey, 2009). It provides support on an individualised basis, rather than in a diagnosis-led manner. This would present young people with choices around how they understand their experiences, allowing them to feel listened to, less stigmatised, and therefore more invested in engaging with services and following plans for their care (CQC, 2018).

1.8.3.2. *Wider Provision of Psychological Therapies:* In the current diagnostic-pathway-led system, individuals who do not meet the threshold for care (or whose distress falls between the strict criteria of services) tend to fall by the wayside (CQC, 2017). By nature of taking a needs-led approach, communities would also see a wider provision of psychological therapies. An intervention like MoL, which does not require a diagnosis for referral, could provide transdiagnostic care to individuals who might not otherwise be eligible. This fits well into the “Getting Help” or “Getting More Help” categories of the needs-led THRIVE framework (Wolpert et al., 2019), in particular as it would provide support for every young person who requires support, regardless of ‘thresholds.’

It would require a significant reconstruction of the current mental health system for young people, from diagnosis-led care pathways to the needs-led THRIVE framework. It would also be a significant challenge to achieve this overhaul whilst managing the long lists of young people currently waiting to be seen.

1.8.3.3. *Heterogeneity and Comorbidity:* A recent NHS survey (Sadler et al., 2018) reported that one in seven young people aged 11-19 had at least one “mental health disorder” in 2017, and a follow-up report indicated that this number may have since increased (Vizard et al., 2020). Similar statistics have also appeared across the world (Australian Institute of Health and Welfare, 2020; Jörns-Presentati et al., 2021; Kovess-Masfety et al., 2016; Whitney & Peterson, 2019) where an increased number of young people with overlapping/multiple “mental health diagnoses” has been reported. MoL might be beneficial where comorbidity or heterogeneity of experiences of psychological distress occur as it focuses on alleviating the underlying distress rather than specific diagnostic symptoms (Mansell et al., 2008). Rather than deliver successive courses of therapy that target one individual ‘disorder’ at a time, MoL could provide one inclusive and comprehensive intervention for varying experiences of psychological distress in a timely manner. This would be more cost-effective, and also less distressing than subjecting young people to consecutive forms of therapy.

1.8.3.4. *Efficiency in Cost and Provision of Service:* Alongside this, MoL is also efficient in other areas. In order to provide therapy in current diagnosis-led services, clinicians are required to be trained in a variety of disorder-specific interventions, a burden on precious funding, time and energy (Addis et al., 1999; Barlow et al., 2020). Training clinicians in a single transdiagnostic intervention is far more efficient, as the protocols are identical irrespective of the client’s difficulty (Carey, 2006). This could also reduce both the teaching time away from services and the funding allocated to training and manuals. It could also mean supervision and therapy protocols would be more accessible across services (Hollon et al., 2002). As well as this, the scheduling system of MoL (where clients have control over booking their appointments) has been shown to significantly reduce the number of cancellations, allowing service resources to be used more efficiently, and it appears that clients appreciate this autonomy (Carey et al., 2013; Carey & Mullan, 2008).

1.8.3.5. *Client-Led and Person-Centred Care:* Therapeutic change has been highly associated with a ‘transformation of the self to become more confident’ and ‘autonomy when problem-solving’ (Donald et al., 2014). Similarly, research has shown the importance of allowing young people to guide the direction of therapy to what feels most appropriate for their self-growth and developmental stage, and to support them in upskilling themselves to better manage their distress (Carey & Oxman, 2007). In fact, in recent CQC investigations, young people in the U.K. have verified the importance of this themselves (CQC, 2018). This approach to therapy is known as ‘client-led’ and ‘person-centred’ interventions (Wolpert et al., 2019).

MoL could be considered a valuable intervention for young people which aligns with the principles proposed by the THRIVE model (Wolpert et al., 2019), as it embodies the ‘client-led’ and ‘person-centred’ practice. Young people’s therapy attendance is often dictated by outside sources, like parents or teachers (Fazel et al., 2014; Hanley et al., 2017), which has been shown to have a detrimental impact on the effectiveness of therapy (Carey & Oxman, 2007). In MoL, people choose the frequency and duration of their therapy appointments through an appointment booking system (R. Griffiths et al., 2019), which could give young people greater control over the psychological care they receive. During MoL, people also choose the focus and direction of the therapeutic discussion (R. Griffiths et al., 2019), which provides young people with a voice in making decisions about their care and tailoring therapy to their specific needs. These choices are often offered to young people as the ‘exception’ rather than the rule, despite young people and staff saying how beneficial choice can be for engagement and recovery (CQC, 2017, 2018).

1.8.3.6. *Applications for Marginalised and Minoritised Groups:* It should be acknowledged again that young people in Britain are not a homogenous group (see sections 1.2.2. and 1.3.2.). Due to systemic racism and classism, young people from marginalised and minority groups experience psychological distress at higher rates than others, and are often less represented in mental health services in the U.K. (Ayo et al., 2019). Young people are frequently offered protocolised interventions based on western values and priorities, leaving little in the way of individualised care which accounts for cultural and social narratives.

The client-led nature of MoL means that as people ‘move up levels’ they are actively encouraged to engage with their social and cultural ‘stories’ and incorporate them into their sessions (McClelland & Mansell, 2019). By examining the roles and values assigned to themselves and those in their social and cultural group, young people can reorganise how they perceive a given situation and retell these stories in more meaningful ways compared to the dominant narrative. Due to the flexible nature of MoL (which allows for a lot or little detail to be revealed to the therapist), if young people were concerned about stigma, they would also be able to talk about these difficult issues without having to specifically name them. For example, a young person from a minority ethnic background might be encouraged to consider how some systemically racist narratives in wider society may influence how they see themselves, rather than accepting that these narratives are inherent to who they are as a person. However, to achieve this, they would not have to specifically name these societal biases to the therapist, but could talk about them in abstract form if they felt more comfortable. To reflect the importance of incorporating social and cultural narratives into MoL practice, MoL has been delivered with individuals from a variety of different cultural backgrounds in many different languages (Grzegrzolka & Mansell, 2021; Mansell, 2018; Mansell et al., 2016). Similarly, MoL has also been delivered to marginalised groups in rural areas with limited access to mainstream mental healthcare (Carey et al., 2013).

Overall, the client-directed nature and transdiagnostic approach of MoL makes it a suitable approach for actualising the principles of the THRIVE framework (Wolpert et al., 2019) and reflects the desires of numerous other reports of what young people need in mental healthcare (CQC, 2017, 2018). Therefore, consideration should be given to its accessibility.

1.8.4. How can MoL be Made More Accessible for Young People?

Another principle of the THRIVE framework is accessibility. For years prior to the pandemic young people have been asking for flexible models of care to increase access to mental health support (CQC, 2018; Healthwatch Northumberland, 2018). In fact, the 2018 CQC report even recommended that young people's mental health services introduce online therapy sessions to reduce the travel- and stigma-related barriers young people face when seeking mental health support (CQC, 2018). However, it was not until the COVID-19 pandemic that accessibility to mental healthcare became a more pressing matter.

The COVID-19 pandemic led to numerous lockdowns and restrictions throughout the U.K. These events meant a restriction on the daily activities that ordinarily maintained the mental wellbeing of young people (e.g. face-to-face social interactions, team sports, in-person classes or activities), and also reduced their access to mental health support when their general wellbeing declined. Young people reported that the lockdown worsened their psychological wellbeing, and this decline was particularly pronounced in those already identified as experiencing significant psychological distress (Vizard et al., 2020).

The pandemic saw a shift in how mental health support could be offered, and many services moved to virtual working (CQC, 2021). Of the 2438 young people surveyed by Young Minds (2021) during the pandemic, 1817 noted that they required mental health support at some point, with 73% receiving virtual support. A number of reports suggested that the shift to digital working increased their ability to offer support to young people, compared to the pre-pandemic setting (CQC, 2021). Many young people were already familiar with digital technologies when the COVID-19 pandemic began, and emerging global studies have shown that young people appreciated the increased flexibility, stigma reduction and convenience of online therapy (Hanley, 2021; Hanley & Wyatt, 2021; Hawke et al., 2021; YoungMinds, 2020, 2021).

Since restrictions have eased (perhaps temporarily), it appears that the mental health of young people has improved (Office for Health Improvement and Disparities, 2021; Shum et al., 2021). However, this does not mean that research on online therapies should stop. Young people have now seen the benefits of being offered therapy virtually, and the COVID-19 pandemic will no doubt have changed the way we offer therapy forever. There is a renewed encouragement for services to provide a flexible variety of therapy delivery options, online therapy being one of them (CQC, 2021). The NHS has clearly emphasised the importance of a digital transformation in how service-users receive support for their mental health (Mental Health Taskforce, 2016; NHS England, 2019b), and the COVID-19 pandemic should be seen as a unique catalyst for exploring the utility of online therapy for young people. Continuing this research could mean expanding the standard service offer for young people's mental health support in line with the THRIVE principles of accessibility (Wolpert et al., 2019).

1.9. Online Therapy for Young People

'Online therapy' is a broad term for psychological therapy that can take place through a chat function (Frith, 2017; Hanley, 2021; King et al., 2006), a pre-designed psychoeducation platform (Liverpool et al., 2020) or with a therapist via videoconferencing software (e.g. Skype, Zoom, WebEx, Microsoft Teams) (Nelson & Bui, 2010; Nelson & Patton, 2016). Recent systematic reviews show the comparative usefulness of online therapies to face-to-face psychological therapy in adults, including on scores of measures of low mood (Berryhill et al., 2018) and anxiety (Berryhill et al., 2019), and in meta-analyses across “diagnostic categories” (Fernandez et al., 2021). Online psychological therapy for young people is also not new, and services already exist worldwide, including in the U.K. (Hanley, 2021; Hanley & Wyatt, 2021), Australia (Glasheen & Campbell, 2009), Europe (Vossler & Hanley, 2010) and in Africa (Pattison et al., 2012).

A meta-analysis found comparable effectiveness of these technology-based psychotherapies with young people to in-person psychotherapies (Venturo-Conerly et al., 2021). However, they noted that the effectiveness of these therapies increased when clients had direct audio-visual contact with a therapist to discuss their distress via videoconferencing, compared to chat-based interventions or purely digitised psychological programs with no therapist-contact (Venturo-Conerly et al., 2021). As such, suggestions have been made for services to specifically utilise videoconferencing technology when delivering mental healthcare to young people (Sanderson et al., 2020).

Although the research on the successes of psychological therapy via videoconferencing with adults is rapidly expanding (Berryhill et al., 2018, 2019; Fernandez et al., 2021), there is currently a limited understanding of the effectiveness and utility of psychological therapy through videoconferencing with young people (Duncan et al., 2014). In fact, the key studies on the acceptability and utility of online videoconferencing with young people have a predominantly focused on psychiatric assessment (Elford et al., 2000; Greenberg et al., 2006; Myers et al., 2006; Yellowlees et al., 2008) or ‘medical treatment adherence’ (A. M. Davis et al., 2013; K. C. Fox et al., 2008; Freeman et al., 2013) rather than mental health support through therapy.

1.10. Review of the Literature

1.10.1. Search Strategy

To determine the utility of MoL with young people in an online videoconferencing setting, it is necessary to explore whether this approach has previously proven beneficial within this group.

Utilising Booth, Sutton and Papaioannou’s (2016) approach for reviewing literature, the initial phase identified the ‘who,’ ‘what,’ and ‘how’ of the literature. In this case, ‘who’ being young people, ‘what’ being MoL, and ‘how’ being the online videoconferencing setting.

Four databases were searched (Academic Search Complete, Child Development and Adolescent Studies, CINAHL Plus with Full Text, and APA PsycInfo (which includes APA PsycArticles)) for research that evaluated the effectiveness of MoL with young people in an online, videoconferencing setting. Alongside this, a search of grey literature (through Google Scholar and other open source platforms) alongside the exploration of relevant study and report reference lists was also conducted. This search included studies published since the establishment of each database until December 31st 2021. See Appendix A for the full list of search terms and Appendix B for the exclusion criteria.

The initial methodical database search including all the search terms relevant to the study, unfortunately, did not generate any results. Therefore, the scoping review was divided into two search strands to adequately inform the study aims: (I) Online videoconferencing therapy with young people, and (II) MoL with young people (See Appendix A for search terms).

In the first strand, twelve articles were identified as suitable for review, and in the second strand, three articles were identified (See Appendix C for flow diagrams for study inclusion). These studies are discussed below. A table with a summary of each individual study can also be found in Appendix D.

1.10.2. Summary of Studies from *Strand I: Online videoconferencing-based therapy with young people*

1.10.2.1. *U.K.-Based Study:* Only one U.K.-based study on videoconferencing was found in the search. Haig-Ferguson et al. (2019) conducted a qualitative review with young people, their parents and healthcare professionals from a Chronic Fatigue Syndrome (CFS) service. It explored the ongoing experiences of providing one-to-one psychological interventions with young people, comparing videoconferencing to face-to-face delivery. Following a thematic analysis, the predominant themes were “challenges and concerns,” “benefits, and “treatment provision.” The main challenges and concerns expressed by participants were: difficulties with technology, feeling that the online aspect diminished the sense of connection, and issues of privacy and confidentiality (if there were limited private spaces). The benefits identified by participants included the increased accessibility, flexibility and convenience of the online intervention, greater openness in sessions (due to less social pressures compared to face-to-face interactions), and an appreciation for the comfort of being at home. Finally, an exploration of the intervention provision uncovered mixed preferences about videoconferencing compared to face-to-face, the utility of videoconferencing in the context of CFS services, the additional preparation required for sessions, and challenging assumptions that all young people appreciate videoconferencing. Although there were mixed responses amongst the participants regarding their experiences or perceptions of therapy via videoconferencing, overall there tended to be a positive attitude towards this method of therapy delivery. This promising study indicated that videoconferencing was particularly beneficial for U.K. youth in terms of its accessibility and flexibility, and it should be included as an option within person-centred care plans.

The authors acknowledged that the small participant numbers and specific CFS focus of the study may have limited its generalisability. The study also centred around the qualitative accessibility and helpfulness of videoconferencing in the delivery of cognitive-behavioural interventions, and there was no quantitative measure of how these videoconferencing-based interventions impacted psychological distress. To get a more holistic evaluation of the impact of videoconferencing therapy, changes on measures psychological distress should ideally be explored.

1.10.2.2. *Single Case Studies*: Studies by Shealy et al. (2015) and Nelson & Patton (2016) both incorporated an evaluation of psychological distress when assessing the effectiveness of videoconferencing-based psychological therapy. In a case study, Shealy et al. (2015) found that a ten-session Trauma-Focused CBT (TF-CBT) intervention via videoconferencing led to a significant a reduction in scores on measures of "PTSD," low mood and "externalising behaviours," and an increase in "pro-social behaviours." Alongside this, the videoconferencing method was also deemed satisfactory by the participant, specifically achieving high ratings of accessibility and helpfulness. Nelson & Patton (2016) also presented three case studies where various psychological interventions were provided via videoconferencing. They similarly found a decrease in scores on measures of "ADHD and ODD behaviours" and family conflict, increases in age-appropriate health and social behaviours, and increased engagement with cognitive strategies.

These case studies indicated the potential for videoconferencing technology to support a shift in psychological distress during therapy with young people. However, the authors of these papers note that these findings should be viewed with caution due to the small sample sizes. It is possible that not all young people benefit equally from therapy via videoconferencing, and that some might maintain a preference for face-to-face interventions. Therefore, this required investigation within larger samples.

1.10.2.3. *Larger Sample Size Studies*: Larger studies by McLellan et al. (2017) and Zepeda et al. (2021) provided additional evidence to suggest the effectiveness of psychological therapy via videoconferencing. Following a CBT-based anxiety management program (McLellan et al., 2017), young people's (n=16) psychological distress appeared to decrease on measures of anxiety ("diagnostic criteria" and "symptom severity"), low mood ("symptom severity") and "externalising behaviours." A three-session CBT program for COVID-anxiety (Zepeda et al., 2021) showed similar significant reductions in measures of "social anxiety" and approaching significance in measures of "total anxiety" (n=27). They also found that, on scales of acceptability, young people highly rated the videoconferencing format.

These studies showed further promise for the generalisability of videoconferencing-based interventions. However, one glaring limitation is that much of this research focused on younger adolescents or children, and excludes young people in ‘late adolescence.’ In fact, the average age of the participants in all the aforementioned studies was under 15. There are hypotheses that older adolescents are frequently excluded from research due to confusion around consent and the ethical responsibilities of researchers when delivering interventions to them (Santelli et al., 2017). However, this has led to a significant gap in the literature, leaving a group of vulnerable young people neglected by an area of research that they need most.

1.10.2.4. *Studies Including Older Adolescents:* Several studies included young people in the developmental stage of ‘late adolescence’ (16-19). Three studies investigated the utility of videoconferencing when delivering a psychoeducational and behavioural intervention designed to support young people with tic disorders, known as the Comprehensive Behavioural Intervention for Tics (CBIT). Himle et al. (2012) demonstrated that both videoconferencing and face-to-face delivery of CBIT led to a significant decrease in tics post-intervention, with no between group differences (n=20). A later study (Ricketts, Bauer, et al., 2016) established the feasibility of CBIT via videoconferencing, with promising results indicating a decrease in scores of measures of “tic severity” and “responsiveness” to the CBIT intervention in two participants. Ricketts, Goetz, et al. (2016) later reported a significantly greater decrease in clinician-rated and parent-reported tic severity in a videoconferencing-based CBIT intervention compared to a waitlist-control.

In the two studies assessing acceptability (Himle et al., 2012; Ricketts, Goetz, et al., 2016), both young people and their parents rated both the videoconferencing service and the therapeutic alliance highly. From both studies, it appeared that young people found online CBIT equally acceptable to both face-to-face CBIT, and when compared to a waitlist control. Young people also experienced a strong therapeutic relationship regardless of the method of delivery (Himle et al., 2012; Ricketts, Goetz, et al., 2016).

Two US-based studies explored the effectiveness and feasibility of videoconferencing in the delivery of Trauma-focused CBT (TF-CBT) (a cognitive-behavioural intervention designed to treat trauma-exposed individuals) with young people. Stewart et al.'s (2017) study showed clinically significant decreases across all clinical outcome measures (scores on trauma, anxiety and depressive measures) following intervention. 100% of participants expressed satisfaction with the videoconferencing approach, and there was a 0% dropout rate, which was comparable to results from previous face-to-face delivered TF-CBT studies (Jensen et al., 2014; Salloum et al., 2016). Stewart et al. (2020) then completed a larger scale version of this study (n=70) and found clinically significant decreases in scores of measures of trauma and low mood following therapy, from both young people and caregiver reports.

Hollmann et al. (2021) investigated the acceptability and feasibility of CBT for OCD via a videoconferencing approach in a German population of young people. Most notably, there was a significant reduction in measures of “OCD symptoms” scores from pre- to post-intervention, and a significant improvement in social functioning. Young people did not show a statistically significant preference for the face-to-face sessions over videoconferencing sessions, and the intervention was highly rated as ‘helpful and understandable.’ Their findings were comparable to other family-based online OCD studies (Comer et al., 2017; Lenhard et al., 2017).

Overall, these studies demonstrated that not only is videoconferencing a feasible option for delivering a psychoeducational and cognitive-behavioural interventions (like CBIT, TF-CBT and CBT for OCD) compared to face-to-face interventions, but some studies indicated that they also hold effectiveness when compared to a waitlist control group. These studies also showed promising potential in the acceptability of these interventions, and the strong therapeutic alliance that can be maintained in videoconferencing-based therapy. This method of delivering therapy could also lead to greater accessibility for young people in rural and remote locations.

However, an important limitation to note is that much of this literature on videoconferencing-based interventions for young people is based on problem-specific interventions. As discussed previously, there are controversies around diagnostic labels (Bentall & Beck, 2003; Boyle, 2007; Ehrenreich, 2021; Hoagwood et al., 2001) and a high prevalence of comorbid experiences of psychological distress amongst young people (Sadler et al., 2018; Vizard et al., 2020). This means that the utility of these problem-specific 'evidence-based' interventions may not translate into clinical practice (Shafran et al., 2009). To understand whether transdiagnostic therapeutic approaches in a videoconferencing setting might be more effective when routinely implemented in practice, there needs to be further investigation into their utility.

1.10.2.5. *Transdiagnostic Interventions with Young People*: Only one study exploring the utility of transdiagnostic interventions with young people via videoconferencing technology appeared in this literature search. Anderson (2019) explored the utility of using a videoconferencing system to deliver three solution-focused therapy sessions to four male young offenders in the US. Although the measures were collected daily across the 8 weeks, the study outcomes did not show any significant differences in measures of "externalising behaviour" scores or youth-reported hope measures following the three sessions of therapy. The author hypothesised that some limiting factors to the study may have been a lack of clinician assessment measure, and participant burn-out related to completing measures on a daily basis.

This study highlighted the importance of expanding the evidence-base for transdiagnostic literature with young people, particularly with a larger sample size. Another point to note is that the majority of the studies from the literature search were based outside the U.K. Some U.K.-based research on online chat- or program-based therapies exists (Hanley, 2006), but the literature on online videoconferencing therapy with young people was mostly conducted outside the U.K. As described previously, the context for British youth is experientially different on many social and cultural factors (Mind UK, 2021a, 2021b) and, thus, this area of research requires exploration within a U.K.-based sample.

1.10.3. Summary of Studies from Strand II: MoL with Young People

The research of exploring the utility of MoL with young people is in its early stages. Only six studies were found through the methodical search (Appendix A); three of which were part of a parent-child dyadic intervention. The three studies described below were selected as they specifically focus on the changes in outcome measures following one-to-one MoL with young people, and a qualitative series of interviews exploring young people’s impressions following MoL.

Churchman, Mansell and Tai (2019) completed a feasibility study of MoL in a school setting with 16 U.K.-based young people aged 11-16. Researchers retained 75% of the participants for the entirety of the study. Psychological measures of distress (Twigg et al., 2016) appeared to decrease during the intervention period, with five young people being classed as ‘recovered’ following the intervention, and seven classed as having made no change.

The authors went on to extend the analysis to explore the clinical and process changes involved in MoL (Churchman et al., 2021). On average, young people attended 7.62 sessions, with the majority attending between one and three sessions (range: 1-18 sessions). There did not appear to be any identifiable patterns to the frequency of sessions attended. A visual case analysis indicated that, at the end of therapy, eight participants increased in their sense of empowerment and ‘goal-conflict reorganisation’ ability, whilst nine participants displayed a decrease in scores on psychological measures. This was maintained at the two-month follow-up point, but at four months a greater number of young people (n=8) reported increased ‘goal-conflict reorganisation’ skills than levels of empowerment (n=6). Reliable change scores were varied for each individual, across the outcome measures, and the authors questioned what scores were most relevant to understanding a young person’s wellbeing. These papers indicated the importance of the personalised and flexible approach of MoL, and explained how an in-depth exploration of data could provide a better understanding of young people’s ability to address their psychological distress through MoL.

Fourteen young people from the study participated in interviews to assess their experiences of MoL (Churchman, Mansell, Al-Nufoury, et al., 2019). Four themes emerged: “therapy style,” “therapy experience,” “exploring problems” and “choice and control.” Young people appeared to particularly appreciate the freedom and accessibility of booking their own sessions, and both the questioning style and process of breaking things down in MoL. They felt “listened to and understood,” and a sense of “trust and confidentiality” during MoL sessions. Young people also found

MoL a helpful way to talk, gain insight into their problems, change their perspective and find solutions. Overall, young people recognised the choice and control in the delivery of MoL, and especially found the choice and control both in and out of sessions as particularly helpful and accessible.

Although the majority of the recently established literature on MoL with young people has been performed in the U.K., these studies were limited to samples local to the researcher. MoL has not yet been investigated online with young people. As the evidence has suggested, online therapies are significantly more effective with a videoconferencing setup (Venturo-Conerly et al., 2021) and, therefore videoconferencing must be investigated as a means to deliver MoL online with U.K. youth to determine its MoL's utility, accessibility and effectiveness across a wider-reaching cross-section of the population. A further limitation to these MoL studies is that they did not involve older adolescents. Weak systemic and financial transition processes between young people's and adult's mental health services has led to gaps in care (Chui et al., 2021) at a developmental stage where young people are particularly vulnerable to psychological distress (see sections 1.2.2. and 1.3.2.). Therefore, research should strive to specifically investigate interventions to support this vulnerable group.

1.11. The Proposed Study

1.11.1. Study Rationale and Aims

As mentioned in the scoping review, there are significant gaps in the current research on videoconferencing-based psychotherapeutic interventions with young people. Much of the literature focuses on small samples or single case studies, and where there are larger studies, they are mostly diagnosis-focused, do not include older adolescents or are not U.K.-based. Currently are no published studies exploring the utility of transdiagnostic interventions with U.K. youth people in an online setting using videoconferencing methods.

This study aims to address some of the limitations of the existing literature by conducting the study with young people based in the U.K., particularly focusing on videoconferencing as a means of delivering therapy. Although much of the literature and many policy documents span across the developmental age bracket of ages 10-24, given the increasing number of factors within late adolescence that lead to psychological distress (Davies, 2014; Vizard et al., 2020), this research will specifically focus on older adolescents (i.e. the ‘late adolescence’ stage of ages 16-19).

To expand the research beyond a diagnostic focus, the current study will not restrict the intervention to a specific diagnostic category of young people and will instead include young people with a range of self-identified ‘difficulties/diagnoses’ and multiple ‘difficulties/diagnoses.’ Alongside this, the study will seek to build upon the research on videoconferencing-based transdiagnostic interventions with young people, to expand its potential accessibility. The technique of identifying disruptions and the dialogical nature of MoL’s questioning style makes it highly suitable for a videoconferencing interface, and this study will focus on the utility of MoL in an online videoconferencing setting (hereby known as ‘online MoL’).

Drawing upon elements from the current literature, this study aims to explore the patterns of attendance, effectiveness, and participant experiences (i.e. acceptability, accessibility and helpfulness) of online MoL with young people. To understand how young people engage with online MoL, patterns of attendance will be explored. More specifically, the number of sessions attended, cancellation and non-attendance rates and time between sessions will be investigated. To determine if this intervention has the potential to be effective with this population, the study will examine symptom-based measures of psychological distress, a process-based measure (i.e. the transdiagnostic process of reorganisation of conflict (Higginson & Mansell, 2008)), and a life-functioning-based measure. Finally, a youth-consulted feedback survey will be employed to determine the acceptability, accessibility and helpfulness of online MoL with young people. Young people reported that they value accessibility and control in psychotherapeutic interventions, particularly when online (Plaistow et al., 2014), however, more research is needed to explore this area, particularly with the recent uptake of online therapy due to the COVID-19 pandemic.

In line with the principles of the THRIVE framework (Wolpert et al., 2019), the current study hopes to provide an innovative direction for improving access to mental health support for young people.

1.11.2. Research Questions

These study aims will be achieved through answering the following research questions within the following themes:

Patterns of Attendance

Question 1. What are the patterns of attendance for online MoL?

Effectiveness:

Question 2. Does online MoL with young people significantly change scores on a) symptom-based measures b) process-based measures c) life functioning-based measures

Question 3. Does online MoL with young people lead to clinically significant changes in symptom-based measures?

Acceptability, Accessibility and Helpfulness:

Question 4. How do young people experience online MoL and its participant-led practices?

Question 5. What aspects of online MoL do young people find helpful or unhelpful?

2. METHOD

2.1. Chapter Overview

This chapter describes the epistemological stance that underpins the study to provide context for the design choices in the study. Ethical considerations are then discussed in the context of the potential impact they may have on participants. Following this, the design, participants, materials, procedure, and data analysis are then clearly outlined.

2.2. Epistemology

A critical realist epistemological approach underpins the current research. A realist stance asserts the existence of a reality that is independent of the constraints of humanity's capacity to conceptualise the world around them (Bhaskar, 1998, 2008). However, a critical realist stance specifically accepts a degree of fallibility in obtaining this scientific knowledge, such that it is often uncertain and incomplete (Bhaskar, 2008). When tied to the field of clinical psychology, critical realism explains that human mental health (including psychological wellbeing and distress), as well as any changes through therapy, are real, observable constructs that change in any given context. However, it maintains that these constructs exist discretely from the limitations of the human conceptualisation of the world (e.g. through language or theory). These limited conceptualisations mean humanity can only estimate the true nature of those constructs.

This stance assumes a realist ontological position, that is, that there is an observable, objective reality that exists independent of cognition (Willig, 2016). This reality can be both observed and measured. Within this reality exists numerous dimensions (including subjective client experiences) (Willig, 2016). Psychological change is therefore understood as a 'real,' measurable event, but one that occurs within a historical and socio-political context.

This research examined the use of an approach founded on the fundamentals of PCT (Powers et al., 1960), which acknowledges the possibility of an objective reality, but states that this is only understood through our own limited perceptions of the world. PCT attempts to explain the internal perceptions and reference states of an individual, and this study adopts methods to support this theory. In line with this critical realist stance, the researcher notes that changes in psychological distress and wellbeing can only be explored through a client's experience, and uses MoL to provide a platform for this exploration.

Although limited by our conceptualisation of these internal processes, a realist stance maintains that these internal processes should be documented as they occur, independently of our understanding of them. Efforts to assess changes in psychological distress and wellbeing using symptom-based measures in this research are an attempt to capture these experiences. However, the researcher acknowledges that each measure assesses data through the diagnostic lens. Therefore, in addition to these measures, process-based measures are included to capture an alternative description of distress and wellbeing. This approach aligns with a critical realist epistemological stance, which assumes the existence of an objective experiences independent of our knowledge of them (Creswell & Plano Clark, 2011). Although it is assumed that using PCT to understand these processes may be limited, there is hope this will evolve in time.

2.3. Ethical Considerations

Ethical approval for the research was granted by the University of East London Ethics Committee (see Appendix E) in June 2021. Due to challenges with online and school-based recruitment (due to the timing of the project coinciding with the end of the school year), an amendment was made to include charities, community organisations and other third sector organisations as sources of participants (See Appendices F and G). Approval was granted for recruitment from all these sources in July 2021. No additional ethical approval was required, as recruitment did not take place in clinical services. Ethical considerations revolved around matters of informed consent, confidentiality, data storage and transfer, and avoidance of harm for participants.

2.3.1. Informed Consent

Participants were provided, via email or downloadable pdf link, with an in-depth information sheet regarding the study (Appendix H). It explained the aims, eligibility criteria, procedure, confidentiality and data protection guidance, as well as any potential risks and benefits of taking part in the project. The contact details of both the researcher and supervisor were listed. As the age of consent is 16 in the U.K. (NHS UK, 2019), parental consent was not sought, and the young people were asked to sign a consent form themselves indicating that they understood the information provided and agreed to take part (Appendix I). It was explained to participants that they could withdraw from the study at any time and this would not impact their care. It was explained that participants would have 3 weeks from their last point of contact (after a session or following a questionnaire pack) to request to leave and withdraw their data as, following this, the data was anonymised and analysed.

2.3.2. Confidentiality

Throughout the research project, confidentiality of participant data was upheld. All data and material from the project were anonymised. Participants were given numerical ID codes for booking sessions and for questionnaires to ensure their answers could not be linked to personal identifiers, but to also ensure continuity in their scores and data. Any identifiable information was securely stored separately from research data. Participants were informed of the possibility of unidentifiable extracts from feedback information being included in the final write-up and any future publications in the information sheet.

Identifiable information (including contact information) was only accessible by the researcher on a password-protected folder on the UEL OneDrive. To prevent any contact information being accessed beyond this protected system, only programs associated with the UEL Office 365 package were used (i.e. sign-up form, appointment booking system, email reminders). These were all connected to the researcher’s UEL account, meaning that the researcher had sole access to the use of this contact information throughout the duration of the intervention within a contained system.

2.3.3. Data Storage and Transfer

2.3.3.1. *Electronic Data Storage:* Electronic identifiable data (e.g. digitally signed consent forms, contact information) were securely stored separately from all other research data (e.g. demographic information, measures, feedback forms) collected in the course of the study in a password protected UEL OneDrive folder. There was minimal transfer of research data, using password protected links where necessary. Only the research team (including the researcher, supervisor and, where necessary, the qualified MoL therapist rater or research assistant) had access to the relevant anonymised files and folders.

Booking information was stored securely on the Microsoft Bookings page, as part of the UEL Microsoft Office secure package. A record of attendance was kept in a password protected spreadsheet on the UEL OneDrive. Once the researcher leaves UEL, all anonymised data will be shared with the supervisor and the supervisor will store this data on the UEL OneDrive. This will then be deleted after 3 years. See Data Management Plan (Appendix J) for further details.

2.3.3.2. *Audio Recordings*: Audio recordings were saved and encrypted on the researcher's password protected UEL OneDrive cloud service. Any anonymised recordings required for rating of MoL fidelity were sent via password-protected email link to a qualified MoL therapist rater on the research team (separately to the password). Once 10% of these recordings were rated by the qualified MoL therapist and documented in a spreadsheet, they were all deleted from both the recorder and the UEL OneDrive.

2.3.4. Avoidance of Harm

2.3.4.1. *Ineligibility*: Although all participants who signed up were considered eligible at screening, there was still potential for a young person to be rejected from the study, which may have left them feeling disheartened or unsupported. As such, a debrief letter for potential rejections contained an explanation of their ineligibility, validation of their potential disappointment, a list of more appropriate services to support the mental health needs of the young person and an opportunity to reply with any further questions (Appendix K).

2.3.4.2. *Potential Distress or Risk*: Psychological therapy is aimed at reducing psychological distress and online MoL was not expected to increase difficult feelings more than other types of therapy. Participants were allowed to take breaks or stop therapy at any time without providing a reason for doing so. Where appropriate (either during therapy or if they scored 2 or 3 on question 9 of the PHQ-9), they were given the numbers of other services that they could contact if they needed immediate support outside of the sessions (which were already provided in the information pack and at the bottom of contact emails).

Risk management is an important factor when working with young people. As such, a risk assessment protocol was developed (Appendix L). If a young person disclosed risk (to themselves or to others), the session was stopped to conduct a full risk assessment. If the risk was deemed low (i.e. there were no immediate risks and no plans or intentions to act on any thoughts of self-harm or suicide), the participant was asked if they would like to continue or end the session. They were then signposted to support services. If the participant was considered to have active risk, the session was terminated and the MoL therapist remained with the participant to create a safety plan, refer to local crisis services, and, if needed, until an ambulance/police/mental health service was contacted and arrived. Supervisors were advised.

2.3.4.3. *Measures*: The questionnaires used were not deemed to contain sensitive content, however, the questions asked may have been challenging to some young people. The measures were specifically chosen such that they could be successfully completed alone without inducing distress. However, the contact details of the research team were included in each email alongside the link to the questionnaires to provide the opportunity to raise any questions or concerns.

2.3.4.4. *Debriefing*: Participants were debriefed at the end of each session (specifically asking how they found the session), and were provided with a debrief sheet when they elected to complete therapy, or at the end of the intervention period (Appendix M).

2.4. Design

A quantitative approach was employed, using outcome measures and open-ended questions. A within-subjects pretest-posttest design was utilised (Dimitrov & Rumrill, 2003), with participants completing electronic self-report questionnaires pre-intervention (weekly for 3 weeks), at completion of therapy and at a one-week and one-month follow-up. Open-text feedback questions were used to explore perceptions of the acceptability, accessibility, and helpfulness of the intervention.

2.5. Consultation with Young People

Prior to initiating the recruitment phase, all advertisements, study materials, and measures were reviewed by a volunteer group of young people from the target age group, who were attending the schools contacted to gauge interest in the project. The researcher provided these materials to five young people (aged 16-19, and of mixed genders). After providing them with time to review the materials, the researcher liaised with each young person to provide feedback on the materials. The language and communication style of the documents were amended based on feedback and suggestions from these young people. Although some of the documents were lengthy in nature, young people commented that they understood why all the content included was necessary and found the length acceptable. Following these amendments, two of the original young people agreed to review the final materials and provide additional feedback via email (the other three noted that the were unable to provide additional feedback due to academic deadlines).

2.6. Participants

2.6.1. Inclusion Criteria

In line with transdiagnostic principles, the inclusion criteria were broad. To be eligible to participate in the study, participants were required to be aged 16-19 and able to understand verbal and written information in English. They must have been able to give consent to participate (including being willing to discuss in therapy the challenges they were facing) and have been based in the U.K. It was not required for the young people to have a diagnosis or to have sought mental health support before. It was also not of concern if their mental health problems were considered ‘mild’ or ‘moderate’ or ‘severe.’ Although there are ethical considerations when limiting studies to English-speakers, the nature of online MoL meant that multiple online interpreters would have been required, at potentially short notice, which was beyond the capacity of the project.

2.6.2. Exclusion Criteria

Participants were ineligible if they were receiving ongoing professional mental health support from a therapist or through a care package from a local service (e.g. CAMHS), as having two forms of therapy at once is not recommended. Also, if they had a significant brain injury or were using alcohol, drugs or self-harm to manage difficult emotions they would not be able to participate (as there were other specialist services that were more suitable to their needs).

2.6.3. Recruitment

Participants were recruited through social media (e.g. Instagram), colleges, schools, universities, charities, community groups and other third sector organisations, and these sources were contacted via email with a request to distribute the flyer (Appendix N) with a link to a social media page (Appendix N) to students aged 16-19. These sources were not be required to enforce sign-ups to the project, but were encouraged to discuss the project with particular young people if they felt they would benefit from MoL.

2.7. Materials

2.7.1. Demographic Questionnaire

A participant demographic form (Appendix O) was created to describe the sample characteristics including age, gender, ethnicity, level of education/employment status, and both previous and current engagement with mental health services.

2.7.2. Validated Questionnaires

2.7.2.1. *Symptom-based Measures (Appendix P)*: To measure self-reported changes in symptoms of psychological wellbeing, the study utilised two symptom-based measures which are widely used in mental health literature, psychological services in the NHS and are well-validated for anxiety and depressive symptoms (Kroenke et al., 2010).

The Patient Health Questionnaire-9 (PHQ-9) (Kroenke & Spitzer, 2002) is a 9-item self-report measure of experiences of low mood. Each item has a rating from 0 (“not at all”) to 3 (“nearly every day), with a total score calculated by summating all items and ranging from 0-27. Higher scores denote more severe depression. The PHQ-9 has been utilised with populations aged 18 and over (Spitzer et al., 1999, 2000), as well as young people aged 13-17 (Richardson et al., 2010). The PHQ-9 has shown good internal consistency (Cronbach’s α = between 0.86 and 0.89), sensitivity (88%) and specificity (88%) (Kroenke et al., 2001, 2010; Spitzer et al., 1999).

Alongside this, the Generalised Anxiety Disorder Questionnaire (GAD-7) (Spitzer et al., 2006) is a 7-item self-report measure of experiences of anxiety. Each item has a rating from 0 (“not at all”) to 3 (“nearly every day), with a total score calculated by summating all items and ranging from 0-21. Higher scores denote more severe generalised anxiety. The GAD-7 has been utilised with populations aged 18 and over (Löwe et al., 2008; Spitzer et al., 2006), as well as young people aged 12-17 (Mossman et al., 2017). The GAD-7 has shown good internal consistency (Cronbach’s α = 0.92), sensitivity (89%), and specificity (82%) (Löwe et al., 2008; Ruiz et al., 2011).

2.7.2.2. *Process-based Measures:* The Reorganisation of Conflict Scale (ROC) (Higginson & Mansell, 2008) was included as it measures an individual’s likelihood to partake in processes that assist with or impede the process of reorganisation, according to Perceptual Control Theory (PCT). The 23 items are rated from 0 (“I don’t believe this at all”) to 100 (“I believe this completely”). It has two subscales: “inflexible, conflicted or arbitrary problem solving,” and “goal conflict reorganisation” (Higginson & Mansell, 2008). Early investigations of the scale’s psychometric measures demonstrated good internal reliability for the “goal conflict reorganisation” component (Cronbach’s α = 0.83), but the other subscale did not meet acceptable values (Bird, 2013; Higginson & Mansell, 2008). An adapted version using only the ‘goal conflict reorganisation’ scale (Bird, 2013) is most commonly used in MoL studies (Churchman, Mansell, & Tai, 2019; Churchman et al., 2021; R. Griffiths et al., 2018, 2019), and reportedly has acceptable internal reliability with young people (N'Danga-Koroma, 2018). Therefore, this adapted version (Bird, 2013) was used in the present study. For this 'goal conflict reorganisation' subscale, a higher indicated a greater capacity for reorganisation (i.e. greater ability to resolve problems through the process of reorganisation (See section 1.7.1.3.). This has not been included in the appendices for copyright reasons.

2.7.2.3. *Life-functioning-based Measures (Appendix P)*: The Outcome Rating Scale (ORS) (Miller et al., 2003) is a four-item questionnaire which measures intervention-related changes to four areas of life functioning (i.e. individual, interpersonal, social, overall). It was developed for individuals with a reading age of 13 and above (Miller et al., 2003) and a recent review of adolescent mental health measures found that the ORS had good therapeutic utility (Bentley et al., 2019). Although the written ORS was freely available, the online format of the ORS was restricted to a paid-subscription-based website, which did not integrate with UEL's permitted data collection systems. Instead, the ORS was delivered using Miller's ICCE guidance for the verbal administration of the ORS (ICCE, 2020). Participants were asked to view the analogue scale (which was a 10cm long line) and report a number (including 1 decimal place) from 0 ("low levels" or "going poorly") to 10 ("high levels" or "going well") that matched their feeling related to the subscale. A higher total score indicates greater life functioning. The ORS has shown good Internal consistency (Cronbach's α = 0.93) (Miller et al., 2003).

2.7.3. Feedback Questionnaire (Appendix Q)

A feedback survey, created by the researcher, included questions exploring the acceptability, accessibility, and helpfulness of online MoL through both closed and open text-box questions.

2.8. Procedure

2.8.1. Online MoL

Online MoL took place on Microsoft Teams videoconferencing software. The therapy was facilitated by the researcher in their dual role as researcher-clinician in line with the two main objectives outlined by Mansell et al. (2012): to support the participant to explore their psychological distress, and to direct their attention to any 'background thoughts', in order to examine them further. By shifting the participant's consciousness to this higher level of perception, they could become aware of conflicts, which may enable reorganisation of thought and action (Tai, 2016). This reorganisation was facilitated by a questioning process by the researcher and content of the sessions drew upon what the participant felt was bothering them.

The researcher provided an intervention window of 12 weeks per participant, offering a maximum of one session per week due to researcher time constraints. In line with the principles of control in PCT and MoL (Carey, 2008b), participants were provided with control over their sessions (i.e. session quantity, frequency and length (up to 50 minutes) via an online session booking system (Microsoft Bookings). Outcome measures were completed after each session.

Participants were also given the opportunity to change their mind about attending sessions at any time. If they felt they had had the right amount of online MoL sessions for them, they could stop without providing a reason at any time before the end of 12-week period.

2.8.2. Data Collection

The entire study (including delivery of intervention and data collection) was conducted online. All measures were administered by the researcher both verbally and using the data collection survey site Qualtrics. Once participants reviewed the information statement (Appendix H) and signed the online consent form (Appendix I), they then completed a form which asked for demographic information (i.e. age, ethnicity, gender, any previous mental health diagnoses and previous engagement with therapy etc) (Appendix O).

Quantitative data was collected via the administration of a 'questionnaire pack' (which took approximately 10 minutes to complete). The questionnaire pack contained the symptom-based measures, process-based measures and life-functioning measures (see section 2.7.2.). This data was collected weekly pre-intervention for a period of 3 weeks, at the start of therapy, and following each therapy session attended in the 12-week intervention window (to ensure post-therapy data was captured if the participant decided to attend no further sessions). Once the participant notified the researcher that they had attended sufficient sessions, or the 12-week intervention window was complete, the follow-up phase began. The aforementioned data was then collected at both one-week and one-month follow-up points.

At the one-week follow-up, participants were also contacted to complete an additional feedback questionnaire, alongside the outcome measures questionnaire pack. Following the completion of the one-month follow-up questionnaire, participants were provided with the debrief sheet (Appendix M).

2.8.3. MoL Fidelity

As the sole person delivering the intervention, the researcher was required to ensure that they were adequately proficient in the delivery of MoL To ensure fidelity to the MoL guidelines (Carey, 2006), the following steps were taken: The researcher attended a training course on MoL therapy in September 2020 run by qualified and experienced clinicians. Prior to and during the study the researcher also attended weekly peer supervision sessions (N>50) run by qualified MoL clinicians. These 1-hour sessions were attended by MoL practitioners across the U.K. No personally identifying information was discussed in these sessions, and the focus was on developing the researcher's skills as a therapist. Information regarding this was included in the participant information sheet.

During the intervention phase, each online MoL session was audio recorded. Ten percent of these recordings were randomly selected and submitted to the qualified MoL therapist on the research team, to be rated on MoL fidelity using the MoL Session Evaluation Form (Tai & Carey, 2012 - see Appendix R). The researcher also completed the self-reported rating for each of these sessions (Tai & Carey, 2012, see Appendix R), and the inter-rater reliability of the two sets of ratings were analysed.

2.9. Data Analytic Strategy

The data analysis was conducted using SPSS Version 27 (IBM Corp, 2020). All participants who attended at least one online MoL session were included in the analysis. Descriptive statistics were used to summarise the demographic information, feedback information and any variables from symptom-, process- or life-functioning-based measures used.

Prior to analysis, data was checked for outliers and to confirm that the required parametric assumptions were met (i.e. normality and sphericity). It was assumed that any missing data was 'missing at random.'

2.9.1. Sample Size

Based on the studies in the review of the literature (See section 1.10.), sample sizes range between four and seventy (on average 21.25) participants. To detect a significant result at the acceptable power level of 0.8 (Hintze, 2008; Serdar et al., 2021) and medium effect size of 0.25 (Cohen, 1988; Kang, 2021), G*Power (Erdfelder et al., 1996) calculated that a sample size of 24 participants was required. Therefore, the study sought to recruit 24 participants.

2.9.2. Patterns of Attendance

Descriptive statistics of participation rates, cancellations, non-attendance and average number of days between sessions indicated the participant attendance.

2.9.3. Effectiveness

2.9.3.1. *Statistically Significant Change:* A visual analysis of the pre-intervention scores (Appendix S) determined that participants had consistently stable scores for the first three weeks of the study, and that an average of their pre-intervention scores could be used to reflect their pre-test position.

A Mixed Analysis of Variance (ANOVA) was then conducted to test for between-group differences (according to the number of sessions attended), whilst measuring change in the symptom-, process- and life-functioning-based measures over four time points (pre-intervention, post-intervention, 1-week follow-up, 4-week follow-up) around the online MoL intervention (Field, 2017). The between-subjects variable of ‘sessions attended’ was categorised in line with previous MoL research (Carey, 2005; Carey & Mullan, 2008), comparing those who attended ‘one session’ to those who attended ‘more than one session’.

Where any significant violations of assumptions occurred, a Repeated Measures ANOVA was conducted, testing for change in the symptom-, process- and life-functioning-based measures over four time points (pre-intervention, post-intervention, 1-week follow-up, 4-week follow-up) around the online MoL intervention (Field, 2017). In these cases, the number of sessions attended was examined through descriptive statistics.

2.9.3.2. *Clinically Significant Change:* To determine whether the changes in symptom-based measures from pre- to post-intervention were reliable, a reliable change index (RCI) (Jacobson et al., 1984; Jacobson & Truax, 1992) was calculated using the following formula: RCI = (posttest - pretest) / (SD* $\sqrt{1-r_{11}}$) (where r11 is the reliability of the measure, most commonly the coefficient alpha). That is, the difference between pre- and post-intervention scores was divided by the standard error of the difference between these two scores. An RCI greater than 1.96, then the difference is deemed ‘reliable’ (Jacobson et al., 1984; Jacobson & Truax, 1992). These analyses were used to investigate if the participants experienced a reliable change in these respective measures.

2.9.3.3. *Fidelity:* An analysis of inter-rater reliability was performed on six online MoL sessions, which were randomly selected and assessed by two raters (the researcher and the qualified MoL therapist on the research team) using the MoL Session Evaluation (Tai & Carey, 2012 - see Appendix R). As the data was continuous and normally distributed, and a consistent sample of two raters was involved, the intraclass correlation coefficient (ICC) was used for the analysis. This was chosen instead of a Pearson correlation, due to its increased flexibility (Landers, 2015; Shrout & Fleiss, 1979) and decreased likelihood of over- or under-estimation of rater agreement (Stemler, 2019). Koo and Li’s (2016) guidelines for the interpretation of the ICC were then used to interpret the degree of reliability (<0.50, Poor; 0.50-0.75, Fair; 0.75-0.90, Good; 0.90-1, Excellent).

2.9.4. Acceptability, Accessibility and Helpfulness

2.9.4.1. *Acceptability and Accessibility:* Data regarding the acceptability and accessibility of the intervention (in particular, the participant-led practices) were explored through the descriptive statistics of recruitment and retention information and quantitative survey data. Any qualitative data from the follow-up survey (e.g. participant reflections on potential improvements to online MoL) was categorised and descriptive statistics were examined.

2.9.4.2. *Helpfulness:* Data regarding the helpfulness of the intervention was explored through the descriptive statistics of quantitative survey data. Qualitative data from the follow-up survey (e.g. participant reflections on helpful aspects of online MoL) was categorised and descriptive statistics were examined.

3. RESULTS

3.1. Overview

This chapter will begin with a summary of sample characteristics. Following this the patterns of attendance, data distribution and the outcomes of the analyses for symptom-, process- and life-functioning measures will be explored. Finally, feedback will be examined through descriptive information. All relevant SPSS output (including graphs) can be found in appendices T-Z.

3.2. Sample Characteristics

Of the total participants who signed up to the study (n=25), 19 participants engaged with online MoL. Appendix T details the full characteristics of these participants.

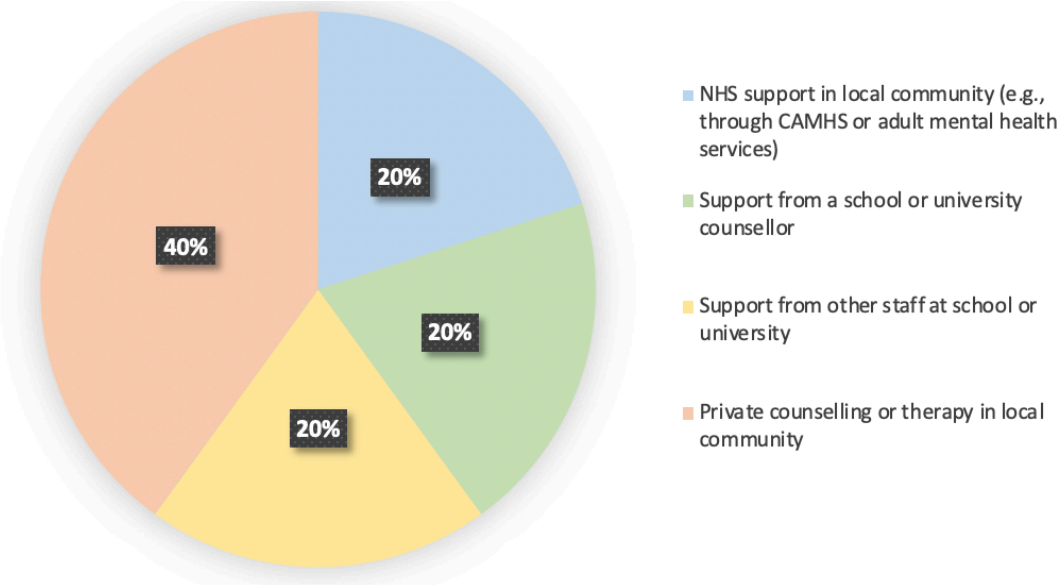
- Participant age ranged from 16-19 years (M=18.53, SD=0.96), with a predominantly self-identified female population (n=17 female, n=2 male), and 1 participant identified as transgender.
- 89.5% of participants identified as ‘White’ and 10.5% as ‘Asian.
- 63.2% of participants reported attending university at the time of the study, with 31.6% undertaking their AS/A Levels.
- Three participants (15.8%) reported having their day-to-day activities limited because of a health problem or disability which had lasted, or was expected to last, at least 12 months, and one participant (5.3%) reported having a learning difficulty (specifically, dyslexia and dyspraxia).

The characteristics for the participants who did not engage with online MoL (n=6) are detailed in Appendix U. In non-engaged sample, 66.7% of participants identified as ‘White,’ 16.7% identified as ‘Asian’ and 16.7% as ‘Black.’ There did not appear to be any further significant differences across other demographic and mental health categories compared to the engaged participants.

Seventeen participants (89.5%) reported experiencing ‘mental health difficulties.’ The majority of participants reported experiencing anxiety (n=6, 35.3%) or a combination of anxiety and low mood (n=6, 35.3%). Two participants (n=2, 11.8%) described only experiencing low mood, whilst two described experiencing a combination of anxiety and low mood alongside either symptoms of trauma (n=2, 11.8%) or gender dysphoria (n=1, 5.9%). Six participants (31.6%) stated they had previously received formal diagnoses from a health professional, which included Anxiety Disorders (n=4, 66.7%), Mixed Anxiety and Depressive Disorder (n=1, 16.7%) and Mixed Anxiety and Depressive Disorders plus a diagnosis of Post-Traumatic Stress Disorder (n=1, 16.7%). Four participants (21.1%) had taken medication in the last 12 months, two having taken Citalopram, and two who were unsure of their medication. Only two of these participants (50.0%) were taking medication at the time of the study.

Regarding mental health support engagement, 57.9% (n=11) noted that they had sought support for their mental health in their lifetime. Five participants (26.3%) had sought mental health support within the last 12 months. Forty percent of these participants sought support from private counselling or therapy in their local community (see Figure I for reported sources of support).

Figure I



Mental Health Support Sources Accessed in Past 12 Months (n=5)

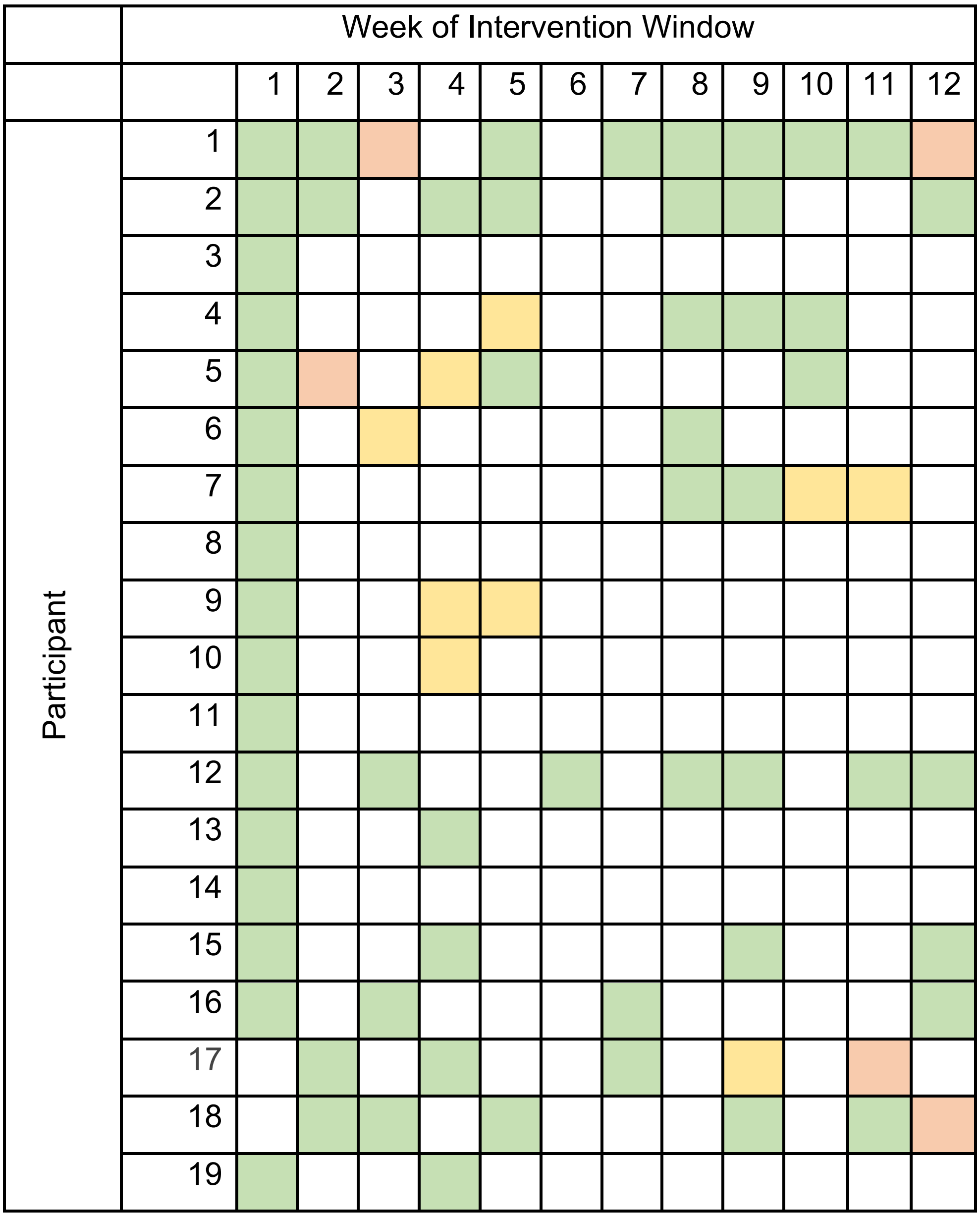
3.3. Patterns of Attendance

Participants attended on average 3.16 sessions (SD=2.24), with a minimum of one session and a maximum of eight sessions. Six participants (31.6%) attended only one session, whilst 13 participants (68.4%) attended two or more sessions (See Appendix V). The average number of days between sessions was 22.62 (SD=9.41), ranging from 10.29 to 45.00 days.

Of the 74 sessions booked, 60 sessions (81.08%) were attended as planned. Only 9 sessions (12.16%) were cancelled in advance, ranging between 0 and 2 per participant (M=0.47, SD=0.70), and 5 sessions (6.76%) were not attended without notice, ranging between 0 and 2 per participant (M=0.26, SD=0.56).

Through a visual analysis of a summary calendar of individual participant attendance (See Figure II), there did not appear to be any patterns of attendance across participants. All participants appeared to have individualised attendance patterns.

Figure II



		Week of Intervention Window											
		1	2	3	4	5	6	7	8	9	10	11	12
Participant	1	🟩	🟩	🟧	⬜	🟩	⬜	🟩	🟩	🟩	🟩	🟩	🟧
	2	🟩	🟩	⬜	🟩	🟩	⬜	⬜	🟩	🟩	⬜	⬜	🟩
	3	🟩	⬜	⬜	⬜	⬜	⬜	⬜	⬜	⬜	⬜	⬜	⬜
	4	🟩	⬜	⬜	⬜	🟨	⬜	⬜	🟩	🟩	🟩	⬜	⬜
	5	🟩	🟧	⬜	🟨	🟩	⬜	⬜	⬜	⬜	🟩	⬜	⬜
	6	🟩	⬜	🟨	⬜	⬜	⬜	⬜	🟩	⬜	⬜	⬜	⬜
	7	🟩	⬜	⬜	⬜	⬜	⬜	⬜	🟩	🟩	🟨	🟨	⬜
	8	🟩	⬜	⬜	⬜	⬜	⬜	⬜	⬜	⬜	⬜	⬜	⬜
	9	🟩	⬜	⬜	🟨	🟨	⬜	⬜	⬜	⬜	⬜	⬜	⬜
	10	🟩	⬜	⬜	🟨	⬜	⬜	⬜	⬜	⬜	⬜	⬜	⬜
	11	🟩	⬜	⬜	⬜	⬜	⬜	⬜	⬜	⬜	⬜	⬜	⬜
	12	🟩	⬜	🟩	⬜	⬜	🟩	⬜	🟩	🟩	⬜	🟩	🟩
	13	🟩	⬜	⬜	🟩	⬜	⬜	⬜	⬜	⬜	⬜	⬜	⬜
	14	🟩	⬜	⬜	⬜	⬜	⬜	⬜	⬜	⬜	⬜	⬜	⬜
	15	🟩	⬜	⬜	🟩	⬜	⬜	⬜	⬜	🟩	⬜	⬜	🟩
	16	🟩	⬜	🟩	⬜	⬜	⬜	🟩	⬜	⬜	⬜	⬜	🟩
	17	⬜	🟩	⬜	🟩	⬜	⬜	🟩	⬜	🟨	⬜	🟧	⬜
	18	⬜	🟩	🟩	⬜	🟩	⬜	⬜	⬜	🟩	⬜	🟩	🟧
	19	🟩	⬜	⬜	🟩	⬜	⬜	⬜	⬜	⬜	⬜	⬜	⬜

Key:

🟩 = Attended
⬜ = No Appointment Booked
🟧 = Did Not Attend
🟨 = Cancelled

Participant Attendance (n=19)

3.4. Effectiveness

3.4.1. Statistically Significant Change

3.4.1.1. *Missing Data:* Missing data is common in psychology research, with some psychological studies missing up to 20% of participant data (Enders, 2003). However, where more than 10% of data is missing, an analysis may become biased and, therefore, non-generalisable (Bennett, 2001; Schafer, 1997). Missing data is categorised as missing at random (MAR), missing completely at random (MCAR) or missing not at random (MNAR). MCAR data may reduce the analysable sample, but it does not introduce bias to the analysis (Dong & Peng, 2013). It is uncommon for data to meet MCAR criteria (Mack et al., 2018).

When an ANOVA is performed, any incomplete lines of data are automatically removed in a process called 'complete case analysis' (Dziura et al., 2013), which is associated with reducing the amount data available for analysis (Davey & Savla, 2009).

The most commonly suggested options for managing missing data in repeated measures studies are: mixed models approaches or imputing data (Maxwell et al., 2017; Schafer & Graham, 2002). In considering a mixed models approach, generalised estimating equations are recommended when working with smaller samples (Muth et al., 2016). However, these analyses can be more sensitive to both outliers (Khajeh-Kazemi et al., 2011) (a number of which appear in the current dataset) and violations of normality (Grilli & Rampichini, 2015; Heagerty & Kurland, 2001), and also require the strict assumption that data is MCAR (Aloisio et al., 2014). Imputation is the process of substituting missing data with computed values. This process provides greater flexibility, as it allows missing data to be MAR or MNAR, and therefore more appropriate for the current missing data (Aloisio et al., 2014; Baraldi & Enders, 2010). Multiple imputation (the preferable method of imputation) and mean imputation (another acceptable option) are both deemed useful where less than 5% of variable data is missing (Tabachnick & Fidell, 2018). However, due to the small sample size of the study, approximately 5.3% of participant data was missing from the 1-week follow-up (n=1), and approximately 10.5% was missing from the 4-week follow-up (n=2). Therefore, this option was not utilised.

All possible options for adjusting for missing data were exhausted for the current dataset. Although it meant that participants with missing data were automatically excluded by the ANOVA analysis, accepting the automatic deletion process was the most preferable option to prevent the introduction of any bias to the observed data.

3.4.1.2. *Mixed ANOVA*

3.4.1.2.1. *Parametric Assumptions (Appendix W):* In the data split by ‘Number of Sessions Attended,’ seven outliers in three participants were identified in those who only attended one session, three of which were deemed ‘extreme’ outliers by SPSS. Two outliers in two participants were identified in those who attended more than one session, none of which were deemed ‘extreme’ by SPSS. Regarding normality, the Shapiro-Wilk test was significant ($p<0.05$) for the ORS (pre-intervention) indicating that this variable was not normally distributed. For those that only attended one session the skewness and kurtosis of the GAD-7 (pre-intervention, post-intervention, and at 1-week follow-up), the PHQ-9 (pre-intervention, 1-week follow-up and at 4-week follow-up), and the ORS (all four time points) were all considered outside the range of normality (±1.96) (Field, 2017; George & Mallery, 2021). No other variables were outside the range of normality. Box’s test of equality of covariance matrices was violated for the ROC ‘goal conflict reorganisation’ subscale ($p<0.01$). Mauchly’s test of sphericity was violated for the ORS, $\chi^2(5) = 13.07$, $p = 0.02$. One or more of Levene’s test of equality of error variances was violated ($p<0.05$) for the time points in the GAD-7 (1-week follow-up) and the ROC ‘goal conflict reorganisation’ subscale (post-intervention).

3.4.1.2.2. *Mixed ANOVA Analysis (Appendix X)*: Due to these assumption violations, it seemed more appropriate to analyse the data from a purely within-subjects approach using a one-way repeated measures ANOVA. However, although the results should be viewed with caution, it should be noted that there did not appear to be any between-subjects effects (with the between-subjects group variable of ‘number of sessions attended’) in any of the Mixed ANOVA analyses.

3.4.1.3. *One-Way Repeated Measures ANOVA*

3.4.1.3.1. *Parametric Assumptions (Appendix Y):* Parametric testing requires that certain assumptions be met, as the interpretations of statistical analysis can be undermined if these assumptions are violated. A One-way ANOVA with repeated measures holds key assumptions that there should be no significant outliers in related groups, the distribution of the dependent variables should be approximately normally distributed, and the data must achieve sphericity.

3.4.1.3.1.1. *Outliers* (Appendix Y)*:* Univariate outliers were uncovered through the calculation of standardized Z-scores of the various total measures and subscales. Where the absolute value of the Z-score was greater than 3.29 (two-tailed), the score would be deemed an outlier (Tabachnick & Fidell, 2018). Using this method, there did not appear to be any significant outliers. Further inspection using box-plot analysis, showed three potential outlier scores from two participant (as indicated by a circle) in the pooled data.

Determining the inclusion or exclusion of outliers is a highly debated topic within statistical analysis (Aguinis et al., 2013; Leys et al., 2013), and each method above (exploring standardised scores, or analysing box plots) produced different outcomes. It is recommended to include outliers in a dataset if they represent the genuine scores of a sample, as exclusion of them can lead to a disingenuous constraint of both the scope of the data (McNamara et al., 2005) and implications of the analysis (Mohrman & Lawler, 2012). A decision was made to include these scores as “interesting outliers” (Aguinis et al., 2013) rather than exclude them as errors. Thought was given to transforming the data, however, this was not performed due to the potential inclusion of unnecessary bias and the possibility of diminishing the value of the outliers (Ghosh & Vogt, 2012).

3.4.1.3.1.2. *Normality:* Normality was determined using both statistical and graphical techniques (See Appendix Y). Table I includes the means (M), standard deviations (SD), minimum (Min) and maximum (Max) scores, skewness, kurtosis and Shapiro-Wilk (SW) statistics across all measures.

Table I

Distribution Data for All Measures and All Data (n=19)

Scale	M	SD	Min	Max	Skew-ness	Kurt-osis	Shapiro-Wilk
GAD-7							
Pre-Intervention	10.28	4.64	4.00	21.00	0.60[a]	0.29	0.37
Post-Intervention	10.05	4.78	3.00	21.00	0.55[a]	-0.04	0.60
1-Week Follow-Up	9.17	5.75	2.00	19.00	0.57[a]	-1.04	0.05[+]
4-Week Follow-Up	9.82	5.49	2.00	19.00	0.06	-1.33	0.31
PHQ-9							
Pre-Intervention	11.11	6.88	1.67	27.00	0.74[a]	-0.03	0.18
Post-Intervention	10.58	6.80	0.00	27.00	0.67[a]	0.34	0.60
1-Week Follow-Up	9.89	7.48	1.00	27.00	0.77[a]	-0.20	0.13
4-Week Follow-Up	10.88	6.63	1.00	23.00	0.52[a]	-0.96	0.12
ROC (Reorganisation Subscale)							
Pre-Intervention	65.26	13.58	44.33	87.00	0.10	-1.45	0.12
Post-Intervention	72.32	12.80	44.00	95.00	-0.45	-0.14	0.70
1-Week Follow-Up	74.00	13.94	52.00	95.00	-0.39	-1.10	0.13
4-Week Follow-Up	72.65	14.92	47.00	91.00	-0.52[a]	-1.14	0.07
ORS							
Pre-Intervention	23.36	6.26	7.33	32.13	-0.91[a]	0.84	0.28
Post-Intervention	21.56	6.91	10.00	31.00	-0.37	-1.04	0.20
1-Week Follow-Up	25.29	6.32	12.50	33.30	-0.63[a]	-0.46	0.13
4-Week Follow-Up	23.75	5.63	13.00	32.00	-0.65[a]	-0.27	0.21

Note. * indicates significant at $p<0.05$ level. [+] indicates exact $p=0.050482$. Therefore, not considered significant at $p<0.05$ level. [a] indicates variable is moderately skewed (Bulmer, 2003).

The SW test was selected in favour of the Kolmogorov-Smirnoff test, due to its greater power in testing normality, particularly with smaller samples (Mishra et al., 2019; Thode, 2002). A skewness and kurtosis value close to zero indicates the normal distribution of a variable, but a significant ($p<0.05$) SW test suggests that the distribution of the sample variable significantly differs from a normal population (Field, 2017). The SW test was not significant ($p<0.05$) for any measures.

To further understand the data distribution, it is recommended to examine the skewness, kurtosis, histograms and Q-Q plots in conjunction with the SW test (Ghasemi & Zahediasl, 2012). Some variables were considered moderately skewed according to Bulmer's (2003) categorisation of skewness (see Table I note). However, much of the literature suggests that skewness and kurtosis between the limits of ±1.96 is considered within normality (Field, 2017; George & Mallery, 2021). By this criteria, all the variables were within this acceptable range.

The normal distribution of data can be a particularly contentious topic in statistics (Micceri, 1989; Rasmussen & Dunlap, 1991) and arguments could be made that the self-selection of the range of acceptable skewness opens researchers up to biased results. However, Blanca et al. (2017) provided significant evidence for the robustness of the ANOVA in the case of non-normally distributed data, and maintain that the Type I error did not significantly increase across various manipulated conditions. Therefore, utilising a parametric test was still both preferable and possible.

Finally, visual examination of the histograms and Q-Q plots indicated that the distribution of the current data appeared close to normality (See Appendix Y). Therefore, parametric tests were deemed acceptable for the analysis.

3.4.1.3.1.3. *Sphericity:* The sphericity assumption requires the variances of all difference scores (between the various combinations of related groups) of the independent variables be equal in the population. Where Mauchly's test for sphericity was non-significant, sphericity is assumed.

Mauchly’s Test of Sphericity indicated that the assumption of sphericity was not violated for the GAD-7 ($\chi^2(5) = 6.61$, $p = 0.25$), PHQ-9 ($\chi^2(5) = 1.99$, $p = 0.85$) or the ‘goal conflict reorganisation’ subscale of the ROC ($\chi^2(5) = 6.40$, $p = 0.27$).

Mauchly’s test indicated a violation of sphericity for the ORS, $\chi^2(5) = 13.73$, $p = 0.02$. To overcome the potential increased risk of a Type I error, a correction should be applied to the results (Field, 2017; Howell, 2020). Some approaches suggest that if the Greenhouse-Geisser Epsilon was > 0.75, Huynh-Feldt results are reported, and if the Greenhouse-Geisser Epsilon was < 0.75, Greenhouse-Geisser results are reported (Field, 2017; Howell, 2020). In this case, since sphericity is violated ($\varepsilon = 0.61$), Greenhouse-Geisser corrected results are reported in section 3.4.1.3.2.
It is considered a common occurrence for sphericity to be violated (Field, 2017; Howell, 2020), and this has been known to occur in repeated measures ANOVA when sample sizes are small and there are a large number of data collection points (Haverkamp & Beauducel, 2017). Mauchly’s test of sphericity appeared to be met for the majority of variables, and there were corrections available to obtain a valid *F*-values for the variables that violated this assumption. Therefore, proceeding with the use of parametric testing was considered appropriate for the current sample.

3.4.1.3.2. *One-Way Repeated Measures ANOVA Analysis*: A repeated measures ANOVA determined that the scores on the ROC (‘goal conflict reorganisation’ subscale) differed significantly between time points, $F(3, 48)=5.95$, $p=0.00$, $\eta_p^2=0.27$). Post hoc analysis with a Bonferroni adjustment revealed that the capacity for ‘goal conflict reorganisation’ significantly increased from pre- to post-intervention (-8.12 (95% CI, -15.99 to -0.24), $p<0.05$), and was approaching significance from pre-intervention to the 1-week follow-up (-8.00 (95% CI, -16.26 to 0.26), $p=0.06$) and from pre-intervention to the 4-week follow-up (-7.88 (95% CI, -16.43 to 0.67), $p=0.08$). However, evidence was found for linear ($F(1,16)=7.23$, $p=0.02$, $\eta_p^2=0.31$) and quadratic ($F(1,16)=6.91$, $p=0.02$, $\eta_p^2=0.30$) trends. This suggests that participants experienced a significant improvement in their capacity for ‘goal conflict reorganisation’ following online MoL, and that this trend of improvement persisted even four weeks after the intervention ended. The quadratic trend indicated that there may have been a slight downward curve or plateau in this pattern.

A repeated measures ANOVA with a Greenhouse-Geisser correction was performed to compare the effects of online MoL on life functioning (as measured by the ORS). There were statistically significant differences in ORS scores across time points (*F*(1.82, 29.13) = 3.63, p=0.04, η_p^2=0.19). A post hoc analysis with a Bonferroni adjustment did not reveal statistically significant mean differences in ORS scores between any specific paired time points, however, evidence was found for a cubic trend, *F*(1,16)=10.40, p=0.01, η_p^2=0.40. Although there was a slight decrease in scores at the post-intervention phase, there was an upwards trend in participants' ORS scores at the 1-week follow-up, suggesting a potential delayed improvement in life-functioning. There was a slight decrease in ORS scores at the 4-week follow-up point suggesting that this effect may not have persisted.

No further relationships were significant (See Table II).

Table II

Means, Standard Deviations and One-Way Repeated Measures Analyses of Variance of Measures (n=17)

Measure	Pre-Intervention	Post-Intervention	1-Week Follow-Up	4-Week Follow-Up	F-ratio	p	η_p^2
GAD-7	9.94 (3.93)	10.00 (4.51)	8.59 (5.36)	9.82 (5.49)	0.93	0.44	0.06
PHQ-9	10.78 (6.51)	10.47 (6.70)	9.41 (7.43)	10.88 (6.63)	0.87	0.46	0.05
ROC (reorganisation subscale)	64.76_b (13.58)	72.88_b (12.93)	72.76 (13.32)	72.65 (14.92)	5.95	<0.01	0.27
ORS	23.87_a (4.93)	21.48_a (7.03)	25.49_a (6.46)	23.75_a (5.63)	3.63^+	0.04	0.19

Note. Standard deviations are presented in brackets. Means with different subscripts differ at the p=0.05 level with Bonferroni's test. $^+$ indicates Mauchly's test of sphericity was violated (and correction reported).

3.4.2. Clinically Significant Change

3.4.2.1. *Reliable Change Index:* To determine the presence of any reliable changes or clinically significant changes (CSC), the reliable change index (RCI) (Jacobson & Truax, 1992) was used. The RCI determines if the amount of the observed change is greater than what could be expected due to errors in measurement alone. The RCI requires valid criterion to be used. For the GAD-7, the clinical and comparison group norms, and the test-retest reliability score of 0.87 were drawn from Bischoff et al. (2020), and a CSC cut-off score of 8 was drawn from Belk et al. (2016). For the PHQ-9, the clinical and comparison group norms were drawn from McMillan et al. (2010), the test-retest reliability score of 0.94 was drawn from Zuithoff et al. (2010) and a CSC cut-off score of 10 was drawn from Belk et al. (2016). The research data and the above criterion were entered into an RCI calculator (Morley & Dowzer, 2014). Where participants crossed above the upper confidence interval set by the RCI value, they were classed as having reliably 'declined.' Where participants crossed below the lower confidence interval set by the RCI value, they were classed as reliably 'improved.' However, if they did not exceed the clinical cut-off value for improvement set by previous studies, they were not noted as having a 'clinically significant change.' All other participants were considered to have made no change.

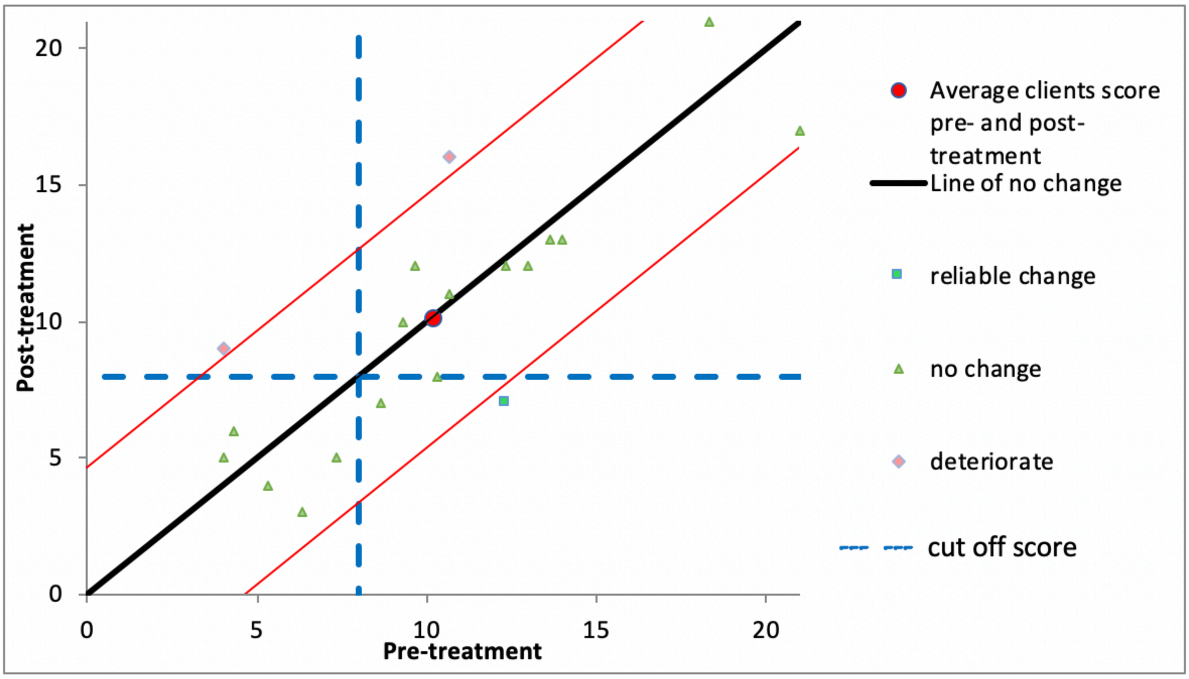
Overall, clinically significant changes in GAD-7 scores were made in 5.26% of participants between pre- and post-intervention, 22.22% of participants between pre-intervention and 1-week-follow-up and 11.76% of participants between pre-intervention and 4-week-follow-up. Clinically significant changes in PHQ-9 scores were made in 10.52% of participants between pre- and post-intervention, 16.67% of participants between pre-intervention and 1-week-follow-up and 5.88% of participants between pre-intervention and 4-week-follow-up. Only the effect size values for the reliable change scores between pre-intervention and 1-week-follow-up appeared to suggest a moderate to high practical significance for both the GAD-7 (d=0.30) and the PHQ-9 (d=0.23). All other effect sizes suggested low practical significance. See Table III for further details.

Table III

Change from pre-intervention *to three separate time points (post-intervention, 1-week and 4-week follow-up) with proportions improved and declined*

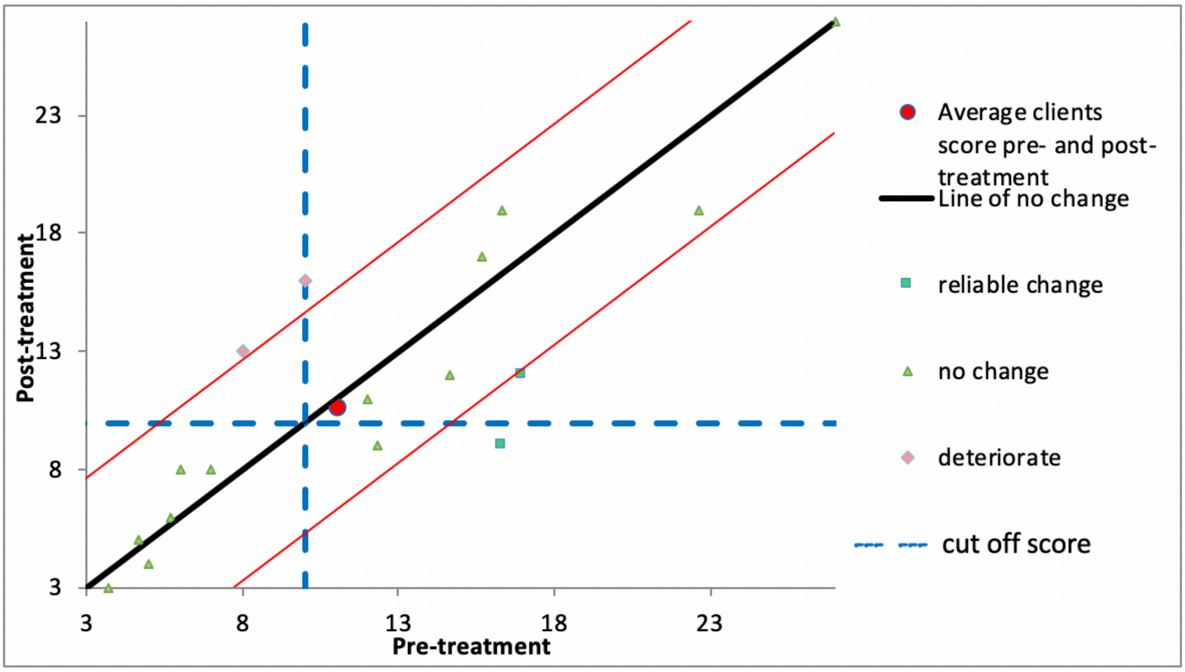
	RCI Value (Std. Error)	Effect Size (d)	Reliable Improvement n (%)	Clinically Significant Change n (%)	Reliable Decline n (%)
GAD-7					
Pre-intervention – Post- intervention (n=19)	4.64 (1.67)	0.05	1 (5.26)	1 (5.26)	2 (10.52)
Pre-intervention – 1-week-follow-up (n=18)	4.61 (1.66)	0.30	4 (22.22)	4 (22.22)	1 (5.56)
Pre-intervention – 4-week-follow-up (n=17)	3.92 (1.42)	0.03	2 (11.76)	2 (11.76)	2 (11.76)
PHQ-9					
Pre-intervention – Post-intervention (n=19)	4.67 (1.68)	0.08	3 (15.79)	2 (10.52)	2 (10.52)
Pre-intervention – 1-week-follow-up (n=18)	4.69 (1.69)	0.23	4 (22.22)	3 (16.67)	0 (0.00)
Pre-intervention – 4-week-follow-up (n=17)	4.42 (1.60)	0.02	1 (5.88)	1 (5.88)	2 (11.76)

Figure III



Plot of Individual Pre-Post Intervention Change Scores (GAD-7)

Figure IV



Plot of Individual Pre-Post Intervention Change Scores (PHQ-9)

3.4.3. Fidelity

The qualified MoL therapist rater's evaluation resulted in a mean score of 67.83/80 (SD=2.639), and a high score of 72/80 was given in a session illustrating best practice. Within the self-scored ratings, a mean score of 67.17/80 (SD=2.639) was achieved, and a high score of 70/80 was given in a session illustrating best practice. As per the test selection guidance (Perinetti, 2018), a two-way random-effects model based on the mean of multiple raters was used to assess the inter-rater repeatability. The Intra-Class Correlation Coefficient for inter-rater reliability was considered 'excellent' (Koo & Li, 2016), 0.92 (95% CI [0.55-0.99]). This meant a high degree of reliability was found between the self and other ratings of MoL protocol fidelity, $F(5, 5) = 13.93$, $p<0.05$.

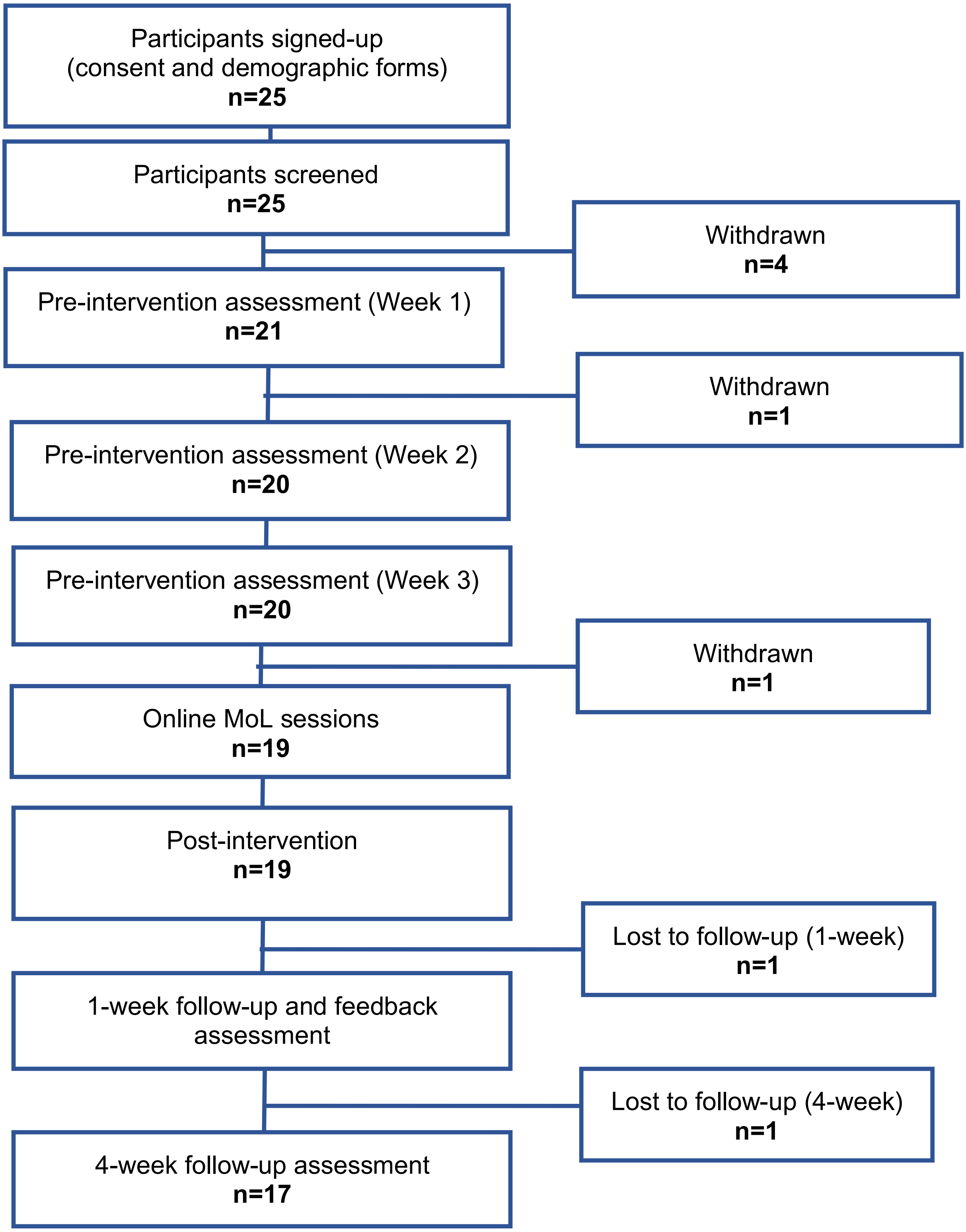
3.5. Acceptability, Accessibility and Helpfulness

Of the 19 participants who engaged with online MoL, 18 provided feedback on the acceptability, accessibility and helpfulness of the therapeutic intervention via an online survey. Due to low response numbers and short-response feedback, a content analysis was not necessary for the open-ended data collected, and the data was categorized and presented descriptively.

3.5.1. Acceptability

3.5.1.1. *Recruitment and Retention:* 25 participants initially signed up to the study. Of those participants, 19 engaged with online MoL sessions (76%) and 17 completed all stages of the study (68%) (See Figure III), which is considerably high for longitudinal studies in young people (generally 44%-88%) (Hanna et al., 2014; Kazdin, 1996). Of those who withdrew before engaging with online MoL (n=6), one participant completed an initial questionnaire, and one participant completed all pre-intervention questionnaires but did not book an online MoL session during the intervention phase and was considered 'withdrawn' following the participant information instructions. Of the 19 participants who engaged with at least one online MoL session, 17 (89.47%) participants completed all stages of the study.

Figure V



Flowchart of Engagement

3.5.1.2. *Comparison with Other Therapies:* Fifty percent (n=9) of participants noted that they had engaged with psychological therapy in the past. Only three of these participants felt MoL was similar to past experiences of therapy. One mentioned that both allowed them to have control over the topic of therapy (n=1, 33.3%), and two noted both therapies helped them break down their problems (n=2, 66.7%). However, all nine participants gave feedback on how they felt MoL was unique compared to their past experiences of therapy. Thirty three percent (n=3) of these participants felt more listened to in online MoL, 22.2% (n=2) noticed that questions were asked more than advice was given and 11.1% (n=1) found appreciated MoL's unique approach to exploring disruptions. One (11.1%) of these nine participants commented that the amount of control in online MoL felt tiring compared to their past experiences of therapy, and another (11.1%, n=1) felt the lack of structure meant less certainty compared to other therapies. However, 11.1% of participants (n=1) appreciated that more control was given compared to their other experiences of therapy. See Appendix Z for sample participant quotes.

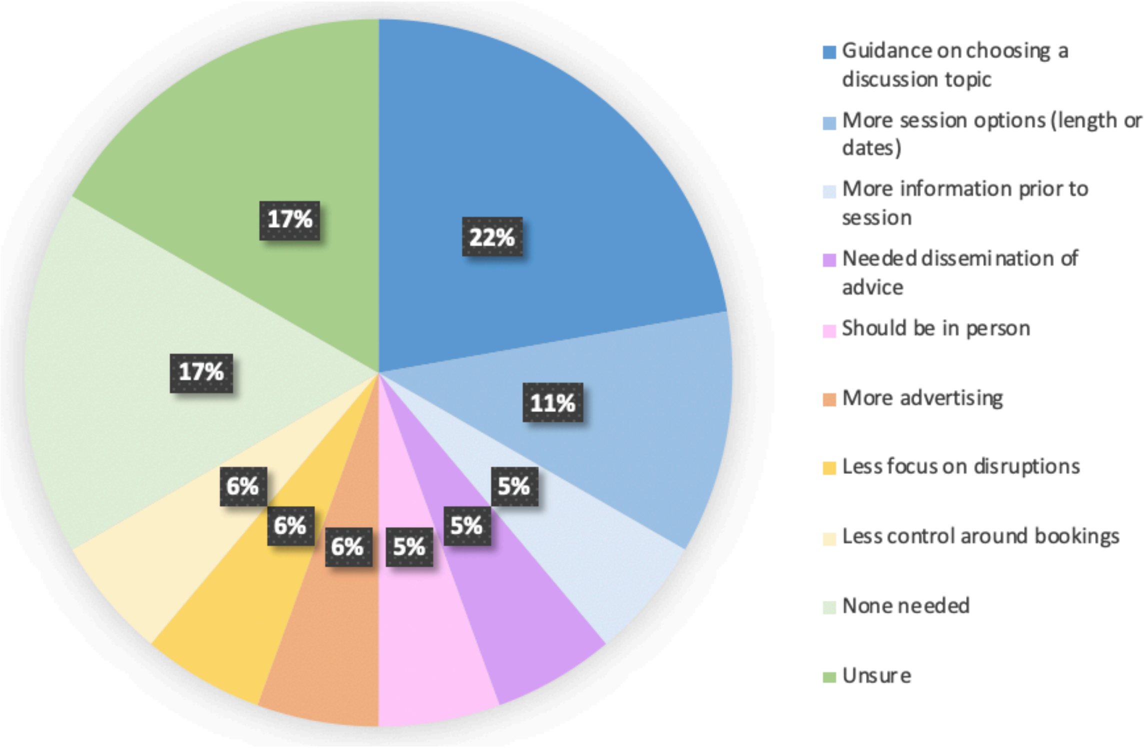
Seventy-eight percent of participants (n=14) reported that they would use online MoL if they were offered it by their school, and 94.4% (n=17) noted that they would recommend online MoL to a friend.

Six respondents provided additional feedback. Two participants (33.3%) noted that they felt that online MoL required more advice to be acceptable to young people, whilst one (16.7%) found it helpful to get to the root of their problem, and one found it (16.7%) non-judgmental. One participant (16.7%) noted that they had continued using MoL strategies beyond therapy, and another complimented the therapist on their style of delivery of online MoL (n=1, 16.7%).

3.5.2. Accessibility

3.5.2.1. *Improvements*: Participants were asked to provide feedback on what improvements could be made to help make online MoL more engaging and accessible to young people. The majority of participants felt that no changes needed to be made (n=4, 22.2%) or were unsure of what changes could be made (n=3, 16.7%). Participants suggested that it would be helpful to have guidance on how to choose a topic for discussion in session (n=4, 22.2%) and for there to be greater options for session bookings (i.e. times of day, or dates available in the 12-week period (n=2, 11.1%). For a summary of the accessibility feedback, see Figure IV, for sample participant quotes see Appendix Z.

Figure VI



Improvement recommendations for online MoL (n=18)

3.5.2.2. *Virtual Aspect of Intervention:* ‘Being able to attend appointments virtually,’ although given a high average score of 7.89/10 (SD=2.52) on helpfulness, was only ranked as the fifth most helpful aspect in the list of eight options. Of the participants who provided feedback specifically on the virtual aspect of online MoL, two young people spoke about it as being accessible. One example included:

> *“[To improve MoL it should be] more advertised to young people, it being spoken about as an accessible method for therapy”*

One young person reported finding the virtual aspect unhelpful (without further explanation) and, when suggesting improvements, another young person reported:

"I feel like for me, I would benefit from in-person sessions, this could make me feel more comfortable around the therapist and able to share more"

3.5.2.3. *Client-led Booking System:* 'Being able to book their own appointments for times/days that suited them' (M=9.17, SD=1.25) and 'Being able to book as many appointments as they wanted during the course of therapy' (M=8.83, SD=1.34) were rated the two most helpful aspects of the intervention. Of the participants who provided feedback specifically on the client-led booking system, two young people spoke about it as being accessible. One example included:

"[I would have liked even] more sessions, more time frames."

One young person suggested the following regarding improvements to the booking system:

"Perhaps slightly less responsibility for booking appointments - if it is left entirely up to someone they are more likely to avoid or procrastinate it."

3.5.3. Helpfulness

3.5.3.1. *Helpfulness Ratings*: When asked to rate the helpfulness of key aspects of online MoL out of 10, participants felt that the two most helpful aspects were related to the client-led booking system (see section 3.5.2.3.), closely followed by 'Breaking problems down' (M=8.78, SD=1.40). For a full summary of the helpfulness ratings, see Table IV.

Table IV

Helpfulness Ratings of Aspects of Online MoL

	M	*SD*	*Range*
Being able to book my own appointments for times/days that suited me	9.17	1.25	6-10
Being able to book as many appointments as I wanted during the course of therapy	8.83	1.34	6-10
Breaking problems down	8.78	1.40	7-10
Being asked about what I was thinking or why I did particular actions	7.89	1.81	4-10
Being able to attend appointments virtually	7.89	2.52	3-10
Being able to choose the topic of conversation in sessions	7.44	2.60	0-10
Being able to finish sessions when I wanted	7.22	2.84	0-10
Being asked questions rather than being given advice	6.89	2.49	3-10

3.5.3.2. *Additional Helpfulness/Unhelpfulness Feedback:* Of the eight participants who provided additional feedback on the helpful aspects of online MoL, the most commonly commented on aspects were being in control (n=2, 28.6%), and the approach of online MoL to breaking down problems (n=2, 28.6%).

Of the three participants who gave additional feedback on the unhelpful aspects of online MoL, two participants (66.7%) found that the lack of advice unhelpful and one (33.3%) thought the lack of provision of a focus or discussion topic was unhelpful. See Appendix Z for sample participant quotes on helpful and unhelpful aspects.

4. DISCUSSION

4.1. Overview

This chapter outlines the aims and summarises the findings of the current study. Following a discussion of the sample characteristics, each of the research questions are explored in the context of the current evidence base, and their implications for practice are considered. The strengths and limitations, as well as areas for future research based on the study's findings are also described.

4.2. Study Aims and Summary of Findings

This study aimed to explore the patterns of attendance, effectiveness of online MoL (through both statistically and clinically significant changes), and participant experiences (i.e. acceptability, accessibility and helpfulness) of online MoL with young people.

The main findings included:

- Mean attendance of between 3-4 online MoL sessions.
- Scores on the ROC ('goal conflict reorganisation' subscale) differed significantly between time points (with significant linear and quadratic trends), and specifically between pre- and post-intervention.
- There were statistically significant differences in ORS scores across time points, and evidence was found for a cubic trend
- Only the effect size values for the reliable change scores between pre-intervention and 1-week-follow-up appeared to suggest a moderate to high practical significance for both symptom-based measures.
- Participants reported various patient-led aspects of MoL as acceptable and accessible (e.g. control over session direction, client-led booking system, online aspect of intervention).
- Participants found the most helpful aspects of online MoL were related to the self-booking system (self-scheduling and frequency of appointments).

4.3. Findings in Relation to Research Questions and Literature

4.3.1. Sample Characteristics

The nineteen participants who engaged with online MoL predominantly self-identified as cis-female and of a white ethnic background. The majority of participants were at university at the time of the study. Three participants felt their day-to-day activities were limited by a health problem or disability, and one participant reported having a diagnosis of dyslexia and dyspraxia. The limitations of the uniformity of this sample will be discussed later in the chapter (section 4.5.1.).

Seventeen participants reported experiencing psychological distress, with most self-describing their distress as ‘anxiety’ or a ‘combination of anxiety and low mood.’ Six participants had previously received a formal diagnosis from a mental health professional, and four participants were taking medication for their mental health. The mixed nature of young people’s descriptions of their psychological distress further supports the research that psychological distress should not be categorised (as when it is, it is frequently comorbid (Vizard et al., 2020). Also, 89.5% of young people were able to describe experiences of psychological distress outside of formal diagnostic labels, which suggests that mental health exists beyond these categories (Bentall & Beck, 2003; Keyes, 2005). Without labels, these young people were better able to understand and express their psychological distress, which could impact their sense of stigma around mental health and how they seek support.

Approximately half the participants had sought support for their mental health at one point in their lives, five of which within the last 12 months. Young people have long described their reluctance around seeking mental health support (e.g. stigma, waiting times, feeling unheard) (CQC, 2018), and this sample appeared to be no different. It was also noticeable that the majority of those that sought support had received it through private means. One possible explanation for this could be that this sample of young people were similarly faced with extensive waiting times associated with receiving help through the NHS (CQC, 2017), so private care may have been a more timely option. These particular participants (with a majority currently university-educated) might also have had greater financial means to access private support as a first port of call. This calls into question the equality and accessibility of the current mental healthcare system, where disadvantaged groups are forced to wait to receive much needed care.

4.3.2. Research Question 1: What are the patterns of attendance for online MoL?

4.3.2.1. *Number of Sessions Attended:* The mean attendance of 3-4 online MoL sessions, with nine participants (47.4%) attending just one or two sessions, parallels MoL trends with both adults (Carey, 2005; Carey et al., 2009; Carey & Mullan, 2008) and children (Churchman et al., 2021; Churchman, Mansell, & Tai, 2019). This suggests that offering a predetermined number of sessions might not be useful for all young people. In IAPT services, almost half the interventions are considered "incomplete" (A. Davis et al., 2020) (i.e. only one or two sessions out of six are attended). This approach can lead to misleading and inappropriate labelling, such as 'dropouts' or 'non-engagers' when the young person may have attended as many sessions as they required at that time. Providing a flexible and client-led approach to appointment scheduling could be a more useful and efficient alternative.

4.3.2.2. *Cancellations and Non-Attendance:* This efficient attendance was accompanied by low rates of cancellations (12.16%) and non-attendance (6.76%). In CAMHS approximately 11-13% of appointments are non-attended by children and their families (NHS Benchmarking Network, 2019; NHS Digital, 2019) and in adult IAPT services, non-attendance rates can be 45-48% (Marshall et al., 2016). 'Drop out' from CAMHS in late adolescence (particularly when approaching transition to adult services) can be as high as 46.8% (Reneses et al., 2022). The non-attendance rates in the current study are lower than in services currently offered by the NHS, which may highlight how control over session attendance (an integral and effective component of MoL (Carey et al., 2013)) resulted in a promising positive impact on the session attendance rates of young people in late adolescence.

4.3.2.3. *Time Between Sessions:* The mean number of days between sessions in the current study was 22.62 which, like past MoL research (Carey et al., 2013; Carey & Mullan, 2008), challenges the notion of offering therapist-dictated weekly sessions. Research suggests that whether sessions are conducted weekly or more spread out, they are usually equally effective at reducing psychological distress (Erekson et al., 2015). Alongside this, an increased frequency in sessions is associated with self-reported increases in psychological distress in young people (Brookman-Frazee et al., 2008). Young people are adept at understanding when they are feeling distressed and how often they should seek therapy to support their wellbeing, and it appears this can be just as effective when they are offered to go at their own pace. Therefore, if young people are capable of taking responsibility over their own wellbeing and therapy attendance, as well as ending therapy, they should then be able to make these decisions for themselves. Further feedback on this is provided in sections 4.3.6. and 4.3.7.

4.3.3. Research Question 2: Does online MoL with young people significantly change scores on a) symptom-based measures b) process-based measures c) life functioning-based measures

It should be noted that prior to conducting the one-way repeated measures ANOVA, the Mixed ANOVA indicated there did not appear to be any significant differences (on any measures) between those who had only attended one session and those who had attended more than one. Although these findings should be viewed with caution, due to a small number of assumption violations, it was promising that the number of sessions attended did not have a significant impact on the changes in scores across time. The positive effects of MoL should not be bound by the number of sessions attended, reflecting the PCT principle that change in individuals is not linear (Carey, 2006; Mount, 2020).

4.3.3.1. *Symptom-based Measures:* There did not appear to be any significant within-subjects changes in scores on either the GAD-7 or the PHQ-9 over time. These findings are not in line with previous research, which has shown the effectiveness of MoL in reducing scores in symptom-specific measures in adults (Bird et al., 2020; Carey & Mullan, 2008) and children (Churchman et al., 2021; Churchman, Mansell, & Tai, 2019). However, the main aim of MoL is not to reduce symptomology, but rather to facilitate the process of ‘reorganisation’ and reframe one’s understanding of their distress and ability to problem solve (Mansell et al., 2012). Therefore, it may be possible that while their ‘symptoms’ did not change, their understanding of their distress did - a notion which is also reflected in the literature (Mirowsky & Ross, 2002; Noronha, 2018).

4.3.3.2. *Process-based Measures:* Following this, a significant linear trend was found for the ‘goal conflict reorganisation’ subscale of the ROC, indicating that the capacity for ‘goal conflict reorganisation’ increased linearly over time. The only significant difference between specific time points was between pre-intervention and immediately post-intervention, indicating that the change in capacity for ‘goal conflict reorganisation’ occurred most drastically at that time. The fact that these scores remained high at the one- and four-week follow-up may suggest that this skill might be retained for up to four weeks. Although the quadratic trend was significant, it was very slight. This provides a tentative indication that the capacity for ‘goal conflict reorganisation’ might decrease, but would need further investigation. The linear trend accounted for 31% and the quadratic trend accounted for 30% of variance in ‘goal conflict reorganisation’ scores, both of which were also considered large effect sizes (Cohen, 1988; Miles & Shevlin, 2000; Watson, 2021). This suggests the potentially strong practical significance of these findings. Overall, this suggests that online MoL may have played an influential part in increasing young people’s capacity to understand the distressing conflicts between their desired goals, and then generate solutions until the best possible outcome is found, for up to four weeks.

Changes in this process-based measure occurred without significant within-subjects changes in the symptom-based measures. One explanation for this is that a reduction in ‘symptoms’ may not adequately reflect the transdiagnostic processes that occur when receiving MoL. In line with the principles of PCT (Powers, 1973), conflict (i.e. a loss of control) occurs when a ‘preferred state’ is unattainable, and results in psychological distress (Carey et al., 2015). Changes to one’s sense of control are not necessarily covered by the scope of the GAD-7 or PHQ-9. MoL is specifically designed to understand how ‘bothered’ a person is by this conflict. It works with service users to generate alternative ways of accessing and understanding their distress, which may better describe changes in their mental health compared to symptom-based measures. A young person might be experiencing the ‘symptoms’ described by the GAD-7 or PHQ-9, but if they have reframed them in a way that allows them to live meaningfully and with a sense of control, they may not be as ‘bothered’ or distressed.

That these symptom-based measures did not detect significant changes in psychological distress may dispute the utility of diagnostic-focused measures to adequately report changes in distress at all (Oliveira-Maia et al., 2016; Schrank & Slade, 2007; Timimi, 2014). This disputation is similarly reflected in young peoples' views on diagnosis-focused assessments of psychological distress (CQC, 2018; Hoagwood et al., 2001; The Children's Society, 2020). The changes in these conflict-based processes, in conjunction with the participant feedback of MoL outlined below (sections 4.3.6. and 4.3.7.), may indicate that process- and life-functioning-based measures may provide a more appropriate account of changes in psychological distress.

4.3.3.3. *Life-functioning-based Measures:* A significant cubic trend was found for ORS scores across time. Although there was an initial dip in life functioning immediately following the final session of MoL, there appeared to be an increase in life functioning at the 1-week follow-up. Life functioning then appeared to return to average scores similar to pre-intervention. This non-linear pattern parallels other MoL studies. Churchman, Mansell, & Tai (2019) used the Youth Empowerment Scale as a means of measuring a young person's control over their life functioning, and found that although there was an increase in scores in the short-term after therapy, these scores decreased at the 4-month follow-up. Similarly, Griffiths et al. (2019) used the ORS to determine life-functioning, and found an increase in ORS scores at the end of 10-month therapy window, but a slight decrease in scores at the follow-up 4 months later. One explanation for these findings (including the current study) could be that MoL may not elicit positive changes in life-functioning in young people on an ongoing basis. However this, in fact, aligns well with the ethos of the MoL approach. MoL proposes that as new decisions appear in life, conflicts may arise regarding our goals (Carey, 2006; Mansell et al., 2012). In the current study, by the time one month had passed, new conflicts could have arisen in their lives, which may have impacted their sense of life functioning, as change is not a linear processes (Carey, 2006; Mount, 2020). The large proportion of variance in ORS scores accounted for by the cubic trend (19%), also suggests the potentially strong practical significance of these findings (Cohen, 1988; Miles & Shevlin, 2000; Watson, 2021).

4.3.4. Research Question 3: Does online MoL with young people lead to clinically significant changes in symptom-based measures?

There were some reliable improvement rates for both these symptom-based measures in up to 22% of the sample. It should be noted that "recovery" rates (i.e. where a client's scores fall below the ascribed threshold for being considered as having "severe enough symptoms" of depression or anxiety (NHS Digital, 2017)) in IAPT services are often only around 30-34% if a client's scores were in the "moderate range at baseline", and 21-26% if their scores were in the "severe range at baseline" (C. A. Griffiths & Griffiths, 2015). The reliable change rates for the GAD-7 and PHQ-9 in IAPT services have also been reported in some services as up to 50% (C. A. Griffiths & Griffiths, 2015). Therefore, although the rates of change in scores appeared small for the current study, they may be considered comparable to some cases of the mainstream use of these measures.

The greatest number of participants made a reliable improvement in GAD-7 and PHQ-9 scores one week after their final session, which may suggest the variable impact of online MoL on mood. However, this reliable change did not persist for those participants into the 4-week follow-up, which substantiates the notion accepted in MoL that change is not a linear process and that different conflicts (and the reorganisation of them) can occur on any given day (Carey, 2006; Mount, 2020). It also questions the idea that providing six consecutive sessions is useful for clients, as the challenges faced by clients are unlikely to occur in a similar six-week consecutive pattern. Sessions should be offered in a way that reflects this.

A number of participants experienced a reliable 'decline' in their scores following online MoL. Researchers who follow traditional diagnostic approaches may interpret these results as online MoL 'worsening' a participant's psychological distress. However, this might ignore the reality of psychological change. Instead, following the MoL principle of 'goal conflict reorganisation,' a reliable decline in scores could indicate that a person may be experiencing stress or low mood as they increase awareness of the true nature of their distress or conflict (Mansell et al., 2012). Alternatively, reorganisation involves a 'trial-and-error' process of problem solving, and it may be that some individuals were engaged with strategies that increased their stress or low mood at the time of assessment. Or, finally, it may be that another conflict had emerged for these participants at that point in time.

4.3.5. Fidelity

The high reliability between the researcher and qualified MoL therapist on the protocol fidelity reflected the researcher's adherence to the MoL protocol. Therefore, reasonable comparisons can be made between this study and other studies in the MoL literature.

4.3.6. Research Question 4: How do young people experience online MoL and its participant-led practices?

4.3.6.1. *Acceptability:* When comparing online MoL to their previous experiences of therapy, young people reported that they felt more listened to in online MoL. This is important as young people frequently report 'being listened to' as a crucial aspect of therapy in both research (Cooper, 2004, 2009; C. L. Fox & Butler, 2009), and in recent CQC reports (CQC, 2017, 2018, 2021). 'Feeling listened to' also aligns with the principles of the THRIVE framework (Wolpert et al., 2019), as listening to young people is a key driver in a needs-led approach. Churchman et al.'s (2019) exploration of qualitative feedback from young people (about their experiences with MoL) showed that the sense of control provided in MoL uniquely enhanced young people's sense of being listened to compared to what psychotherapy ordinarily provides.

In the current study, young people overall appreciated (or found unique) the greater amount of control in online MoL as compared to other therapies, with just one person stating that they felt the amount of control felt tiring. One possible explanation for the 'tiring' aspect of control could be that this young person may not have remembered that they could determine the pace or end sessions as they felt best. To make the client-led aspect of MoL more acceptable for this age group, clearer guidelines of how MoL is conducted might need to be set. The initial focus group of young people acknowledged that although the study information pack was long, they understood why it might need to contain a lot of information from a research perspective. However, if MoL were to be accepted by young people in mainstream services, it might be useful to provide engaging resources about MoL (e.g. an informational video, a video of a sample session or a list of sample questions and topics based on MoL sessions with other young people). In particular, instructions of what young people could control (e.g. session date, length and pace) could be included with upcoming session reminders. This may provide those young people still new to MoL and its participant-led practices with a better understanding of how MoL works.

Young people noted that what online MoL had most in common with other therapies was that it helped break down problems. However, they reported that what made online MoL different was that their problems could be broken down in a non-judgmental way and at their own pace. Stigma is a powerful force which impacts the relationship between young people and their therapist (CQC, 2018), as they are concerned they will be judged when they disclose sensitive thoughts and feelings. The reorganisation system described by PCT is, by its very nature, impartial and non-judgmental (Mansell et al., 2012). It implements a ‘trial and error’ approach, where there is no ‘right or wrong.’ MoL aims to facilitate a client’s discussion of their current problem and ask questions about disruptions in a way that replicates this. MoL therapists are discouraged from offering interpretations or persuading a client towards a particular viewpoint. Instead they are encouraged to offer curious questions where nothing is implicitly assumed. Where a young person states that they “feel stressed,” an MoL therapist might clarify this by asking “When you say “stressed” what do you mean by that?” (Mansell et al., 2012).

Client-determination of the pace of a session is an important feature of MoL (Carey et al., 2015), as young people need to be able to retain control over how they explore particularly sensitive topics. Clients are often offered a check-in during the conversation to enable them to regulate the tempo of the session. The identification of this as an acceptable feature of online MoL aligns well not only with the client-led nature of the THRIVE framework (Wolpert et al., 2019), but also the importance young people place on having their needs ‘listened to’ (CQC, 2018). The stringent approach to curious questioning combined with the control over the pace of the session as unique features of MoL may make it suitably align with young people’s definition of a non-judgmental space in therapy.

Seventy-eight percent of young people reported that they would use online MoL if it was offered by their school and 94.4% would also recommend to a friend. This draws attention to the need to broaden how support is delivered to young people and how it can be accessed by them. Schools and universities remain a key place where young people's mental health needs are first identified (CQC, 2018). Providing MoL at schools not only eases accessibility to mental health support at the first point of contact (Churchman, Mansell, Al-Nufoury, et al., 2019), but may reduce both the stigma and the waiting times associated with specialist services (Lally, 2020).

4.3.6.2. *Accessibility:* It was positive that of the 25 participants who initially signed up to the study, 17 (68%) completed all stages of the study. This was considered quite a high retention rate for research with young people (which normally expects dropout of 44-88%) (Hanna et al., 2014; Kazdin, 1996). It was unclear as to why six young people dropped out before receiving MoL, but one possible explanation may be that, due to delays with the set-up of the study, recruitment occurred during university exam period and summer break.

When asked how to improve MoL and make it more accessible for young people, many felt that no changes were needed. However, two participants suggested that participants should be provided with guidance on potential discussion topics. Although this is not strictly in line with the practice of MoL, it is recognised that the client-led approach might be quite new for some young people. The medical model is ingrained in our understanding of mental health services, where professionals are regarded as authoritative experts in the needs of others. Young people are also often in spaces that are structured and where they are not given the responsibility or opportunity for control. To increase opportunities for young people to better understand and engage with the client-led practices of MoL, MoL therapists could spend more time explaining how MoL works and that topics are generated by the client, spend more time with the client generating topics, explore the feelings of discomfort that might arise when generating a topic (to understand why it feels uncomfortable), and circulate more information about MoL generally.

To increase accessibility, young people also requested even more options for booking sessions. This desire for increased flexibility was a positive sign. Decisions are often made on behalf of young people about their attendance and engagement with therapy, as if professionals are more knowledgeable in understanding a young person’s mental health needs (Gibson & Cartwright, 2013). However, the requests for increased flexibility in booking times, potential for longer sessions and an extended intervention time frame indicated that young people are more than capable of deciding what their therapy attendance should be, and when they feel they have received sufficient support. To truly expand the flexibility, MoL should be offered by schools, universities, youth centres and other places which engage with young people (this is further explored in section 4.4.).

Young people rated ‘Being able to attend appointments virtually’ as highly helpful on average (7.89 out of 10). This was, however, lower down on the list of helpful aspects of online MoL. The pandemic had rapidly shifted online therapy into a mainstream option, and online working had become a constant for young people (due to online school work and socialising), which may have left them feeling saturated with online engagement. This may explain why young people rated online access as something less uniquely helpful compared to the other aspects of online MoL.

However, the high rating of the virtual aspect of online MoL should not be discounted. Paired with this was positive feedback describing online MoL’s virtual aspect as both helpful and accessible. This mirrors previous findings that young people find videoconferencing-based therapy helpful in terms of flexibility and accessibility in the U.K. (Haig-Ferguson et al., 2019) and abroad (Himle et al., 2012; Ricketts, Goetz, et al., 2016). The small minority of young people who found the virtual aspect unhelpful (n=1) or would have preferred a face-to-face intervention (n=1) also reflects the “It's not one size fits all” notion of the previous U.K. study on videoconferencing therapy with young people (Haig-Ferguson et al., 2019). To truly align with a needs-led model like the THRIVE framework (Wolpert et al., 2019), the preferences of young people must be accounted for. Although studies have shown that young people appreciate the increased flexibility, stigma reduction and convenience of online therapy (Hanley, 2021; Hanley & Wyatt, 2021; Hawke et al., 2021; YoungMinds, 2020, 2021), virtual therapies like online MoL should be utilised based on young people’s preferences, and as part of person-centred care plans.

Continuing with this theme, young people rated the accessibility of 'Being able to book their own appointments for times/days that suited them' and 'Being able to book as many appointments as they wanted during the course of therapy' as the most helpful aspects of online MoL. This, once again, shows how creating choices in therapy not only increases accessibility of said intervention, but is something particularly helpful for young people maintain in their mental healthcare. MoL and its booking system are based on the principles of PCT, which posits that change is dynamic and individual (Carey, 2006; Powers, 1973). As such, young people would require varying numbers of sessions and time between sessions (R. Griffiths et al., 2018). The online MoL self-scheduled booking system encourages the increased choice and control that young people have advocated for (CQC, 2018; Hanley et al., 2017) and empowers them to book sessions and end therapy according to their needs. Adult studies have shown that this style of booking system has many other helpful benefits, such as improved service efficiency and shorter waiting times (Carey et al., 2013; Carey & Mullan, 2007), and adolescent studies have shown this approach also positively impacts therapeutic engagement (Wilson & Deane, 2001). The main reason that flexibility was limited in this study was due to the researcher's capacity as the only provider of MoL.

4.3.7. Research Question 5: What aspects of online MoL do young people find helpful or unhelpful?

As mentioned (section 4.3.6.), Being able to book their own appointments for times/days that suited them' and 'Being able to book as many appointments as they wanted during the course of therapy' were the two most helpful aspects of online MoL. Breaking down problems was also rated as a highly helpful aspect of online MoL and parallels previous MoL research with young people (Churchman, Mansell, Al-Nufoury, et al., 2019). MoL is specifically designed to support young people to break down what is bothering them. By talking about their problems (i.e. shifting awareness towards conflicting goals), young people can better understand their psychological distress. Further exploration of the nuances of this distress may help them shift their perspective and discover possible solutions to their difficulties through reorganisation.

Both of these themes (‘flexibility in appointment booking’ and ‘breaking problems down’) parallel previous studies which obtained feedback from young people after receiving MoL (Churchman, Mansell, Al-Nufoury, et al., 2019), but are not commonly notable themes in other studies on therapy with young people (Bury et al., 2007; Cooper, 2009; Lynass et al., 2012). The helpfulness of these aspects may be unique to MoL.

In terms of what young people reported as unhelpful, only two participants found the lack of advice challenging. This parallels studies which have shown that only a minority of young people express a preference for advice following MoL (Churchman, Mansell, Al-Nufoury, et al., 2019) or other psychotherapies (Bondi et al., 2006; Cooper, 2013). Some appreciated the active opinions of the therapist whilst others preferred support with breaking down problems to understand where advice could be drawn from (e.g. within the young person themselves, from peers/guardians or from mental health resources) (Bondi et al., 2006; Cooper, 2013). From a PCT perspective, gathering advice may be a method of expanding their knowledge of potential options for the ‘trial and error’ process of reorganisation. Regardless of the advice offered by a professional, ultimately the decision of what outcome best resolves their goal-conflict is up to the young person. Young people can disengage when they feel like decisions about their mental health are being made on their behalf, but are more engaged when they are given control to make informed decisions about their care (CQC, 2018). MoL therapists have a duty to help young people regain control over their life, where goal conflicts are causing them psychological distress. However, in order to support their reorganisation process without violating the client-led principle of MoL, a young person’s advice-seeking could be incorporated into the discussion. MoL therapists could explore why the young person seeks advice, or what advice could look like. The young person may then go and select advice-giving resources as a starting point, and bring them to a session so a discussion can be facilitated to support them to be in control and choose what outcome best suits them.

4.4. Implications

4.4.1. Service-User Level

The findings of the present research suggest that online MoL might be an acceptable transdiagnostic intervention for young people who experience psychological distress. Offering online MoL could mean that young people would not need to access separate specialist services or specific therapies for each ‘presenting problem’ they experience. Not only would this potentially reduce lengthy waiting times, but it would fulfil demands for flexible and accessible approaches which have been made by young people in the U.K. for many years (CQC, 2017, 2018, 2021). Achieving these results through the use of a transdiagnostic approach like online MoL also suggests that diagnostic labels might not be useful or necessary for the provision of therapeutic interventions for young people. This mirrors the principles of the THRIVE framework (Wolpert et al., 2019). In fact, taking a transdiagnostic approach like online MoL on a needs-led basis may decrease the stigma affiliated with these labels and encourage stigma-free engagement with mental health services.

Offering this service online would make it even more flexible and accessible. Young people felt that the style of engagement was quite similar to previous therapies and reflected positively on the online aspect in the feedback. This may indicate that the online aspect of engagement with young people has become mainstream since the beginning of the pandemic, and is highly acceptable to young people. This is encouraging, as it means MoL can be flexibly and inclusively offered to young people online on a needs-led basis, and regardless of their geographic location, financial position or ability.

Young people in late adolescence are at a stage in their lives where they are exploring their autonomy and independence. The flexible booking system and choice of discussion topics appeared acceptable to many of the young people in the study. In fact, four young people requested additional flexibility in appointments and appreciated the control they were given over their sessions, particularly in a system where young people are sometimes pressured to attend appointments by adults or have sessions where the focus is not on what the young person feels is important (Fazel et al., 2014; Hanley et al., 2017). Alongside this, many young people found online MoL helpful in achieving significant changes in their life-functioning and ability to understand and approach their ‘problems’ (i.e. reorganisation) despite the minimal changes in ‘symptomatology.’ This is yet another indicator that reducing ‘symptoms’ might not be the most useful focus for interventions with young people. Interventions, like online MoL, which empower young people to take control over their wellbeing may be helpful in more important ways than disorder-focused interventions directed by authoritative professionals.

4.4.2. Service Provider/Clinician Level

The simplicity and flexibility of online MoL makes it a useful intervention for balancing therapist and service-user-needs. Online MoL prioritises client-led aspects both within and outside of therapy. Having a flexible, transdiagnostic intervention to offer to young people places less stress on a clinician to learn various prescriptive manuals and models, and also allows clinicians to practice true person-centred, client-led ways of working, which young people have already said they truly value in therapy (Carey & Oxman, 2007; CQC, 2018).

Rather than attending weekly sessions, young people attended sessions on average every 22.62 days, with some young people only attending one or two sessions. This challenges the notion of offering therapist-dictated block of weekly sessions. A client-led booking system may mean a lot less administrative pressure on clinicians and less pressure to follow a strict session timetable, which might not be beneficial for client or clinician. Instead it provides young people with a sense of control over their bookings, which they reported an appreciation of.

The high fidelity ratings also indicate that the MoL protocol can be easily learned and flexibly offered online whilst still adhering adequately to the model. This opens up the idea of who could deliver MoL. The creator of MoL maintains that, with the appropriate training and supervision, anyone can become an MoL therapist (Carey, 2021). In fact, it may be not be necessary for this intervention to only be offered by costly psychologists, who are often only involved once a young person’s psychological distress has worsened. Due to their already established rapport or regular contact (and the fact that 78% of participants reported that they would use online MoL if it was offered by their school), young people might find it easier to speak with staff associated with their educational institution rather than mental health professionals. This could include teachers, administrative staff, school nurses, college or university tutors, or pastoral care workers. Staff who receive training in

MoL can then play a key role in ensuring young people receive the support they need, as early as possible.

4.4.3. Service Level

On a broader service-level, current access to mental health support revolves around diagnoses and specialist disorder-specific services. Engaging with a transdiagnostic approach to mental health would mean a complete overhaul of the current system. Ideally, rather than focus on diagnostic tiers of engagement, services should shift towards the seeing young people on a needs-led basis, based on their levels of distress and the degree to which they require support. Services may initially feel unprepared to consider what this may look like on a practical level but, in fact, much of this has already been outlined in the proposed THRIVE framework. In the immediate future, services should aim to begin incorporating transdiagnostic approaches into their services through the THRIVE framework, particularly in newer services.

The current system for service funding is currently tied to key performance measures, such as outcome measures and session attendance (Oliveira-Maia et al., 2016; Schrank & Slade, 2007). If government bodies are to continue funding services on this basis, this research may be impactful. The current findings should encourage services to consider whether symptom-based measures are truly effective indicators of change, particularly where the change process is non-linear. A shift towards process-based (e.g. ROC) or life-functioning-based (e.g. ORS) measures, could be a realistic step away from disorder-specific models and towards measures which more appropriately reflect the dynamic nature of mental health, and what interventions encourage these changes in wellbeing.

Alongside this, the low number of non-attended MoL appointments is highly encouraging. In the U.K. 11-13% of mental health appointments are missed in the CAMHS system (NHS Benchmarking Network, 2019; NHS Digital, 2019) and between 25-48% in adult IAPT systems (Marshall et al., 2016; Office for Health Improvement and Disparities, 2022), and almost half of IAPT intervention programs are considered “incomplete” (A. Davis et al., 2020). The current study shows how taking a client-led approach to attendance, as implemented in MoL, has a positive impact on client retention and attendance (at their own pace). This would greatly increase efficiency on a service-level; reducing the likelihood of non-attendance, providing more opportunities for appointments where appointments cannot be attended, and reducing delays to mental health support for young people.

Seventy-eight percent of young people reported that they would use online MoL if they were offered it by their school, which also calls into consideration the potential use of MoL outside of mental health services. As explained previously (section 1.8.1.), MoL training is not restricted to mental health professionals, and could be delivered by staff at schools. Young people have reported that the stigma of accessing mental health services is frequently a barrier to engagement (CQC, 2018; Lally, 2020). There might be other places beyond educational institutions where young people might feel less stigma receiving support. Youth centres, family hubs, religious centres, mentor schemes, and regular sports or activity clubs could all be places which offer MoL or online MoL. Offering MoL in spaces where young people are already engaged aligns with the needs-led and accessibility principles of the THRIVE framework (Wolpert et al., 2019) and youth feedback on mental health support (CQC, 2017, 2018; YoungMinds, 2018).

4.5. Strengths and Limitations

4.5.1. Sample and Generalisability

The current study sought to evaluate online MoL with young people. As mentioned in section 2.9.1., the current study sought to engage 24 participants in online MoL. However, only 19 young people attended at least 1 online MoL session. The sample size may have impacted the findings of the study as, although there appeared to be some outcomes that were trending towards significance, a larger amount of data may have determined if these trends were indeed significant. This sample size may limit the generalisability of these findings about online MoL with young people. Counter to this, it should be noted that the study was undertaken with a ‘non-clinical’ population, which may instead indicate a degree of generalisability to wider population of young people.

It should also be noted that the participants of this sample came from a predominantly white ethnic background, and were a majority cis-female sample. One explanation for this might be the bias in the recruitment process. The majority of participants who signed up to the study were from universities across the U.K., and mostly through psychology departments, which frequently have a majority white, cis-female population (Johnson et al., 2020; National Collaborating Centre for Mental Health, 2019; Palmer et al., 2021). Delays in the project leading to part of the recruitment period coinciding with secondary school summer break may also explain why the sample was predominantly older and from universities.

The engagement with this population of young people from within these recruitment sources may also reflect gender biases common to engagement with psychological interventions (Addis & Mahalik, 2003). Young women also make up a higher percentage of engagement in online self-referred chat-based mental health services in the U.K. (Frith, 2017).

Although information on sexual orientation was not explicitly requested, there was only one openly transgender young person who signed up to the study. Research shows that it can be more difficult for LGBTQ+ young people to seek help for psychological distress (McDermott, 2015; McDermott & Roen, 2016), most commonly due to a fear of harassment or being misunderstood (Brown et al., 2016). Young LGBTQ+ people may have experienced similar fears which made them reluctant to engage with the current study. Overall, the limited diversity in age, gender, ethnicity and sexual orientation may mean further research is required to determine if the current findings are reflective of British young people.

4.5.2. Online Data Collection

Online recruitment and engagement meant that the study was able to reach young people from across the U.K., making the intervention accessible, but also practical and convenient for the researcher and participants (Lefever et al., 2007). Collecting data online also reduced the potential for data loss, allowed for more secure and simple data transfer (Bainbridge & Carbonaro, 2000; Ilieva et al., 2002) and has been linked with improved response rates on questionnaires (Ilieva et al., 2002).

At the time of recruitment, young people’s saturation with online working may have limited recruitment numbers. With so many aspects of their lives being relocated to online settings at that point of the pandemic, young people may have been reluctant to engage with yet another online activity, despite rising rates of psychological distress (YoungMinds, 2021).

Another potential limitation was the digital exclusion of those without access to online videoconferencing devices. Digital poverty isolates young people who have difficulty accessing services, and this was particularly exacerbated by the pandemic (CQC, 2021) where face-to-face services were not possible.

4.5.3. Researcher-Clinician Dual Role

The researcher performed many roles in this study, including recruitment, screening, delivery of the therapy and data analysis. There are potential strengths and limitations to this approach. Arguments could be made that this dual role could result in an increase in bias through a conflict of interest, and lead to a lack of external validity (Eisner, 2003; Hay-Smith et al., 2016; Yanos & Ziedonis, 2006). However, some studies have shown positive effects where clinicians also evaluated self-delivered interventions (Eisner, 2003; Yanos & Ziedonis, 2006), with limited differences when the same intervention was evaluated by external researchers. Dual clinician-researchers could also ensure increased model fidelity and a high standard of intervention delivery.

To mitigate against potential bias, much of the data was collected digitally by an online, university-approved program. Participants were then able to complete measures with less influence of a courtesy bias, which can occur in the immediate presence of a researcher. However, participants were aware that the researcher would eventually view the survey results, which may have influenced their responses. A qualified MoL therapist on the research team was also enlisted to ensure adequate fidelity to the MoL intervention delivery through the rating of a random selection of session recordings. The high fidelity ratings reflected the researcher’s adherence to the non-judgmental, impartial delivery of online MoL. However, the researcher acknowledges that by both implementing and evaluating online MoL, there may be potential for some unaccounted bias.

4.5.4. Missing Data and Analyses

In section 3.4.1.1. the researcher acknowledged the protocol of best practice regarding the management of missing data. Having a small sample size meant that any missing data accounted for a larger percent of the total data available. Had a greater sample been recruited, the missing data may have accounted for less than 5%, meaning that the preferable process of multiple imputation may have been possible (instead of automatic listwise deletion).

The small sample size (and even further reduction due to listwise deletion) may also have limited the scope of this analysis. In previous MoL research (R. Griffiths et al.,

2019) an ANCOVA has been used to explore the impact of ‘number of sessions attended’ as a covariate. Other variables (including ‘previous engagement with mental health support’ or age) could also have been investigated as covariates, but this was not possible with the current sample size.

As well as this, the criteria used for the RCI analyses were drawn from predominantly adult samples, as limited information was available on the RCI for the GAD-7 and PHQ-9 with young people (in both clinical and non-clinical samples). Had extensive adolescent data been available for the criteria, a more accurate picture of reliable improvement or decline may have been possible.

4.5.5. Novelty

The current research appears to be the first of its kind in this area. Not only has it expanded the current research on the acceptability of delivering psychotherapeutic interventions via videoconferencing with young people, but it has uniquely focused on young people in late adolescence (rather than younger children), and particularly in the U.K. As well as this, it has specifically demonstrated the helpfulness and effectiveness of a transdiagnostic intervention (MoL) with these young people, in line with the THRIVE framework’s (Wolpert et al., 2019) transdiagnostic approach to mental healthcare. It has uniquely shown the effect of online MoL in young people’s ability to breakdown and manage their problems, and the positive impact on their life functioning in the short term. Young people’s persistent feedback on the usefulness of breaking down their problems in therapy, and the value in having control over their therapy sessions, not only mirrors previous consultations with young people (CQC, 2017, 2018, 2021), but shows that online MoL is a useful demonstration of these requests.

4.6. Future Research

The current research provides support for the transdiagnostic approach of online MoL in the provision of mental health support. Future research should focus on expanding the understanding of the potential of MoL as an acceptable transdiagnostic intervention, rather than focusing on disorder-specific interventions. By broadening the research base of MoL and online MoL, researchers could increase the ecological validity of the current findings and eventually incorporate MoL (and online MoL) as standard practice in services for young people. The following points explore some suggested areas for future research:

- A study with a larger and more diverse (in gender, sexuality and ethnicity) sample (this would allow the researcher to analyse the data in line with previous MoL studies, using ‘number of sessions attended’ as a covariate to see if this impacts the findings on a larger scale). Recruitment would ideally include more participants from across the age bracket.
- Individual interviews to provide a more nuanced understanding of the acceptability, accessibility and helpfulness of online MoL (similar to Churchman, Mansell, Al-Nufoury et. al, (2019)) as current study collected feedback in a qualitative manner. This would also provide much needed qualitative research in late adolescence, an area which is currently lacking (Weitkamp et al., 2016).
- It would be useful to conduct a study comparing the differences in effectiveness of online MoL to face-to-face MoL interventions, or to compare CBT and MoL with young people.
- To further emphasise the futility of disorder-focused approaches and the effectiveness of MoL regardless of severity of psychological distress, it would be useful to conduct a study comparing conventionally described ‘clinical’ and ‘non-clinical’ populations of young people.

4.7. Conclusions

The current research expands the literature available for online therapy with young people, and specifically provides findings on the attendance patterns, effectiveness, acceptability, accessibility and helpfulness of online MoL. This was demonstrated by findings in both process-based and life functioning measures, in descriptive information on attendance, as well as in feedback provided by young people, but only in a limited way on symptom-based measures. This may call attention to the contrariety between the NHS’ desire to support meaningful change in young people’s psychological distress, and their flawed stipulations of what ‘meaningful change’ involves. The most notable changes were found on the process-based measure of reorganisation of conflict and the life-functioning-based measure rating session outcomes. Tentative conclusions were drawn that online MoL may have influenced a young person's capacity for 'goal conflict reorganisation,' and that this skill may have plateaued but been retained after four weeks. Alongside this, life-functioning may have been positively influenced one week after young people's final MoL sessions, but that this effect was not able to be maintained after one month, potentially due to new, arising conflicts. These findings were reflected in the descriptive feedback from participants, with young people reporting that they found online MoL a useful and unique method for breaking down their problems. Young people also noted that flexibility around bookings was the most helpful aspect of online MoL, and gave them ownership and empowerment over their sessions. There was mixed feedback regarding the sense of control provided in sessions, but overall it appeared that this could be useful for all young people. The current findings have implications for the way young people access and engage with therapy, how MoL therapy can be offered by clinicians and how services can redefine how they conceptualise, evaluate and provide mental health care for young people experiencing psychological distress.

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6. APPENDICES

Appendix A: Search Terms

All Search Terms Included:
("Online Therapy" OR "online counselling" OR "telepsychology" OR "teletherapy" OR "telemental" OR "telepsychotherapy" OR "Internet-based intervention" OR "Internet-based psychotherapy" OR "remote therapy" OR "computer assisted therapy" OR "e-mental" OR "emental" OR "e-therapy" OR (“therapy” AND “web”) OR (“voice over internet protocol-delivered” AND “therapy”) OR (“psychological treatment” AND “tele*”)) AND (youth OR youths OR "young people" OR adolescent* OR teen* OR teenager* OR children OR child* OR “young adult” OR “young adults” OR “student” OR “university student” OR “college student”) AND ("face time" OR skype OR "microsoft Teams" OR zoom OR videoconferencing OR "video-conferencing" OR “web-camera” OR “web camera”) AND ("Method of Levels”)

Strand I: Online videoconferencing therapy with young people
("Online Therapy" OR "online counselling" OR "telepsychology" OR "teletherapy" OR "telemental" OR "telepsychotherapy" OR "Internet-based intervention" OR "Internet-based psychotherapy" OR "remote therapy" OR "computer assisted therapy" OR "e-mental" OR "emental" OR "e-therapy" OR (“therapy” AND “web”) OR (“voice over internet protocol-delivered” AND “therapy”) OR (“psychological treatment” AND “tele*”)) AND (youth OR youths OR "young people" OR adolescent* OR teen* OR teenager* OR children OR child* OR “young adult” OR “young adults” OR “student” OR “university student” OR “college student”) AND ("face time" OR skype OR "microsoft Teams" OR zoom OR videoconferencing OR "video-conferencing" OR “web-camera” OR “web camera”)

Strand II: MoL with young people
("Method of Levels”) AND (youth OR youths OR "young people" OR adolescent* OR teen* OR teenager* OR children OR child* OR “young adult” OR “young adults” OR “student” OR “university student” OR “college student”)

Appendix B: Exclusion Criteria

Strand I: Online videoconferencing-based therapy with young people

Not relevant and excluded based on title:

- No mention of psychological therapy

Not relevant and excluded through assessment of abstract

- Therapy did not involve children or young people
- Therapy was not one-on-one (i.e. was group, family or parent focused)
- Article focused on professional development, professional perspectives or the development of professional guidelines
- Therapy component did not involve videoconferencing
- Reviews, meta-analyses or books referencing studies already in search records

Not relevant and excluded through assessment of full-text articles

- Majority of participants older than 19
- Focus purely on therapeutic alliance
- Dissertation of a study already included as published article

Strand II: MoL with young people

Not relevant and excluded based on title:

- No psychological focus

Not relevant and excluded through assessment of abstract

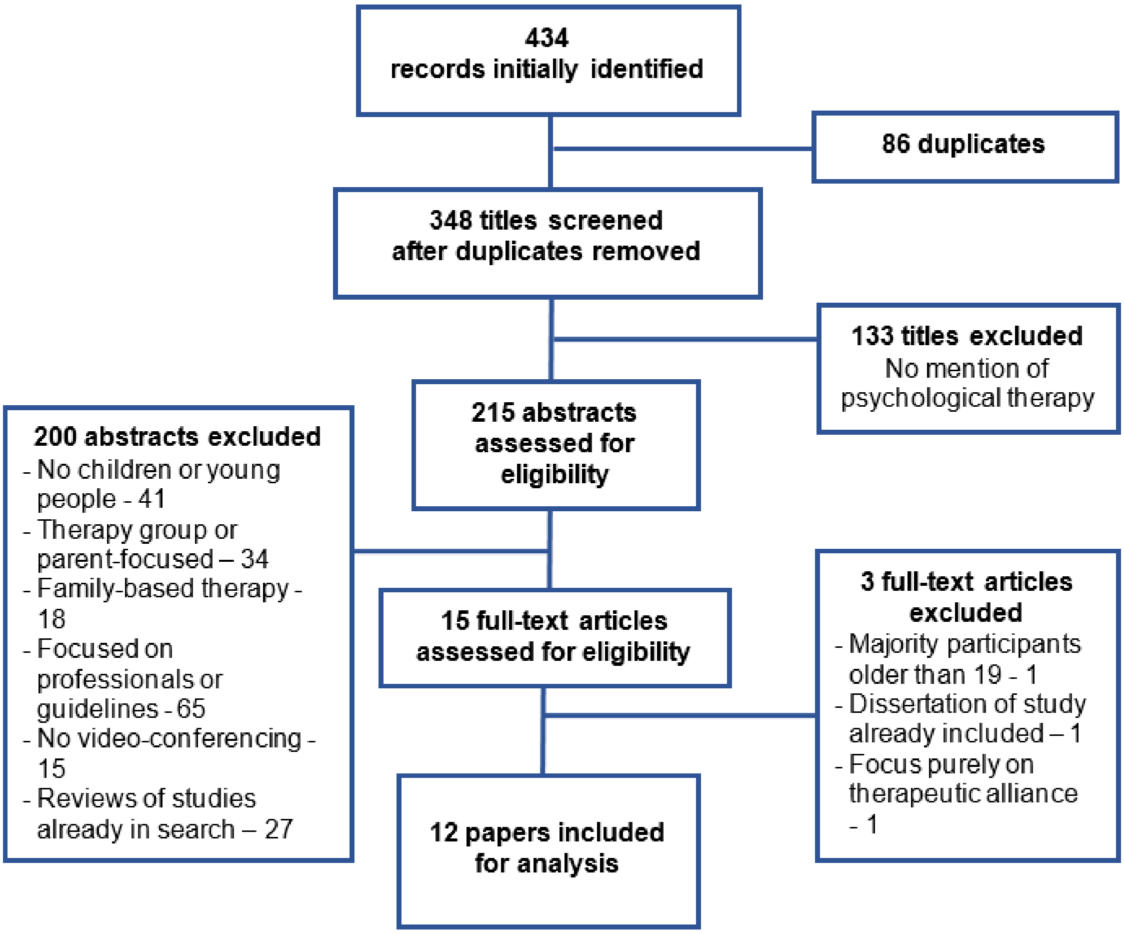
- No mention of MoL as intervention

Not relevant and excluded through assessment of full-text articles

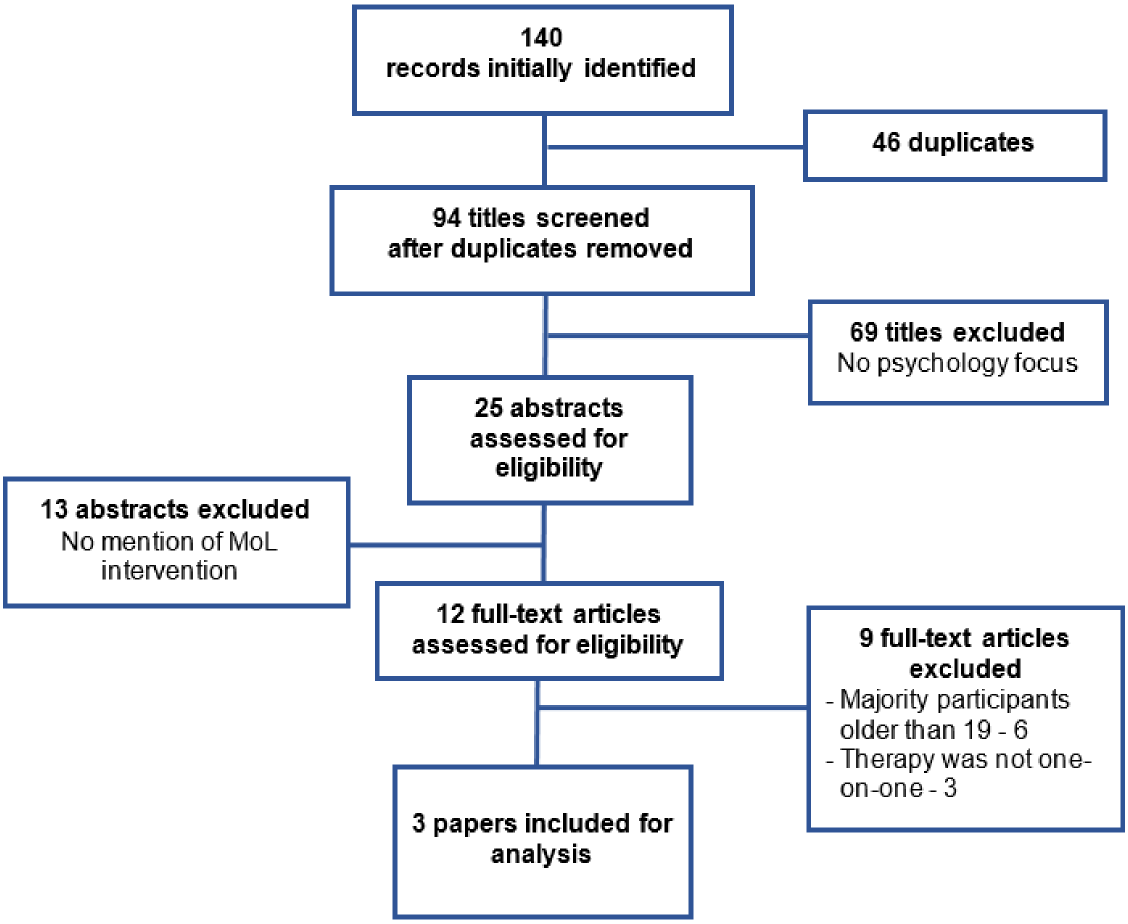
- Majority of participants were older than 19
- Therapy was not one-on-one (i.e. was group, family or parent focused)

Appendix C: Flow Diagrams of Exclusion Process

Flow diagram – Strand I: Online videoconferencing-based therapy with young people



Flow diagram – Strand II: MoL with young people



Appendix D: Summary of Papers from Scoping Review

Strand I: Online videoconferencing-based therapy with young people

Authors	Origin of Study	Intervention delivered via video-conferencing	Design	Young People (n)	Age range	Gender	Summary of Findings
Anderson (2019)	US	3 sessions of Solution-focused therapy	Pre-post intervention comparison	4	13-17	4 male	The study outcomes did not show any significant differences in "externalising behaviours" or youth-reported hope following the three sessions of therapy.
Haig-Ferguson et. al. (2019)	UK	Ongoing sessions of either: Cognitive Behavioural Therapy (CBT), Graded Exercise Therapy (GET) or Activity Management focused on Chronic Fatigue Syndrome (CFS).	Qualitative thematic analysis of experiences comparing sessions delivered face-to-face or via videoconferencing	12	9-18	3 male 9 female	Challenges and concerns: difficulties with technology, feeling that communication was partly lost, privacy issues. Benefits: greater accessibility, flexibility of intervention provision, greater openness in sessions, appreciation for comfort of being home. Intervention Provision: videoconferencing being only one of many options for sessions, the utility of videoconferencing in the context of CFS services, additional preparation for sessions required, assumption that all young people appreciate videoconferencing
Himle, et. al. (2012)	US	8 sessions of Comprehensive Behavioural Intervention for Tics (CBIT)	Pre-post intervention comparison, randomised between	20	8-17	17 male 1 female	Significant reduction in "tic symptoms" (d=0.42) and no significant differences between videoconferencing and face-to-face.

			face-to-face or via videoconferencing				No significant differences in ‘responsiveness to intervention’ in terms of tic “symptom and severity improvement” (80% of young people in videoconferencing condition and 75% of young people in face-to-face condition). Significant improvement in parent assessment of tics across time (d=0.53), but no differences between groups. Significant acceptability and therapist-client alliance ratings for both groups.
Hollmann et. al. (2021)	Germany	13 sessions of Cognitive Behavioural Therapy for obsessive–compulsive disorder (OCD)	Pre-post intervention comparison	9	7-17	7 male 2 female	Significant reduction measures of “symptoms of OCD” from pre- to post-intervention (d=2.02). Significant differences in ‘responsiveness to intervention’ in terms of OCD “symptoms” (d=1.34) and “severity” improvement (d=1.43). Significant improvement in social functioning (d=1.34). Young people did not show a statistically significant preference of the face-to-face session over videoconferencing sessions, and the intervention was most highly rated as ‘helpful and understandable.’
McLellan et. al. (2017)	Australia	10 sessions of Cool Kids Child and Adolescent Anxiety	Pre-post intervention comparison	16	9-12	13 male 3 female	Parent and child reports indicated that 62.5% of young people no longer met the respective “DSM-IV diagnosis of anxiety” following intervention.

		Management CBT Program					Significant decrease in measures of the "severity of anxiety symptoms" following intervention in both child (d=5.962) and parent report (d=2.314). Significant decrease in measures of the "severity of depression symptoms" following intervention in both child (d=2.663) and parent report (d=1.720). Significant decrease in "externalising difficulties" following intervention in both child (d=2.299) and parent report (d=2.163).
Nelson & Patton (2016)	US	Study (1) 4 sessions of Behavioural intervention with ADHD and ODD Study (2) 6 sessions of Psychoeducation and behavioural interventions for encopresis and enuresis management Study (3) CBT for depression	Case study	3	9-17	2 male 1 female	(1) Decrease in guardian ratings on "ADHD and ODD behaviours," decrease in family conflict frequency (2) Increase in appropriate stooling and urinating, decrease in accidents. (3) A range of CBT skills were applied

		(unclear number of sessions)					
Ricketts, Bauer, et al., 2016	US	8 sessions of Comprehensive Behavioural Intervention for Tics (CBIT)	Case study	4	10-13	4 male	Decrease of 29.44% in measures of “tic severity” following intervention (no d reported). Differences in ‘responsiveness to intervention’ in terms of tic “symptoms” and “severity” improvement in two participants. High ratings of therapeutic alliance, caregiver and young person satisfaction with intervention and the use of videoconferencing.
Ricketts, Goetz, et al., 2016	US	8 sessions of Comprehensive Behavioural Intervention for Tics (CBIT)	Randomised, waitlist-controlled. Pre- to post-intervention comparison of waitlist to intervention.	20	8-16	13 male 7 female	Significantly greater decrease in clinician-rated (η_p^2 =0.15) and parent-reported tic severity (η_p^2 =0.26) in the CBIT group compared to the waitlist-control. Therapy acceptability was rated highly by both young people and their parents, and moderately high scores on measures of therapeutic alliance.
Shealy et. al. (2015)	US	10 sessions of Trauma-Focused Cognitive Behavioural Therapy	Case study	1	13	1 male	Significant decreases in measures of “symptoms of PTSD,” “depression,” and “externalising behaviours” (d not reported). Significant increase in activity participation, prosocial interactions. Significant improvement in sleep, appetite and concentration. High caregiver satisfaction with intervention and high ratings of accessibility and helpfulness of use of videoconferencing.

Stewart et. al. (2017)	US	12-20 sessions of Trauma-Focused Cognitive Behavioural Therapy	Pre-post intervention comparison	15	7-16	1 male 14 female	Clinically significant decreases across measures of “symptoms of trauma” (d=2.93), “depression” (d=1.01), “anxiety” (d=1.26) and “emotional and behavioural problems” (d=0.94) 100% of parents expressed satisfaction with videoconferencing approach.
Stewart et. al. (2020)	US	12-24 sessions of Trauma-Focused Cognitive Behavioural Therapy	Pre-post intervention comparison	70	7-18	13 male 57 female	Clinically significant decreases in measures of “DSM-5 posttraumatic symptoms” from both young people (d=2.04) and caregiver reports (d=1.50) following therapy, such that 98.6% of those that completed the intervention no longer met “diagnostic criteria for PTSD.” Clinically significant decreases in measures of “depressive symptoms” from both young people (d=1.24) and caregiver reports (d=1.21) following therapy.
Zepeda et. al. (2021)	US	3 sessions of iCOPE with COVID-19 CBT program for young people who experienced anxiety in relation to COVID-19	Pre-post intervention comparison	27	6-12	9 male 18 female	Intervention was rated highly on measures of acceptability. Significant decreases on measures of social anxiety (d=1.07), and trends towards significance for scores of ‘total anxiety’ (d=-.64).

Strand II: MoL with Young People

Authors	Origin of Study	Intervention delivered	Design	Young People (n)	Age range	Gender	Summary of Findings
Churchman et. al. (2019)	UK	Up to 6 months of face-to-face MoL	Qualitative thematic analysis of experiences	14	11-15	9 male 5 female	Therapy style: Young people appreciated the freedom to book their own sessions, the questioning style of MoL, the process of breaking things down Therapy experience: Young people felt listened to and understood, and a sense of trust and confidentiality Exploring problems: young people found it helpful to talk, gain insight into their problems, change their perspective and find solutions Choice and control: Young people valued the choice and control in session, and recognised choice and control in the style of therapy
Churchman, Mansell & Tai (2021)	UK	Up to 6 months of face-to-face MoL	Pre-post intervention comparison	16	11-15	9 male 7 female	Researchers retained 75% of the participants for the entirety of the study (>60%). Psychological measures of distress appeared to decrease during the intervention period, with five young people being classed as ‘recovered’ following the intervention, and seven classed as having made no change (r=0.56).
Churchman, Mansell	UK	Up to 6 months of	Case series	16	11-15	17 male 1 female	Young people attended 7.62 sessions, with the majority attending between one and three sessions (range: 1-18 sessions).

& Tai (2019)		face-to-face MoL					There did not appear to be any identifiable patterns to the frequency of sessions attended. At the end of therapy, eight participants increased in their sense of empowerment and ability to problem-solve, whilst nine participants displayed a decrease in scores on psychological measures. This was maintained at the two-month follow-up point, but at four months a greater number of young people (n=8) reported increased problem-solving skills than levels of empowerment (n=6). Reliable change scores were varied for each individual, across the outcome measures.

Appendix E: Notice of Ethics Review Decision

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER:	Matthew Jones Chesters
SUPERVISOR:	Trishna Patel
STUDENT:	Nicole Gluckman
Course:	Prof Doc in Clinical Psychology

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED <u>BEFORE</u> THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is <u>not</u> required but the student must confirm with their supervisor that all minor amendments have been made <u>before</u> the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY
(Please indicate the decision according to one of the 3 options above)

APPROVED

Minor amendments required *(for reviewer)*:

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature):Nicole Gluckman*
Student number: 1945453
Date: 15-June-2021

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

Has an adequate risk assessment been offered in the application form? YES

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐ HIGH

Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

☐ MEDIUM (Please approve but with appropriate recommendations)

☒ LOW

Reviewer comments in relation to researcher risk (if any).

Reviewer *(Typed name to act as signature)*: M H Jones Chesters
Date: 22 June 2021

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

RESEARCHER PLEASE NOTE:

For the researcher and participants involved in the above named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UELs Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard

Appendix F: Ethics Approval Application (Amended Version)

UNIVERSITY OF EAST LONDON
School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL FOR RESEARCH INVOLVING HUMAN PARTICIPANTS
(Updated October 2019)

FOR BSc RESEARCH
FOR MSc/MA RESEARCH
FOR PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

1. Completing the application

1.1 Before completing this application please familiarise yourself with the British Psychological Society's Code of Ethics and Conduct (2018) and the UEL Code of Practice for Research Ethics (2015-16). Please tick to confirm that you have read and understood these codes: ☑

1.2 Email your supervisor the completed application and all attachments as ONE WORD DOCUMENT. Your supervisor will then look over your application.

1.3 When your application demonstrates sound ethical protocol, your supervisor will submit it for review. By submitting the application, the supervisor is confirming that they have reviewed all parts of this application, and consider it of sufficient quality for submission to the SREC committee for review. It is the responsibility of students to check that the supervisor has checked the application and sent it for review.

1.4 Your supervisor will let you know the outcome of your application. Recruitment and data collection must NOT commence until your ethics application has been approved, along with other research ethics approvals that may be necessary (see section 8).

1.5 Please tick to confirm that the following appendices have been completed. Note: templates for these are included at the end of the form.

- The participant invitation letter ☑
- The participant consent form ☑
- The participant debrief letter ☑

1.6 The following attachments should be included if appropriate. In each case, please tick to either confirm that you have included the relevant attachment, or confirm that it is not required for this application.

- A participant advert, i.e., any text (e.g., email) or document (e.g., poster) designed to recruit potential participants.
  Included ☑ or
  See Appendices
  Not required (because no participation adverts will be used) ☐

- A general risk assessment form for research conducted off campus (see section 6).
  Included ☑ or
  See Appendices
  Not required (because the research takes place solely on campus or online) ☐

- A country-specific risk assessment form for research conducted abroad (see section 6).
  Included ☐ or

  Not required (because the researcher will be based solely in the UK) ☑

- A Disclosure and Barring Service (DBS) certificate (see section 7).
  Included ☑ or
  See Appendices
  Not required (because the research does not involve children aged 16 or under or vulnerable adults) ☐

- Ethical clearance or permission from an external organisation (see section 8).
  Included ☐ or

  Not required (because no external organisations are involved in the research) ☑

- Original and/or pre-existing questionnaire(s) and test(s) you intend to use.
  Included ☑ or

  Not required (because you are not using pre-existing questionnaires or tests) ☐

- Interview questions for qualitative studies.
  Included ☐ or

  Not required (because you are not conducting qualitative interviews) ☑

- Visual material(s) you intend showing participants.
  Included ☐ or

  Not required (because you are not using any visual materials) ☑

2. Your details

2.1 Your name: Nicole (Nicky) Gluckman

2.2 Your supervisor's name: Dr Trishna Patel (Director of Studies); Dr Paula Corredor-Lopez (Second Supervisor)

2.3 Title of your programme: Professional Doctorate in Clinical Psychology

2.4 UEL assignment submission date (stating both the initial date and the resit date): May 2022

3. Your research

Please give as much detail as necessary for a reviewer to be able to fully understand the nature and details of your proposed research.

3.1 The title of your study: An evaluation of online Method of Levels therapy with young people.

3.2 Your research questions:

Context:

Current approaches to psychological therapy rely on diagnostic templates, which is problematic given the low validity of diagnoses as separate constructed entities, and the low reliability of diagnosis between clinicians (Bentall & Beck, 2003; Boyle, 2014). This stigmatising, flawed strategy not only drives the allocation of interventions based on diagnosis, but also homogenises individuals within a diagnostic category as having the same needs (Boyle, 2007). This critique remains true of child and adolescent services (Hoagwood et al., 2001). However, regardless of the allocated intervention, studies have shown that different psychological interventions have equivalent outcomes (Stiles et al., 2008). This may indicate key therapeutic elements that facilitate successful therapy, and there has been a trend towards transdiagnostic therapies as a result.

One such transdiagnostic therapy is Method of Levels (M.O.L.). Evidence for the utility of M.O.L. with young people has only emerged more recently (Churchman et al., 2021; Churchman, Mansell, & Tai, 2019). Churchman et. al. (2019) found medium to large effect sizes regarding M.O.L.'s effectiveness in improving the wellbeing of 16 young people (aged 11-16). In their follow-up interviews (Churchman, Mansell, Al-Nufoury, et al., 2019), participants valued being given control over booking sessions, the session focus, and ending therapy. These are distinctive features of M.O.L., and were a significant part of their acceptability.

There are currently no published studies that explore the effectiveness of M.O.L. in an online videoconferencing setting.

The NHS has clearly emphasised the importance of a digital transformation in how service-users receive support for their mental health (Mental Health Taskforce, 2016; NHS England, 2019b). Recent systematic reviews show the comparative usefulness of digital therapies to face-to-face psychological therapy for both depression (Berryhill et al., 2018) and anxiety (Berryhill et al., 2019). Support exists for delivering therapy via videoconferencing with young people (Nelson & Bui, 2010; Nelson & Patton, 2016), and participants valued the accessibility and control this mode provided them (Plaistow et al., 2014).

Aims:
The THRIVE framework (Wolpert et al., 2019) emphasises the importance of a needs-led (not diagnosis-led) approach and of giving young people a voice in making decisions about their care. The client-directed nature and the transdiagnostic approach of M.O.L. makes it a suitable approach for actualising the aims of this framework. Currently only five published studies explore the utility of M.O.L. with young people, and this requires further exploration. As such, this study seeks to explore three different strands to determine the utility of M.O.L. with young people: effectiveness, efficiency and acceptability (including accessibility and helpfulness).

Research Questions:

Effectiveness: Does online M.O.L. therapy with young people significantly change scores on symptom-based measures (i.e. Patient Health Questionnaire-9 (PHQ-9), Generalised Anxiety Disorder Assessment-7 (GAD-7)), process-based measures (i.e. Reorganisation of Conflict Scale, RoC), and life functioning-based measures (i.e. Outcome Rating Scale, ORS)

- What are the effect sizes of these aforementioned changes?
- Does online M.O.L. therapy with young people result in clinically significant change in symptom-based measures?

Efficiency:

- What are the patterns of attendance of young people receiving online M.O.L. therapy?
- Does online M.O.L. therapy with young people result in an efficiency ratio close to 1?

Acceptability (accessibility, and helpfulness):

- How do young people experience online M.O.L. therapy and its participant-led practices?
- What aspects of online M.O.L. therapy do young people find helpful or unhelpful?

3.3 Design of the research:

The study will employ a case series design, where baseline, intervention and follow-up data will be collected. This design is best suited to determine the reactive effects of therapy, particularly in the early stages of assessing feasibility and acceptability of M.O.L. with young people in an online setting. Therefore, the study will aim to recruit approximately 12 participants.

3.4 Participants:

The researcher will aim to recruit 12 young people aged 16-19. Should recruitment prove difficult, the age range may be increased to 24 years old (as this is considered to be the upper age limit for the term 'young people' by the World Health Organisation,WHO, 2021).
To be eligible to take part in the study, participants will be required to be aged 16-19 and able to understand verbal and written information in English. They must be able to give consent to participate. If they are receiving ongoing professional mental health support from a therapist or through a care package from a local service (e.g. CAMHS), they will not be able to participate, as having two forms of therapy at once is not recommended. Also, if they have a significant brain injury or are currently using alcohol, drugs or self-harm to manage difficult emotions they will not be able to participate (as there are other specialist services that are recommended as a first port of call).

3.5 Recruitment:

Participants will be recruited through social media, colleges, schools, charities, community groups and other third sector organisations. Schools, colleges, charities, community groups and other third sector organisations will be contacted via email with a request to distribute the flyer (In Appendices) to students aged 16-19. These groups will not be required to enforce sign-ups to the project, but are encouraged to discuss the project with particular students if they feel they would benefit from M.O.L. therapy. A number of schools have already been reached out to, with currently two schools ([REDACTED SCHOOL NAME], and [REDACTED SCHOOL NAME]) expressing interest (See Appendices). A copy of the advertisement will also been set up on Instagram to be circulated informally by young people interested in the project (In Appendices). This is **not** linked to the researcher's personal social media account. The advertisements will contain the researcher's UEL email address, and the Instagram adverts will have links to the participant information statement and the researcher's email address.

The Instagram advert page has not currently been published, as page cannot be publicly uploaded without ethical approval. No copyrighted content included on the Instagram advert page. All content drawn from Participant Information Statement or freely available online (e.g. from public tiktok or Instagram accounts) and content creators appropriately referenced/cited. All content has been included based on recommendations from consultations with young people regarding the principles of M.O.L. therapy (Conflict, control and reorganisation).

3.6 Measures, materials or equipment:

I have consulted with young people from the target age group extensively on all the study materials (participant information sheet, survey, ad etc.). The language and way information has been communicated has been amended based on feedback/suggestions from young people. Although some of the documents may appear lengthy, young people have commented that they understood why all the content included was necessary and found the length acceptable.

Demographic Questionnaire (created by the researcher, included for review)

Symptom-based measures:
Patient Health Questionnaire (PHQ-9) (In Appendices)
Generalised Anxiety Disorder Questionnaire (GAD-7) (In Appendices)

To measure self-reported changes in symptoms of psychological wellbeing, the study will utilise the 9-item PHQ-9 (Kroenke & Spitzer, 2002)), and the 7-item GAD-7 (Spitzer et al., 2006). Both of these measures are widely used in mental health literature, and are well-validated for anxiety and depressive symptoms (Kroenke et al., 2010).

Process-based measure:
Reorganisation of Conflict Scale (ROC)
The ROC (Higginson & Mansell, 2008) is included as it measures the reorganisation of goal conflict that occurs during MoL, according to Perceptual Control Theory (PCT). The 11-item adaptation (Bird, 2013) reportedly has acceptable internal reliability with young people

(N'Danga-Koroma, 2018). I have been granted permission to use the ROC, but this was sent to me by the author so is not included in the appendices.

Life functioning-based measure:
Outcome Rating Scale (ORS) (In Appendices)
The ORS (Miller et al., 2003) measures intervention-related changes to four areas of life functioning (i.e. individual, interpersonal, social, overall). It was developed for individuals with a reading age of 13 and above (Miller et al., 2003) and a recent review of adolescent mental health measures found that the ORS had good therapeutic utility (Bentley et al., 2019). Although the written ORS is freely available, the online format of the ORS is restricted to a paid-subscription-based website. However, to provide flexibility around virtual working, Miller has provided recommendations around the verbal delivery of the ORS. The verbal ORS will be delivered in accordance with Miller's ICCE recommendations available on the website (https://www.youtube.com/watch?v=TjGcnZ_syV8), but is not available to be included as an appendix due to its verbal format. Instead, the written ORS has been included in Appendix.

Feedback Survey (created by the researcher). This includes questions exploring the acceptability, accessibility, and helpfulness through both closed and open text-box questions.

3.7 Data collection:

Participants will be able to view a participant information sheet (Appendix) by contacting the researcher via email, or by viewing them online via the link provided on the advertisement (Appendices). Following this, they will be sent an online consent form (Appendix) where they can agree to participate. They will then be provided a form which asks for demographic information (i.e. age, ethnicity, gender, any previous mental health diagnoses and previous engagement with therapy, etc).

Quantitative data will be collected weekly via questionnaire administration. This data will be collected at baseline for a period of 3 weeks, at the start of therapy, following each therapy session attended in the 12-week treatment window, and at one-week and one-month follow-up points. The two main objectives of M.O.L. are to support the client to explore their psychological distress, and to direct their attention to any 'background thoughts', in order to examine them further (Mansell et al., 2012). By shifting the client's consciousness to this higher level of perception, they may become aware of conflicts, which may enable reorganisation of thought and action (Tai, 2016). This reorganisation is facilitated by a questioning process by the M.O.L. therapist. Another key feature of M.O.L. is that clients are provided with a significant amount of control over their therapy (e.g. the dates and times they attend sessions, the focus of the discussion, the pace and direction of sessions, the frequency of sessions as well as the session length.

Participants will be able to book therapy sessions through a booking website (either Acuity, approved by the Data Protection Office – See Appendix or MS Bookings if approved by Head of IT Applications), and will have the choice of session length of time (up to 50 minutes), and session frequency (at most once a week), during these 12 weeks. Sessions will take place on MS Teams. Participants will not need to have sessions every week.

An ongoing recruitment window across a two-month period will be implemented to allow for recruitment delays. Quantitative and qualitative data will be collected via a Qualtrics survey using both open and closed questions.

Participants can change their mind about attending sessions at any time. If they feel they have had the right amount of M.O.L. sessions for them, they can stop and do not have to give a reason. But this is different to leaving the project altogether. They can choose to stop therapy at any time before the 12-week period. They will still be contacted later to give feedback, and to complete their follow-up questionnaire packs.

If participants decide that they wish to withdraw from the project altogether, they can notify the researcher before they are sent the feedback questionnaire, and their data will not be used as part of the research. Participants will have 3 weeks from their last point of contact (whether that's after a session or following a questionnaire pack) to request to leave and withdraw their data.

3.8 Data analysis:

Effectiveness

To understand changes in the psychological symptom (i.e. PHQ-9, GAD-7), process-based (i.e. ROC), and life functioning (i.e. ORS) outcome measures, the researcher will perform a visual analysis, statistical analysis and analysis of clinical significance.

Visual analysis will descriptively determine any reliable intervention effects and patterns between phases (i.e. compared to baseline and follow-up) (Parsonson & Baer, 2015).

Based on the recommendations by Parker and Brossart (2003), who analysed seven approaches to data analysis in case-series designs, the researcher will adopt either a mean-only difference or mean plus trend difference approach (B. A. Center et al., 1985), depending on the stability of the data during baseline. These approaches are recommended as they were found to be most effective overall, particularly in mitigating the effects of autocorrelation, a known challenge in the analysis of single-case research data (J. Fox, 1991). Effect size will also be used to determine the magnitude of the relationship between M.O.L. and the aforementioned measures.

The Reliable Change Index, which compares individual scores to a Z-distribution will be used to determine clinical significance in symptom-based measures (Jacobson & Truax, 1992).

Efficiency

Descriptive statistics of participation rates will indicate the level of engagement. To determine efficiency, an M.O.L. efficiency ratio (Carey et al., 2013) of effect size to mean number of sessions attended will be used. A ratio closer to one indicates a more efficient intervention.

Acceptability, Accessibility and Helpfulness

The acceptability, accessibility and helpfulness of the intervention will be explored through the descriptive statistics of recruitment information and quantitative survey data, as well as a content analysis of any qualitative data from the follow-up survey (e.g. participant views of M.O.L.).

4. Confidentiality and security

It is vital that data are handled carefully, particularly the details about participants. For information in this area, please see the UEL guidance on data protection, and also the UK government guide to data protection regulations.

4.1 Will participants data be gathered anonymously?

NO

4.2 If not (e.g., in qualitative interviews), what steps will you take to ensure their anonymity in the subsequent steps (e.g., data analysis and dissemination)?

All data and material from the project will be anonymised and any identifiers replaced with pseudonyms or numerical codes. Participants will be given an ID code for booking sessions and for any Qualtrics questionnaires to ensure their answers cannot be linked back to their name, but to ensure continuity in their scores and data.

4.3 How will you ensure participants details will be kept confidential?

Digitally signed consent forms will be recorded on the secure online data storage system associated with the online questionnaire software MS Forms. Electronic consent forms will be saved in a separate H: Drive folder to other research data and will be encrypted.

Similarly, Survey and questionnaire responses will be collected using the Qualtrics secure online survey platform licensed to the UEL School of Psychology and saved on a password protected UEL OneDrive. All IP addresses and other identifiers will be removed upon download from the Qualtrics and prior to saving on UEL One Drive. Each series of questionnaire data will be named with the participants' ID code and the dates of the data completion.

Personally identifying data (names, contact details etc.) will only be stored (securely) for as long as absolutely necessary and then permanently deleted. Unless the participant requests a copy of the publication following the submission, this personal data will be deleted once data collection is complete. This personal data will be stored separately from anonymised raw data, such as spreadsheets and transcripts. It will be stored in a separate password protected folder on the UEL OneDrive for Business system.

4.4 How will the data be securely stored?

For analysis, the anonymised spreadsheet will be downloaded to the researcher's password protected laptop. The laptop is a personal, non-networked, laptop with a password only known to the researcher.

Audio recordings will be saved on the researcher's password protected UEL OneDrive cloud service, which will be encrypted. Any recordings required for rating will have the password sent to them via UEL email to a secure device. Once these recordings have been rated by the qualified M.O.L. therapist, they will then be deleted. The ratings of these recordings will then be stored on OneDrive for Business in the form of a spreadsheet.

Should any transcriptions be necessary, these will be anonymised and stored on the password protected UEL OneDrive folder.

Once the researcher leaves UEL, all anonymised data will be shared with the supervisor and the supervisor will store this data on the UEL OneDrive. All personal and research data will be deleted from the researcher's personal access, and nothing will be stored on personal drives.

Any booking information entered on the online booking system will be password protected with a password only known to the researcher . The attendance data of participants will be entered into a spreadsheet with the corresponding participant ID code. The booking system account will be erased once the thesis has been examined and passed.

As there is an intention to contact participants during the study (e.g. to book appointments), the contact information necessary to do this will be securely stored separately from all other data/information collected in the course of the study in an unshared password protected UEL OneDrive for Business folder. Explicit and informed consent to keep this information and contact participants will be gained.

4.5 Who will have access to the data?

The researcher will collect all questionnaire and survey data and only the research team, supervisor and examiners will have access to anonymised data.
Audio recordings will be uploaded and saved on the UEL OneDrive (encrypted) immediately after the recording has ended. Recordings will then be deleted from the Dictaphone recording device.
Audio files and any transcriptions will be saved with anonymised titles. These will be deleted once the M.O.L. therapist has rated 10% of recordings.
The online Acuity booking system will be password protected with a password only known to the researcher.
Personal and research data will be stored separately.
Anonymised data spreadsheets will be shared with the research supervisor via UEL email. Data lines will be numbered with participant ID code.
Extracts of any transcripts or qualitative feedback will be provided in the final research write up and any subsequent publications. All identifiable information will not be included in these extracts.
Anonymised recordings will be shared with the qualified M.O.L. therapist for rating of M.O.L. fidelity via a password protected OneDrive for Business link.
No one outside the named research team will have access to personal or research data. Examiners will only have access to anonymised data upon request.

4.6 How long will data be retained for?

Recordings, any transcriptions, and electronic copies of booking data and online survey software data will be kept in their respective sources until the thesis has been examined and passed. They will then be erased from UEL servers.

During the research study period, data spreadsheets will be stored on the researcher's UEL secure OneDrive for Business. Spreadsheets will be kept after completion of the clinical doctorate course for dissemination purposes and sent via secure UEL email to supervisors to store on their UEL H: drive. This will then be deleted after 3 years as per data management policy.

Once the researcher leaves UEL, all anonymised data will be shared with the supervisor and the supervisor will store this data on the UEL OneDrive. This will then be deleted after 3 years.

5. Informing participants

Please confirm that your information letter includes the following details (Appendix):

5.1 Your research title: ☑

5.2 Your research question: ☒

Listing the research questions will inform the study findings, however no deception will be used and the study aims are clearly communicated in the participant information sheet.

5.3 The purpose of the research: ☑

5.4 The exact nature of their participation. This includes location, duration, and the tasks etc. involved: ☑

5.5 That participation is strictly voluntary: ☑

5.6 What are the potential risks to taking part: ☑

5.7 What are the potential advantages to taking part: ☑

5.8 Their right to withdraw participation (i.e., to withdraw involvement at any point, no questions asked): ☑

5.9 Their right to withdraw data (usually within a three-week window from the time of their participation): ☑

5.10 How long their data will be retained for: ☑

5.11 How their information will be kept confidential: ☑

5.12 How their data will be securely stored: ☑

5.13 What will happen to the results/analysis: ☑

5.14 Your UEL contact details: ☑

5.15 The UEL contact details of your supervisor: ☑

Please also confirm whether:

5.16 Are you engaging in deception? If so, what will participants be told about the nature of the research, and how will you inform them about its real nature.

NO

5.17 Will the data be gathered anonymously? If NO what steps will be taken to ensure confidentiality and protect the identity of participants?

NO. All data and material from the project will be anonymised and any identifiers replaced with pseudonyms or numerical codes. Participants will be given an ID code for booking sessions and for any Qualtrics questionnaires to ensure their answers can't be linked back to their name, but to ensure continuity in their scores and data.

The results of the project will be submitted to be published in psychology journals and might also be presented to other academics, schools or clinicians in meetings or conferences. In every aspect of the material used that comes from the project, participant identity will be anonymous. It will not be possible to identify participants personally as all this information will have been removed or replaced with participant ID codes.

5.18 Will participants be paid or reimbursed? If so, this must be in the form of redeemable vouchers, not cash. If yes, why is it necessary and how much will it be worth?

NO.

6. Risk Assessment (See Appendices)

Please note: If you have serious concerns about the safety of a participant, or others, during the course of your research please see your supervisor as soon as possible. If there is any unexpected occurrence while you are collecting your data (e.g. a participant or the researcher injures themselves), please report this to your supervisor as soon as possible.

6.1 Are there any potential physical or psychological risks to participants related to taking part? If so, what are these, and how can they be minimised?

Psychological therapy is aimed at reducing psychological distress and Method of Levels therapy is not expected to increase difficult feelings more than other types of therapy. Participants will be allowed to take breaks or stop therapy at any time without providing a reason for doing so. They will be given the numbers of other services that they can contact if they need immediate support outside of the sessions and these will be provided at the start of therapy and end of each therapy session.

Risk management is an important factor when working with young people. Please see Appendix for the full risk assessment protocol. If a client discloses risk (to themselves or to others) (either verbally during therapy or by scoring 2 or 3 on question 9 of the PHQ-9), the session will be stopped to conduct a full risk assessment. If the risk is deemed low (i.e. there are no immediate risks and no plans or intentions to act on any thoughts of self-harm or suicide), the participant will be asked if they would like to continue or end the session. They will be signposted to support services. If the participant is considered to have active risk, the session will be terminated and the M.O.L. therapist will remain with the participant to create a safety plan, refer to local crisis services, and, if needed, until an ambulance/police/mental health service is contacted and arrives. Supervisors will be advised.

Risk will also be managed by ensuring that participants are provided with a list of supporting agencies along within the participant information statement and at the end of each session (as it is unknown when they will decide to stop therapy). (See Appendices for list of supporting agencies included in participant information statement and debrief letter).

6.2 Are there any potential physical or psychological risks to you as a researcher? If so, what are these, and how can they be minimised?

NO. All data collected will be online. The researcher will regularly receive research and clinical supervision throughout the study. A remote working risk assessment has been created and attached in Appendix.

6.3 Have appropriate support services been identified in the debrief letter? If so, what are these, and why are they relevant?

YES. See Appendix. Mental health services related to young people have been included.
Childline, Samaritans, Papyrus, The Mix have all been included for urgent support.
Hub of Hope, On My Mind, Rethink Mental Illness, YoungMinds and Youth Access have all been included as resources for further information on psychoeducation, support and organisations.
Kooth has been included as an additional free counselling service.

6.4 Does the research take place outside the UEL campus? If so, where?

NO. The study will be conducted virtually online using MS Teams in a space where the participant feels comfortable speaking. However, as it is purely online, a risk assessment form of this kind is not needed. As the research involves talking about sensitive issues, a risk assessment form has been completed – This has been attached in the appendices and is good practice.

If so, a 'general risk assessment form' must be completed. This is included below as an appendix. Note: if the research is on campus, or is online only (e.g., a Qualtrics survey), then a risk assessment form is not needed, and this appendix can be deleted. If a general risk assessment form is required for this research, please tick to confirm that this has been completed:

6.5 Does the research take place outside the UK? If so, where?

NO.

If so, in addition to the 'general risk assessment form', a 'country-specific risk assessment form' must be also completed (available in the Ethics folder in the Psychology Noticeboard), and included as an appendix. [Please note: a country-specific risk assessment form is not needed if the research is online only (e.g., a Qualtrix survey), regardless of the location of the researcher or the participants.] If a ‘country-specific risk assessment form’ *is* needed, please tick to confirm that this has been included:

However, please also note:

- For assistance in completing the risk assessment, please use the AIG Travel Guard website to ascertain risk levels. Click on ‘sign in’ and then ‘register here’ using policy # 0015865161. Please also consult the Foreign Office travel advice website for further guidance.
- For *on campus* students, once the ethics application has been approved by a reviewer, all risk assessments for research abroad must then be signed by the Head of School (who may escalate it up to the Vice Chancellor).
- For *distance learning* students conducting research abroad in the country where they currently reside, a risk assessment must be also carried out. To minimise risk, it is recommended that such students only conduct data collection on-line. If the project is deemed low risk, then it is not necessary for the risk assessments to be signed by the Head of School. However, if not deemed low risk, it must be signed by the Head of School (or potentially the Vice Chancellor).
- Undergraduate and M-level students are not explicitly prohibited from conducting research abroad. However, it is discouraged because of the inexperience of the students and the time constraints they have to complete their degree.

7. Disclosure and Barring Service (DBS) certificates

7.1 Does your research involve working with children (aged 16 or under) or vulnerable adults (*see below for definition)?

[✓ YES] / NO

See Appendix

7.2 If so, you will need a current DBS certificate (i.e., not older than six months), and to include this as an appendix. Please tick to confirm that you have included this: ☑

Alternatively, if necessary for reasons of confidentiality, you may email a copy directly to the Chair of the School Research Ethics Committee. Please tick if you have done this instead: ☐

Also alternatively, if you have an Enhanced DBS clearance (one you pay a monthly fee to maintain) then the number of your Enhanced DBS clearance will suffice. Please tick if you have included this instead: ☐

7.3 If participants are under 16, you need 2 separate information letters, consent form, and debrief form (one for the participant, and one for their parent/guardian). Please tick to confirm that you have included these: ☐

7.4 If participants are under 16, their information letters consent form, and debrief form need to be written in age-appropriate language. Please tick to confirm that you have done this ☐

* You are required to have DBS clearance if your participant group involves (1) children and young people who are 16 years of age or under, and (2) 'vulnerable' people aged 16 and over with psychiatric illnesses, people who receive domestic care, elderly people (particularly those in nursing homes), people in palliative care, and people living in institutions and sheltered accommodation, and people who have been involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak to your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible. For more information about ethical research involving children click here.

8. Other permissions

9. Is HRA approval (through IRAS) for research involving the NHS required? Note: HRA/IRAS approval is required for research that involves patients or Service Users of the NHS, their relatives or carers as well as those in receipt of services provided under contract to the NHS.

YES / [✓ NO]   If yes, please note:

- You DO NOT need to apply to the School of Psychology for ethical clearance if ethical approval is sought via HRA/IRAS (please see further details here).
- However, the school *strongly discourages* BSc and MSc/MA students from designing research that requires HRA approval for research involving the NHS, as this can be a very demanding and lengthy process.
- If you work for an NHS Trust and plan to recruit colleagues from the Trust, permission from an appropriate manager at the Trust must be sought, and HRA approval will probably be needed (and hence is likewise strongly discouraged). If the manager happens to not require HRA approval, their written letter of approval must be included as an appendix.
- IRAS approval is not required for NHS staff even if they are recruited via the NHS (UEL ethical approval is acceptable). However, an application will still need to be submitted to the HRA in order to obtain R&D approval. This is in addition to a separate approval via the R&D department of the NHS Trust involved in the research.
- IRAS approval is not required for research involving NHS employees when data collection will take place off NHS premises, and when NHS employees are not recruited directly through NHS lines of communication. This means that NHS staff can participate in research without HRA approval when a student recruits via their own social or professional networks or through a professional body like the BPS, for example.

9.1 Will the research involve NHS employees who will not be directly recruited through the NHS, and where data from NHS employees will not be collected on NHS premises?

YES / [✓ NO]

9.2 If you work for an NHS Trust and plan to recruit colleagues from the Trust, will permission from an appropriate member of staff at the Trust be sought, and will HRA be sought, and a copy of this permission (e.g., an email from the Trust) attached to this application?

YES / [✓ NO]

9.3 Does the research involve other organisations (e.g. a school, charity, workplace, local authority, care home etc.)? If so, please give their details here.

The recruitment of participants may involve [REDACTED SCHOOL NAME], and [REDACTED SCHOOL NAME] among other potential schools and universities (See Appendix). The recruitment phase may also involve contacting charities, community groups and other third sector organisations.

Furthermore, written permission is needed from such organisations if they are helping you with recruitment and/or data collection, if you are collecting data on their premises, or if you are using any material owned by the institution/organisation. If that is the case, please tick here to confirm that you have included this written permission as an appendix: ☐

In addition, before the research commences, once your ethics application has been approved, please ensure that you provide the organisation with a copy of the final, approved ethics application. Please then prepare a version of the consent form for the organisation themselves to sign. You can adapt it by replacing words such as 'my' or 'I' with 'our organisation,' or with the title of the organisation. This organisational consent form must be signed before the research can commence.

Finally, please note that even if the organisation has their own ethics committee and review process, a School of Psychology SREC application and approval is still required. Ethics approval from SREC can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s as may be necessary.

9. Declarations

Declaration by student: I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor.

Student's name (typed name acts as a signature): NICOLE GLUCKMAN

Student's number: 1945453 Date: 09/06/2021

As a supervisor, by submitting this application, I confirm that I have reviewed all parts of this application, and I consider it of sufficient quality for submission to the SREC committee.

APPLICATION FOR RESEARCH ETHICS APPROVAL FOR RESEARCH INVOLVING HUMAN PARTICIPANTS

APPENDICES:

Ethics Approval Additional Appendix A: Recruitment Details

From: [REDACTED]
Sent: 20 February 2021 18:48
To: Nicole GLUCKMAN <u1945453@uel.ac.uk>
Subject: Re: Research Project for Young People (with University of East London)

Dear Nicky
Thanks for your email.
This sounds really interesting and would be something we'd be happy to be involved with.
Our students at [REDACTED] would definitely benefit from this.
Please feel free to let me know next steps and how I can help further.
Kind regards
[REDACTED]

On Mon, 8 Feb 2021 at 10:39, Nicole GLUCKMAN <u1945453@uel.ac.uk> wrote:

Dear [REDACTED],

My name is Nicole 'Nicky' Gluckman, and I am a Trainee Clinical Psychologist at the University of East London. I was given your email to get in touch with you regarding a research project that is currently in the final stages of seeking approval from the university Ethics Committee.

The project is looking to understand more about a new type of psychological therapy called Method of Levels (M.O.L.), which has helped some people improve their mental health and better manage problems in their lives. M.O.L. does not give people a diagnosis or label, but gives people more control and choice over what they talk about during the sessions, and also how the sessions are booked (e.g., booking sessions when they feel like having one, and also choosing how long their session is). M.O.L. has already been researched with different groups and services, and in many countries (e.g. U.K., U.S. & Australia). Young people have said that being able to easily access therapy is important to them, so this project is looking to see if M.O.L. is helpful online (via videocall). We are hoping to get young people aged 16-19 from across the U.K. (who are not already receiving mental health support) to sign up and try out M.O.L. therapy. Between April and November 2021, they will be offered as many free weekly therapy sessions as they would like (with a maximum of 16) across a four-month period, and with two additional follow-up sessions. We are hoping their experiences and feedback can help us give advice to services and schools about improving the experiences and choices around therapy for young people.

At this stage, whilst my research team and I are awaiting final approval from the University of East London Ethics Committee, we are looking to see if there are schools and colleges across the country that would be interested in supporting us to distribute the flyer and encourage students to sign-up (who might benefit from some free psychological therapy). I have attached a copy of the current drafts of the flyer and information pack for your reference.

If you think you might be interested in supporting us to distribute the flyer and encourage students to sign-up, please do get in touch, so that I can send through the official copies of the advert and information pack once they are approved in the coming weeks.

If you have any additional questions about the project, please do not hesitate to get in contact with me.
I look forward to hearing from you.
Kind Regards,
Nicky Gluckman
Trainee Clinical Psychologist
Supervised by Trishna Patel
Professional Doctorate in Clinical Psychology (Cohort 2019-2022)
E-mail: u1945453@uel.ac.uk

From: [REDACTED]
Sent: 09 February 2021 11:02
To: Nicole GLUCKMAN <u1945453@uel.ac.uk>
Subject: RE: Research Project for Young People (with University of East London)

Hi Nicky,
Thanks for your email, this sounds great. Some of our GCSE and Sixth Form students would really benefit from this and we would love to be involved. Please keep me updated on when the project is ready and I can support you with arranging meetings etc with the relevant people. Kind regards, [REDACTED]

From: Nicole GLUCKMAN <u1945453@uel.ac.uk>
Sent: 08 February 2021 10:38
To: [REDACTED]
Subject: Research Project for Young People (with University of East London)

Dear [REDACTED],
My name is Nicole 'Nicky' Gluckman, and I am a Trainee Clinical Psychologist at the University of East London. I was given your email to get in touch with you regarding a research project that is currently in the final stages of seeking approval from the university Ethics Committee.
The project is looking to understand more about a new type of psychological therapy called Method of Levels (M.O.L.), which has helped some people improve their mental health and better manage problems in their lives. M.O.L. does not give people a diagnosis or label, but gives people more control and choice over what they talk about during the sessions, and also how the sessions are booked (e.g., booking sessions when they feel like having one, and also choosing how long their session is). M.O.L. has already been researched with different groups and services, and in many countries (e.g. U.K., U.S. & Australia). Young people have said that being able to easily access therapy is important to them, so this project is looking to see if M.O.L. is helpful online (via videocall). We are hoping to get young people aged 16-19 from across the U.K. (who are not already receiving mental health support) to sign up and try out M.O.L. therapy. Between April and November 2021, they will be offered as many free weekly therapy sessions as they would like (with a maximum of 16) across a four-month period, and with two additional follow-up sessions. We are hoping their experiences and feedback can help us give advice to services and schools about improving the experiences and choices around therapy for young people.
At this stage, whilst my research team and I are awaiting final approval from the University of East London Ethics Committee, we are looking to see if there are schools and colleges across the country that would be interested in supporting us to distribute the flyer and encourage students to sign-up (who might benefit from some free psychological therapy). I

have attached a copy of the current drafts of the flyer and information pack for your reference.

If you think you might be interested in supporting us to distribute the flyer and encourage students to sign-up, please do get in touch, so that I can send through the official copies of the advert and information pack once they are approved in the coming weeks.

If you have any additional questions about the project, please do not hesitate to get in contact with me.

I look forward to hearing from you.

Kind Regards,
Nicky Gluckman

Appendix G: Request for Amendment to an Ethics Application

UNIVERSITY OF EAST LONDON
School of Psychology

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology.

Note that approval must be given for significant change to research procedure that impacts on ethical protocol. If you are not sure about whether your proposed amendment warrants approval consult your supervisor or contact Dr Trishna Patel (Deputy Research Director/Chair of School Research Ethics Committee).

HOW TO COMPLETE & SUBMIT THE REQUEST

1. Complete the request form electronically and accurately.
2. Type your name in the 'student's signature' section (page 2).
3. When submitting this request form, ensure that all necessary documents are attached (see below).
4. Using your UEL email address, email the completed request form along with associated documents to: Dr Trishna Patel at t.patel@uel.ac.uk
5. Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.
6. Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

REQUIRED DOCUMENTS

1. A copy of your previously approved ethics application with proposed amendments(s) added as tracked changes.
2. Copies of updated documents that may relate to your proposed amendment(s). For example an updated recruitment notice, updated participant information letter, updated consent form etc.

3. A copy of the approval of your initial ethics application.

Name of applicant:	NICOLE 'NICKY' GLUCKMAN
Programme of study:	PROFESSIONAL DOCTORATE OF CLINICAL PSYCHOLOGY
Title of research:	An evaluation of online Method of Levels therapy with young people
Name of supervisor:	Trishna Patel

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	Rationale
Including charities, community organisations and other third sector organisations as part of recruitment.	Schools have now closed for the summer, and these organisations seem most appropriate to contact for additional recruitment.

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	X	

Student's signature (please type your name): NICOLE GLUCKMAN

Date: 22/07/2021

TO BE COMPLETED BY REVIEWER		
Amendment(s) approved	YES	
Comments		

Reviewer: Trishna Patel

Date: 22/07/2021

Appendix H: Participant Information Statement

Version 1 09/06/2021

University of East London
Pioneering Futures Since 1898

PARTICIPANT INFORMATION SHEET

An evaluation of online Method of Levels therapy with young people

Contact person: Nicole ('Nicky') Gluckman (MoL Therapist and Researcher)
Email: u1945453@uel.ac.uk
Address: University of East London, University Way. London, E16 2RD

Thanks for getting in touch. My name is Nicky Gluckman and I'm a trainee Clinical Psychologist currently studying at the University of East London. This is my thesis project, and is an important part of my training. In these forms you might see the term 'researcher,' which refers to me, but I have two roles: collecting research data and being your therapist.

Before you make your decision about getting involved in this research project, I'd like to explain a bit about the project and what you can expect to happen. The information below will give you the details of the project, please read this information carefully. Feel free to talk about the project with people that you trust (e.g., your friends, family, etc.) if you think they might be able to help you decide.

The sections below explain the different aspects of the project. If there is anything that you're not sure about, or are worried about, my contact details are at the top of this page and I'm happy for you to contact me with questions.

What is the purpose of the project and what is M.O.L. therapy?

The project is looking to understand more about a new type of psychological therapy called Method of Levels (M.O.L.), which has helped people improve their mental health and better manage problems in their lives. An M.O.L. therapist's job isn't to provide advice or guidance on how to solve a problem, instead their role is to ask lots of questions about how a person is experiencing their problems and what's going through their mind as they're discussing them. The aim of this is to help the person become aware of background thoughts that might be relevant to the problem. The idea is that this should help in managing the problem. M.O.L. is not focused on diagnoses or labels, but gives people more control and choice over what they talk about during sessions, and also how sessions are booked (e.g., booking sessions when you feel like having one, instead of being told when to have one, and also choosing the length of sessions). M.O.L. has already been researched with different groups and services, and in many countries (e.g. UK, US & Australia).

Young people have said that being able to easily access therapy is important to them, so this project is looking to see if M.O.L. is helpful when delivered online (via videocall). Your experiences and feedback will help us give advice to services and schools about improving the experiences and choices in therapy for young people, like you.

Who can get involved?

If you are aged 16-19 living in the U.K., and are able to understand verbal and written information in English, you are eligible to take part and receive up to 12 weeks' worth of sessions. You must be able to give your consent to participate.

If you are receiving ongoing professional mental health support from a therapist or through a care package from a local service (e.g. CAMHS), you will not be able to participate, as having two forms of therapy at once is not recommended. Also, if you have a significant brain injury or are currently using alcohol, drugs or self-harm to manage difficult emotions you will not be able to participate. We will ask you to complete a few questions to check that you meet the above criteria in order to take part in our study. If you do not meet the study criteria, we will send you an email explaining this alongside some suggested services that might be helpful for the kind of support you are looking for.

There is no cost; these sessions are free.

Do I have to take part?

No. It is your choice if you participate in this project. If you do not wish to participate, this will not affect the support you receive from other services or from school.

What will I be asked to do if I agree to take part?

Stage 1: After reading this information, and if you agree to take part (by filling in the consent form next), you will see a form which asks for some demographic information (e.g. age, ethnicity, gender) and contact details (so you can receive questionnaires, and MS Teams videocall links, and we have an emergency contact person for you).

Stage 2: Before starting therapy, you'll receive an ID code, and this ID code will be used for all your bookings and questionnaire packs to keep all your information as private and confidential as possible. You'll be asked to use your ID code to fill out a short online questionnaire pack once a week for 3 weeks using a site called Qualtrics. This is so the researcher (Nicky) can understand how things are going for you. You'll be asked about your mental health, and how you cope with challenges. There are no right or wrong answers.

Stage 3: After these three weeks, you will begin receiving M.O.L. therapy for free, for up to 12 weeks (with me, Nicky, supervised by M.O.L. therapists Dr Anamaria Churchman and Dr Warren Mansell (see details below). You'll use your ID code to book sessions through a booking website, and will receive a link to a Microsoft Teams virtual video session/channel (if you don't already use MS Teams for school, college, or university, you may need to set up an account). When you book, you'll need to ensure the session is at a time when you can speak privately. Sessions will be maximum 50 minutes long, but you can choose to finish earlier. There is a limit of one session per week, but you can have sessions for as many weeks as you like across the 12 weeks. You do not need to have sessions every week if you don't want to. You can also finish therapy any time, even if one session was enough for you.

Therapy sessions will be audio recorded (explained below). Before each session you'll need to fill out a quick check-in on your mood, and after each session you will be asked to fill out the same short questionnaire pack from the first 3 weeks to help explain how you're feeling.

Stage 4: At the end of the 12 weeks/once you tell us you'd like to end therapy, you will be asked to give feedback about your experiences of M.O.L. therapy through an online form.

Stage 5: When therapy is finished, you'll be asked to fill out questionnaire packs one week and one month later, so we can see if the changes you made continue even once you finish.

How long do I have to decide whether I wish to take part?

You have until August 7th 2021 to join the project by signing up using the sign-up link. But keep in mind, we only have 30 spaces available for this project (it's first come, first served).

Can I change my mind?

Yes. You can change your mind at any time. If you feel you've had the right amount of M.O.L. sessions for you, you can stop and do not have to give us a reason. But it's important to remember that this is different to leaving the project altogether. If you've had enough sessions, that's not a problem (even if one was enough). Just let us know and you'll have 1 week to change your mind before you receive a feedback questionnaire (Step 4) and the follow-up questionnaire pack (Stage 5). If you don't book a session for 3 weeks, and you haven't contacted us to say if you've had enough sessions, we might email to check if you'd like to keep your options open for the full 12 weeks, or if you'd prefer to finish and proceed to Steps 4 & 5.

But if you decide that you do not want to participate in the project at all, you can do that too. You'll have 3 weeks from your last point of contact (whether that's after a session or questionnaire pack) to request to leave and withdraw your data. However, after those 3 weeks it will not be possible to delete your research data, as it will be anonymised by then.

Are there any disadvantages to taking part?

Sometimes therapy can make people more aware of difficult emotions, experiences or thoughts. M.O.L. therapy is not expected to increase these difficult feelings more than other types of therapy. You are allowed to take breaks or stop therapy at any time, and you will be given the numbers of services to contact if you need immediate support outside sessions with the researcher (me, Nicky).

Will the information I provide remain confidential?

Yes, no one will be informed of your participation in the study. We also aim to make the information you give us as anonymous as possible. You are given an ID code for booking sessions and for any Qualtrics questionnaires to ensure your answers can’t be linked back to your name once you have submitted them. This is to keep things as confidential as possible.

All anonymous information (e.g. forms, Qualtrics questionnaires, audio recordings) will be kept in a password-protected online storage system, on University servers accessible only by the researcher and research supervisor. These are stored separately to identifiable information (e.g. personal or consent related), which is only accessible by the researcher (me, Nicky). Once I have ensured that all the data is confidential (i.e., no personal information), the Research Assistant (Angela Gabriel) will support the researcher to organise and analyse the data, but will only ever see the ID code number.

Everything discussed in therapy will be kept confidential. This means it is private unless the researcher is worried that you, or someone else, is at risk of harm. If the researcher becomes worried, they may need to speak with someone (i.e., your emergency contact, or other service) as it is our professional responsibility (called ‘duty of care’) to keep you, and others, safe from harm. If this needs to happen, the researcher will try to speak to you about it first.

As mentioned above, the researcher (Nicky) will be attending supervision with Dr Anamaria Churchman and Dr Warren Mansell, to ensure that they are using the M.O.L. techniques appropriately. No personal information will be discussed in these meetings (i.e., nothing that would identify you or any content of information you have shared in sessions).

The audio recordings are for the M.O.L supervisor (Dr Kavus Davis) to check that the researcher (me, Nicky) is providing you the best care possible. These are not compulsory. You can ask for sessions not to be recorded at any time, and you will be able to carry on receiving therapy.

Once the project is completed, audio files will be deleted immediately, and all other anonymised files (i.e., files with only ID code numbers and no names) will be stored on the secure University server for a maximum of 3 years. After this, all files will be deleted. If files need to be transferred via email, this will only be done using the secure University/NHS email accounts and with password-protected files.

How will information about you be used?

When you sign up you’ll be asked for some contact details (e.g. email address). Only I (Nicky) will have access to this information. No one else in the research team or outside the research team can access this information. This is why you are given a unique ID code number, as this will be connected to your information instead of your name.

Once the project is finished, only anonymised data will be kept so that the results can be investigated. When the reports (or works based on the report) are written up, some broad demographic information may appear, but this will be written in a way such that no-one will be able to work out that you participated in the project.

The thesis will be publicly accessible on UEL's 'institutional repository' (ROAR - a library of completed theses) and might be submitted to be published in psychology journals, used in presentations, reports or other methods with academics, or professionals in meetings/ conferences. Again, it will not be possible to identify anyone personally in these submissions. You will be given the option to receive a summary once the project is finished (but will need to provide contact information for this to happen).

Who has reviewed the project?

All research projects at the University must be reviewed by an independent group of people called a Research Ethics Committee. This ensures we can protect the safety, wellbeing, dignity and rights of anyone who participates in a project, throughout the research process. This project has been reviewed and given approval by UEL's Research Ethics Committee.

What if I wish to complain?

If you have any concerns, you can contact me (Nicky), or my supervisor (Dr Trishna Patel) (See below). If want to make a formal complaint, please contact Dr Trishna Patel, Chair of UEL's School of Psychology Research Ethics Committee. (t.patel@uel.ac.uk).

Who can I contact after the project if I have any questions?

You can contact the researcher, Nicky, on the contact information provided below. Also listed below are the other members of the research team:

M.O.L. Therapist and Researcher
Nicole ('Nicky') Gluckman
Trainee Clinical Psychologist
University of East London
London E15 4LZ
u1945453@uel.ac.uk,

Research Project Supervisor
Dr Trishna Patel
Deputy Research Director
Professional Doctorate in Clinical Psychology
University of East London, London E15 4LZ
t.patel@uel.ac.uk,

Research Assistant
Angela Gabriel
Trainee High Intensity Therapist
Brent Talking Therapies
London

M.O.L. Supervisor
Dr Kavus Davis
Clinical Psychologist
Waltham Forest Psychological Therapies Service, London

M.O.L. Supervisor
Dr Warren Mansell
Reader in Clinical Psychology/Clinical Psychologist,
University of Manchester, Manchester

M.O.L. Supervisor
Dr Anamaria Churchman
William Tuke Research Foundation,
Manchester

Thank you for taking the time to read this information sheet.

Support Services

Please see below for a list of services from Mind UK (Mind UK, 2019) for support beyond your sessions with the University of East London.

Childline
0800 1111, childline.org.uk
Support for children and young people in the UK, including a free 24-hour helpline.

Papyrus HOPELINEUK
0800 068 41 41, 07786 209697 (text)
papyrus-uk.org
Confidential support for under-35s at risk of suicide and others who are concerned about them.

Hub of Hope
hubofhope.co.uk
A national database of mental health organisations from across Britain who offer mental health advice and support.

The Mix
0808 808 4994, 85258 (crisis messenger service, text THEMIX), themix.org.uk
Support and advice for under 25s, including a helpline, crisis messenger service and webchat.

On My Mind
annafreud.org/on-my-mind
Information for young people to make informed choices about their mental health and wellbeing.

Mencap
0808 808 1111, mencap.org.uk
Information and advice for people with a learning disability, families and carers.

Refuge
0808 200 0247, refuge.org.uk
Help and support for young people affected by domestic violence.

Youth Access
youthaccess.org.uk
Advice and counselling for young people, including details of free local services.

YoungMinds
85258 (crisis messenger service, text YM)
youngminds.org.uk
Improving the mental health of babies, children and young people. Information on medication for young people.

Samaritans
116 123 (freephone)
jo@samaritans.org, samaritans.org
Samaritans are open 24/7 for anyone who needs to talk.

Kooth
kooth.com
Counsellors available until 10pm every day. Free, safe and anonymous online counselling for young people. Check whether this is offered in your area.

Centrepoint
0808 800 0661, centrepoint.org.uk
Provides advice housing and support for young people aged 16-25 who are homeless or at risk of homelessness in England.

NHS Go
nhsgo.uk
NHS app with confidential health advice and support for 16–25 year olds.

Young Stonewall
0800 050 2020, youngstonewall.org.uk
Information and support for all young lesbian, gay, bi and trans people.

Appendix I: Consent Form

Version 1: 09/06/2021

University of East London

Pioneering Futures Since 1898

CONSENT FORM

An evaluation of online Method of Levels therapy with young people

Contact person: Nicole ('Nicky') Gluckman (MoL Therapist and Researcher)
Email: u1945453@uel.ac.uk
Address: University of East London, University Way. London, E16 2RD

If you have any questions or would like to clarify anything before you sign this form and give your consent (permission), please feel free to contact me using the details at the top.

Please read each statement carefully and tick the box next to the statement to indicate that you agree.

Please tick box

I have read and understood the document called 'Information Sheet' (with the date 09/06/2021 at the top), which gave information about the project, and I have been given a copy to keep. ☐

I have been given the opportunity to discuss this information and ask questions and have had these questions answered in a way that helped me understand what I may not have understood before. ☐

I understand that my participation in the project is voluntary (i.e. my choice) and that I can stop taking part at any time. I also understand that I don't need to give a reason why I don't want to continue. If I decide to stop taking part in this project this will not affect any support I receive from other services or my legal rights. ☐

I understand that anything I speak about will be confidential (i.e. not be repeated to other people) unless I speak about something that might indicate that I, or another person, could be at risk of significant harm. If this happens, the researcher will have to share this information with relevant individuals or any other relevant services for safety purposes. ☐

I understand that I will have 3 weeks from my last point of contact (whether that's after a session or questionnaire pack) to request to leave and withdraw my data. I also understand that, after those 3 weeks, it will not be possible to delete my research data as it will be anonymised. ☐

I understand that leaving the project altogether is different to deciding that I've had enough sessions. I understand that I can choose when I've had enough sessions and that the research team will contact me for follow-up information. ☐

I understand that I can tell the researcher, at any time during the project, if I don't want them to audio record my sessions, and that I will still continue to receive therapy even if I no longer want my sessions recorded. ☐

I understand that my personal information and research data, including any audio recordings of my sessions, will be kept safely and securely on UEL servers, and will be strictly confidential (private). Only the researcher and their team will be able to access this information and I give my permission for this. ☐

I understand that all M.O.L. therapy sessions will take place using Microsoft Teams ☐

It has been explained to me what will happen to the data and information once the research project has finished. ☐

I understand that the anonymised data will be stored on secure UEL servers for three years, after which point they will be deleted. ☐

I understand that short, anonymised quotes from my feedback may be used in the thesis and that these will not personally identify me. ☐

I understand that the thesis will be publicly accessible in the University of East London's Institutional Repository (ROAR) (i.e. a library of completed theses). ☐

I understand that short, anonymised quotes from my feedback may be used in material such as conference presentations, reports, articles in professional and academic journals resulting from the study and that these will not personally identify me. ☐

I would like to be given a summary of the findings (results) of the research once the project is finished, and am willing to give contact details so this can be sent to me. ☐

I agree to take part in the project discussed above. ☐

Participant's name (BLOCK CAPITALS): ....
Signature:...
Date:...

Name of person taking consent (BLOCK CAPITALS): ....
Signature:...
Date:...

Appendix J: UEL Data Management Plan

UEL Data Management Plan: Full

For review and feedback please send to: researchdata@uel.ac.uk
If you are bidding for funding from an external body, complete the Data Management Plan required by the funder (if specified).

Research data is defined as information or material captured or created during the course of research, and which underpins, tests, or validates the content of the final research output. The nature of it can vary greatly according to discipline. It is often empirical or statistical, but also includes material such as drafts, prototypes, and multimedia objects that underpin creative or 'non-traditional' outputs. Research data is often digital, but includes a wide range of paper-based and other physical objects.

Administrative Data	
PI/Researcher	**Nicole Gluckman**
PI/Researcher ID (e.g. ORCiD)	**0000-0003-1592-4313**
PI/Researcher email	**U1945453@uel.ac.uk**
Research Title	An evaluation of online MOL with young people
Project ID	**N/A**
Research Duration	**February 2021 – Sept 2022**
Research Description	The proposed research study will investigate the effectiveness, efficacy, acceptability, accessibility and helpfulness of the transdiagnostic, Perceptual Control Theory-driven, Method of Levels (MOL) therapy. This will be studied specifically with young people in an online setting. The study is anticipated to recruit 12 participants, therefore, it will employ a case series simple (A-B) design. This can determine the reactive effects of therapy, particularly in the early stages of assessing the feasibility of MOL with young people in an online setting. Data will be collected weekly at baseline, at the start of therapy, following each session attended in the four-month treatment window, and at both one- and two-month follow-up points. An ongoing recruitment window across a two-month period will be implemented to allow for recruitment delays. If more than 12 participants are recruited, a within-sample/subject design will be employed with a similar methodology as mentioned above.

	Should the study be unable to recruit more than five participants, data will be collected at all aforementioned time points, and the follow-up survey will be replaced with individual interviews to explore their experiences.
Funder	**N/A – part of Professional Doctorate in Clinical Psychology**
Grant Reference Number (Post-award)	**N/A**
Date of first version (of DMP)	**23-01-2020**
Date of last update (of DMP)	**29-04-2021**
Related Policies	**THE NHS CONSTITUTION ENGLAND** **DATA MANAGEMENT POLICY** **UEL DATA BACKUP POLICY** **UEL Research Data Management policy** **UEL Statement on Research Integrity** **UEL Statement on Research Ethics** **The Data Protection Act**
Does this research follow on from previous research? If so, provide details	**N/A**
Data Collection	
What data will you collect or create?	A minimum of 12 participants will engage in online MOL therapy with the researcher. Demographic data will be collected when the participant signs up to the study (e.g. age, gender, sexual orientation, religious beliefs, ethnicity education/employment status, borough, disability status, mental health experiences). Following this, additional quantitative data will be collected weekly at baseline (for 3 weeks), at the start of therapy, following each session attended in the four-month treatment window, and at both one- and two-month follow-up points. This will include: Patient Health Questionnaire for Adolescents (PHQ-A), Generalised Anxiety Disorder Questionnaire (GAD-7), Reorganisation of Conflict Scale (ROC), Outcome Rating Scale (ORS). Recorded files will be anonymised at the point of recording, with only audio recorded. Each participant will be given a participant number (in chronological

	order of sign up) and any identifiable information anonymised in the spreadsheets, and subsequent write up of the research. Personal data will be collected on consent forms (names) and contact forms. [Should interviews be required (see contingency plan above), they will be transcribed. These will be in word (.docx) format and are estimated to be 500MB]. Data type: Spreadsheets (with questionnaire responses) File format: .csv Estimated size: 1GB. Data type: Audio recordings File format: mp3 Estimated size: Maximum 2GB
How will the data be collected or created?	Feedback from a Qualtrics survey created by the researcher will be collected following the four-month treatment window. MS Teams will be used to meet with participant. Survey and questionnaire responses will be collected using the Qualtrics secure online survey platform licensed to the UEL School of Psychology and saved on a password protected UEL OneDrive. All IP addresses and other identifiers will be removed upon download from the Qualtrics and prior to saving on UEL One Drive. Sessions will be booked through an online booking system via MS Bookings. Consent will be collected using MS Forms. Electronic consent forms will be saved in a separate H: Drive folder to other research data and will be encrypted. Sessions will be audio-recorded by the researcher using a Dictaphone for rating of MOL fidelity by an external qualified MOL therapist. Audio files will be loaded straight from the Dictaphone to the secure UEL OneDrive.
Documentation and Metadata	
What documentation and metadata will accompany the data?	Participant recruitment poster/ form, participant information sheets, consent forms, list of survey and questionnaire questions and debrief sheet. Participants will be given a participant number (in chronological order of sign up). This will allow for anonymisation of the data.

	A list of variables will be used and data will be organised using a folder structure. The list of participant names and allocated participant number will be stored in a password protected file on the researcher and supervisor's UEL H: Drive [accessible from a UEL computer connected to the UEL network which is also encrypted]. Any identifying information will be stored in a password protected file on the UEL secured OneDrive for Business system, which can only be accessed through logging on using my UEL username and password.
Ethics and Intellectual Property	
How will you manage any ethical issues?	Participants will be provided with an information sheet explaining the research project and provided opportunities to ask questions. They will also be requested to complete a consent form on MS Teams. The consent form will ask participants to tick a list of statements to ensure that they understand what they are consenting to in terms of participation, data collection, storage and use. Any identifiable information will be anonymised as reported above. Participants will also be reminded that they are under no obligation to remain in the study if they wish to withdraw and that there are no negative consequences to withdrawing from the study or withdrawing their data from the study following participation They will also be reminded that if they agree to participate, they are free to change their mind and stop participating at any time, and will not need to give a reason. Due to the nature of M.O.L. therapy (whereby clients can decide without notice when they feel they have had sufficient sessions), participants will be reminded that they have until 3 weeks after their last point of contact to request to withdraw their data. Method of Levels therapy is not expected to increase distress more than other types of therapy. Participants are allowed to take breaks or stop therapy at any time. They will be given the numbers of other services that they can contact if they require immediate support outside of the sessions. This information will be provided at the start of the study and end of each therapy session. MS Teams recordings will not be used because of the potential breaches to anonymity and the large files.

	Consultation with young people also raised issues regarding the video component of recordings. They felt that an audio recording would be preferable as it allows for additional anonymity. As MS Teams does not allow for this, a Dictaphone will be used to record sessions where participants have not opted out. There will be a written confidentiality agreement made with young people as part of the consent form. Demographic data will be de-identified and stored separately to any potentially identifiable information. There will be no direct identifiers (eg names, postcode) or collected within the demographic questionnaire that could identify participants.
How will you manage copyright and Intellectual Property Rights issues?	There are no known copyright of Intellectual Property Issues. As this is a doctoral thesis, there are no copyright or intellectual property rights issues. The data will be owned by the research team and thesis supervisors at UEL.
Storage and Backup	
How will the data be stored and backed up during the research?	Digitally signed consent forms will be recorded on the secure online data storage system associated with MS Forms. Electronic consent forms will be saved in a separate H: Drive folder to other research data and will be encrypted. Similarly, any questionnaire data will be collected on UEL's Qualtrics secure questionnaire site. This will be password protected and only accessible by the research team. Each series of questionnaire data will be named with the participants' participant number and the dates of the data completion. Personally identifying data (names, contact details etc.) will only be stored (securely) for as long as absolutely necessary and then permanently deleted. Unless the participant requests a copy of the publication following the submission, this personal data will be deleted once data collection is complete. This personal data will be stored separately from anonymised raw data, such as spreadsheets and transcripts. It will be stored in a separate password protected folder on the UEL OneDrive for Business system. For analysis, the anonymised spreadsheet will be downloaded to the researcher's password protected laptop. The laptop is a personal, non-networked, laptop with a password only known to the researcher.

	Audio recordings will be saved on the researcher's password protected UEL OneDrive cloud service, which will be encrypted. Any recordings required for rating will have the password sent to them via UEL email to a secure device. Once these recordings have been rated by the qualified MOL therapist, they will then be deleted. The ratings of these recordings will then be stored on OneDrive for Business in the form of a spreadsheet. Should any transcriptions be necessary, these will be anonymised and stored on the password protected UEL OneDrive folder. Once the researcher leaves UEL, all anonymised data will be shared with the supervisor and the supervisor will store this data on the UEL OneDrive. All personal and research data will be deleted from the researcher's personal access, and nothing will be stored on personal drives. All study data on the researcher's OneDrive should be erased once the thesis has been examined and passed, except anonymised data which should be sent to the supervisor and retained for three years. Any booking information entered on the online booking system will be password protected with a password only known to the research team. The attendance data of participants will be entered into a spreadsheet with the corresponding participant number. The booking system account will be erased once the thesis has been examined and passed. As there is an intention to contact participants following completion of the study (e.g. to provide a summary of the findings), the contact information necessary to do this will be securely stored separately from all other data/information collected in the course of the study in an unshared password protected UEL OneDrive for Business folder. Explicit and informed consent to keep this information and contact participants will be gained.
How will you manage access and security?	The researcher will collect all questionnaire and survey data and only the research team, supervisor and examiners will have access to anonymised data. Anonymised data spreadsheets will be shared with the research supervisor via UEL's OneDrive for Business's file sharing facility. Data lines will be numbered with participant number.

	UEL storage will be used and accessed from my password protected laptop. Audio files and any transcriptions will be saved with anonymised titles. These will be deleted once the MOL therapist has rated 10% of recordings. The online booking system will be password protected with a password only known to the research team. Recordings will be shared with the qualified MOL therapist for rating of MOL fidelity via a password protected OneDrive for Business link. No one outside the named research team should have access to personal or research data.
Data Sharing	
How will you share the data?	Extracts of any transcripts or qualitative feedback will be provided in the final research write up and any subsequent publications. All identifiable information will not be included in these extracts. The anonymised data underpinning the research will not be deposited and shared on the UEL Research Repository. The thesis will be publicly accessible on UEL's 'institutional repository' (ROAR - a library of completed theses) and might be submitted to be published in psychology journals, used in presentations, reports or other methods with academics, or professionals in meetings/ conferences. Participants will be made aware of this and will be required to consent to this.
Are any restrictions on data sharing required?	Only anonymised extracts of qualitative feedback data will be presented in the thesis and resulting papers, presentations etc. In order to ensure participant confidentiality, apart from anonymised recordings, other data will not be shared with anyone outside of the research team.
Selection and Preservation	
Which data are of long-term value and should be retained, shared, and/or preserved?	Recordings, any transcriptions, and electronic copies of booking data and online survey software data will be kept in their respective sources until the thesis has been examined and passed. They will then be erased from UEL servers. .Spreadsheets will be kept after completion of the clinical doctorate course for dissemination purposes and sent via secure UEL email to supervisors to store on their UEL H: drive. This will then be deleted after 3 years.

What is the long-term preservation plan for the data?	Once the researcher leaves UEL, all anonymised data will be shared with the supervisor and the supervisor will store this data on the UEL OneDrive. This will then be deleted after 3 years
Responsibilities and Resources	
Who will be responsible for data management?	Nicole (Nicky) Gluckman Supervised by Trishna Patel
What resources will you require to deliver your plan?	Access to the UEL one drive and H: Drive via a password protected laptop or computer. MS Teams Dictaphone Qualtrics Acuity
Review	
	Updated plan to be sent to researchdata@uel.ac.uk once confirmation received from IT Services and DPO, and confirmation of 3 year retention policy
Date: 29/04/2021	Reviewer name: Penny Jackson Research Data Management Officer

Appendix K: Participant Debrief Sheet (Rejection from Study)

Version 1: 12/03/2021

University of East London

Pioneering Futures Since 1898

PARTICIPANT DEBRIEF SHEET
ELIGIBILITY UPDATE

An evaluation of online M.O.L. therapy with young people

Contact person: Nicole ('Nicky') Gluckman (MoL Therapist and Researcher)
Email: u1945453@uel.ac.uk
Address: University of East London, University Way. London, E16 2RD

Thank you for your interest in the research study and for taking the time to complete the screening questionnaires.

The aim of this research project is to understand more about a new type of psychological therapy called Method of Levels (M.O.L.), which has helped people improve their mental health and better manage problems in their lives.

Young people have said that being able to easily access therapy is important to them, so this project is looking to see if M.O.L. is helpful online (via videocall). We hope your experiences and feedback can help us give advice to services and schools about improving the experiences and choices around therapy for young people, like you.

Unfortunately, due to [insert reason] you do not meet the project eligibility criteria and therefore it is not appropriate for you to continue with the project.

We understand that you might signed up for this project as you wanted to access support for your mood and wellbeing, and that this may have been a difficult decision to make. If you are interested in accessing talking therapies to support your mood, we recommend you speak with your GP for further information on what is available in your local area. Alternatively, you may find the below links helpful (from Mind UK).

We hope that you have not been too disappointed by this screening process. However, if you found any part of this experience to be distressing and you wish to speak to me or my research supervisor, please contact:

M.O.L. Therapist and Researcher	Research Project Supervisor
Nicole ('Nicky') Gluckman Trainee Clinical Psychologist University of East London London E15 4LZ u1945453@uel.ac.uk,	Dr Trishna Patel Deputy Research Director, Professional Doctorate in Clinical Psychology University of East London, London E15 4LZ t.patel@uel.ac.uk,

Thanks again for your interest in the study.

Support Services

Please see below for a list of services from Mind UK (Mind UK, 2019) for support beyond your sessions with the University of East London.

Childline
0800 1111, childline.org.uk
Support for children and young people in the UK, including a free 24-hour helpline.

Papyrus HOPELINEUK
0800 068 41 41, 07786 209697 (text)
papyrus-uk.org
Confidential support for under-35s at risk of suicide and others who are concerned about them.

Hub of Hope
hubofhope.co.uk
A national database of mental health organisations from across Britain who offer mental health advice and support.

The Mix
0808 808 4994, 85258 (crisis messenger service, text THEMIX), themix.org.uk
Support and advice for under 25s, including a helpline, crisis messenger service and webchat.

On My Mind
annafreud.org/on-my-mind
Information for young people to make informed choices about their mental health and wellbeing.

Mencap
0808 808 1111, mencap.org.uk
Information and advice for people with a learning disability, families and carers.

Refuge
0808 200 0247, refuge.org.uk
Help and support for young people affected by domestic violence.

Youth Access
youthaccess.org.uk
Advice and counselling for young people, including details of free local services.

YoungMinds
85258 (crisis messenger service, text YM)
youngminds.org.uk
Improving the mental health of babies, children and young people. Information on medication for young people.

Samaritans
116 123 (freephone)
jo@samaritans.org, samaritans.org
Samaritans are open 24/7 for anyone who needs to talk.

Kooth
kooth.com
Counsellors available until 10pm every day. Free, safe and anonymous online counselling for young people. Check whether this is offered in your area.

Centrepoint
0808 800 0661, centrepoint.org.uk
Provides advice housing and support for young people aged 16-25 who are homeless or at risk of homelessness in England.

NHS Go
nhsgo.uk
NHS app with confidential health advice and support for 16–25 year olds.

Young Stonewall
0800 050 2020, youngstonewall.org.uk
Information and support for all young lesbian, gay, bi and trans people.

Appendix L: UEL Risk Assessment Form for Research Conducted Off-Campus and 'Risk and Distress Protocol'

UEL Risk Assessment Form for Research Conducted Off-Campus

UEL Risk Assessment Form

Name of Assessor:	**Nicole (Nicky) Gluckman**	**Date of Assessment**	**26-03-2021**
Activity title:	**An evaluation of online M.O.L. therapy with young people**	**Location of activity:**	**UEL Campuses at Stratford**
Signed off by Manager (Print Name)	**Dr Trishna Patel**	**Date and time (if applicable)**	**26-03-2021 13:30**

Please describe the activity/event in as much detail as possible (include nature of activity, estimated number of participants, etc)
If the activity to be assessed is part of a fieldtrip or event please add an overview of this below:

The study will recruit participants from schools, colleges, charities, community organisations, third sector organisations, and social media.
A minimum of 12 participants will engage in online M.O.L. therapy with the researcher. Demographic data will be collected when the participant signs up to the study (e.g. age, gender, sexual orientation, religious beliefs, ethnicity education/employment status, borough, disability status, mental health experiences). Following this, additional quantitative data will be collected weekly at baseline (for 3 weeks), at the start of therapy, following each session attended in the 12-week treatment window, and at both one-week and one-month follow-up points. This will include: Patient Health Questionnaire (PHQ-9), Generalised Anxiety Disorder Questionnaire (GAD-7), Reorganisation of Conflict Scale (ROC), Outcome Rating Scale (ORS).
Feedback from a Qualtrics survey created by the researcher will be collected following the 12-week treatment window.
Sessions will be audio-recorded by the researcher for rating of M.O.L. fidelity by an external qualified M.O.L. therapist. Recorded files will be anonymised at the point of recording, with only audio recorded. Each participant will be given a participant number (in chronological order of sign up) and any identifiable information anonymised in the spreadsheets, and subsequent write up of the research. Personal data will be collected on consent forms (names) and contact forms.

Overview of FIELD TRIP or EVENT:

Guide to risk ratings:

a) Likelihood of Risk	b) Hazard Severity	c) Risk Rating (a x b = c)
1 = Low (Unlikely)	1 = Slight (Minor / less than 3 days off work)	1-2 = Minor (No further action required)
2 = Moderate (Quite likely)	2= Serious (Over 3 days off work)	3-4 = Medium (May require further control measures)
3 = High (Very likely or certain)	3 = Major (Over 7 days off work, specified injury or death)	6/9 = High (Further control measures essential)

Hazards attached to the activity

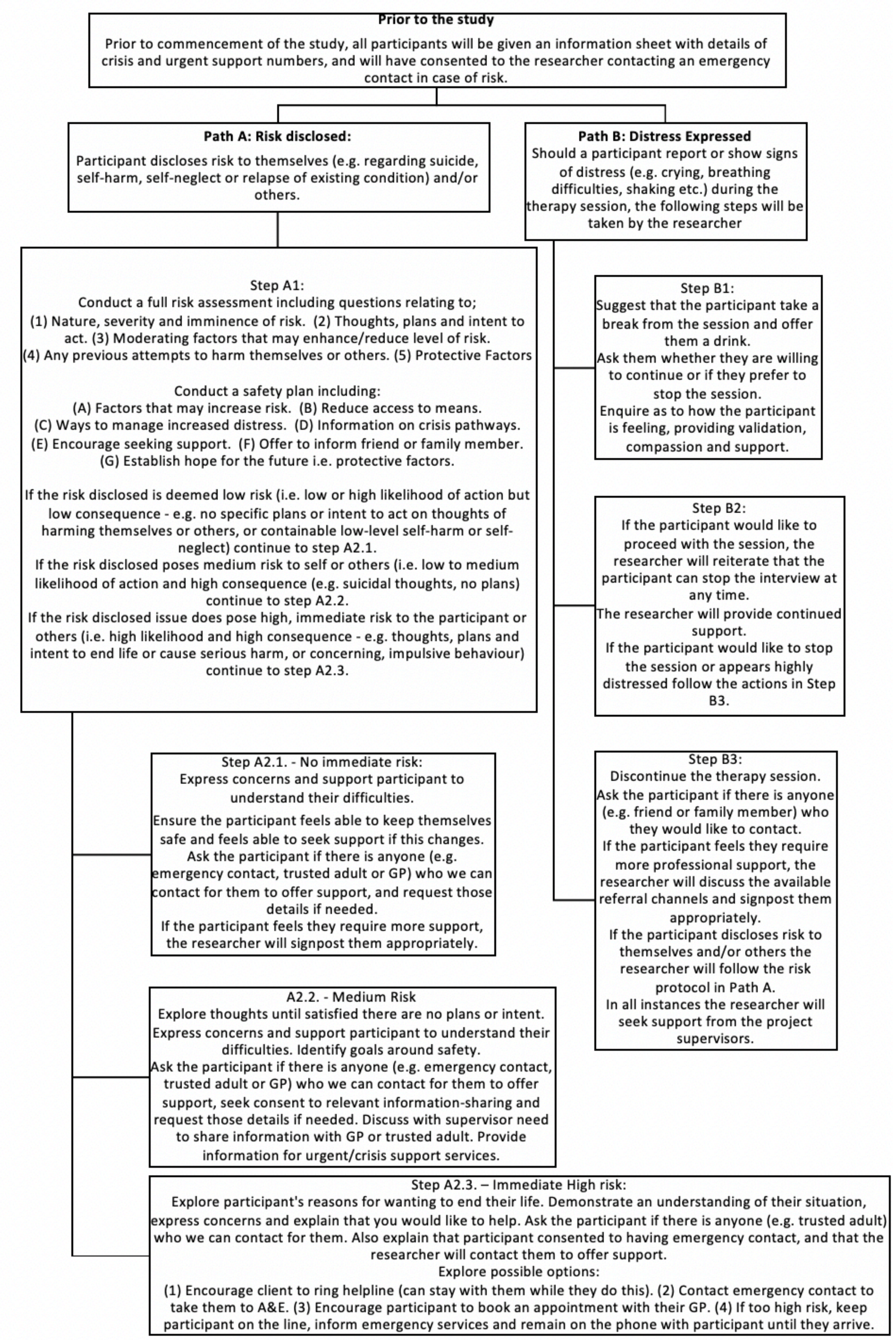
Hazards identified	Who is at risk?	Existing Controls	Likelihood	Severity	Residual Risk Rating (Likelihood x Severity)	Additional control measures required (if any)	Final risk rating
Distress to participants during therapy sessions	Participant	Method of Levels therapy is not expected to increase distress more than other types of therapy. Participants are allowed to take breaks or stop therapy at any time. They will be given the numbers of other services that they can contact if they require immediate support outside of the sessions. This information will be provided at the start of the study and end of each therapy session.	1	1	1	Risk protocol created in case of medium to high of harm to self or others (see below)	1
Distress to researcher during therapy sessions	Researcher	Weekly supervision with qualified M.O.L. therapist to explore any challenges around therapeutic experiences and ability to access DoS if any concerns raised.	1	1	1	N/A	1

Review Date

A comprehensive guide to risk assessments and health and safety in general can be found in UEL's Health & Safety handbook at http://www.uel.ac.uk/hrservices/hs/handbook/ and a comprehensive guide to risk assessment is available on the Health & Safety Executive's web site at http://www.hse.gov.uk/risk/casestudies/index.htm. An example risk assessment is also included below.

Risk and Distress Protocol

RISK AND DISTRESS PROTOCOL - An evaluation of online M.O.L. therapy with young people



Prior to the study

Prior to commencement of the study, all participants will be given an information sheet with details of crisis and urgent support numbers, and will have consented to the researcher contacting an emergency contact in case of risk.

Path A: Risk disclosed:

Participant discloses risk to themselves (e.g. regarding suicide, self-harm, self-neglect or relapse of existing condition) and/or others.

Step A1:
Conduct a full risk assessment including questions relating to;
(1) Nature, severity and imminence of risk. (2) Thoughts, plans and intent to act. (3) Moderating factors that may enhance/reduce level of risk. (4) Any previous attempts to harm themselves or others. (5) Protective Factors

Conduct a safety plan including:
(A) Factors that may increase risk. (B) Reduce access to means. (C) Ways to manage increased distress. (D) Information on crisis pathways. (E) Encourage seeking support. (F) Offer to inform friend or family member. (G) Establish hope for the future i.e. protective factors.

If the risk disclosed is deemed low risk (i.e. low or high likelihood of action but low consequence - e.g. no specific plans or intent to act on thoughts of harming themselves or others, or containable low-level self-harm or self-neglect) continue to step A2.1.
If the risk disclosed poses medium risk to self or others (i.e. low to medium likelihood of action and high consequence (e.g. suicidal thoughts, no plans) continue to step A2.2.
If the risk disclosed issue does pose high, immediate risk to the participant or others (i.e. high likelihood and high consequence - e.g. thoughts, plans and intent to end life or cause serious harm, or concerning, impulsive behaviour) continue to step A2.3.

Step A2.1. - No immediate risk:
Express concerns and support participant to understand their difficulties.
Ensure the participant feels able to keep themselves safe and feels able to seek support if this changes.
Ask the participant if there is anyone (e.g. emergency contact, trusted adult or GP) who we can contact for them to offer support, and request those details if needed.
If the participant feels they require more support, the researcher will signpost them appropriately.

A2.2. - Medium Risk
Explore thoughts until satisfied there are no plans or intent.
Express concerns and support participant to understand their difficulties. Identify goals around safety.
Ask the participant if there is anyone (e.g. emergency contact, trusted adult or GP) who we can contact for them to offer support, seek consent to relevant information-sharing and request those details if needed. Discuss with supervisor need to share information with GP or trusted adult. Provide information for urgent/crisis support services.

Step A2.3. – Immediate High risk:
Explore participant's reasons for wanting to end their life. Demonstrate an understanding of their situation, express concerns and explain that you would like to help. Ask the participant if there is anyone (e.g. trusted adult) who we can contact for them. Also explain that participant consented to having emergency contact, and that the researcher will contact them to offer support.
Explore possible options:
(1) Encourage client to ring helpline (can stay with them while they do this). (2) Contact emergency contact to take them to A&E. (3) Encourage participant to book an appointment with their GP. (4) If too high risk, keep participant on the line, inform emergency services and remain on the phone with participant until they arrive.

Path B: Distress Expressed

Should a participant report or show signs of distress (e.g. crying, breathing difficulties, shaking etc.) during the therapy session, the following steps will be taken by the researcher

Step B1:
Suggest that the participant take a break from the session and offer them a drink.
Ask them whether they are willing to continue or if they prefer to stop the session.
Enquire as to how the participant is feeling, providing validation, compassion and support.

Step B2:
If the participant would like to proceed with the session, the researcher will reiterate that the participant can stop the interview at any time.
The researcher will provide continued support.
If the participant would like to stop the session or appears highly distressed follow the actions in Step B3.

Step B3:
Discontinue the therapy session.
Ask the participant if there is anyone (e.g. friend or family member) who they would like to contact.
If the participant feels they require more professional support, the researcher will discuss the available referral channels and signpost them appropriately.
If the participant discloses risk to themselves and/or others the researcher will follow the risk protocol in Path A.
In all instances the researcher will seek support from the project supervisors.

In all instances the researcher will seek support from the project supervisor.

Follow up:

- The researcher will offer to contact the participant via phone or email the following day.
- The researcher will offer the participant the opportunity to withdraw from the study and for their data to be destroyed.
- The researcher will reiterate details of further support and signpost accordingly.
- The researcher will encourage the participants to attend A&E or contact crisis services if they feel at risk of harming themselves and/or others.

Appendix M: Participant Debrief Sheet (Post-Therapy)

Version 1: 09/06/2021

Pioneering Futures Since 1898

PARTICIPANT DEBRIEF SHEET
POST-ONLINE M.O.L. THERAPY

An evaluation of online M.O.L. therapy with young people

Contact person: Nicole ('Nicky') Gluckman (MoL Therapist and Researcher)
Email: u1945453@uel.ac.uk
Address: University of East London, University Way. London, E16 2RD

Thank you for participating in this research project. The aim of the project is to examine the usefulness and accessibility of online Method of Levels (M.O.L.) therapy with young people. We also hope it will help us understand the usefulness of M.O.L. therapy with adolescents experiencing psychological distress and inform the type of support offered by mental health services and schools in the future.

The thesis will be publicly accessible on UEL's 'institutional repository' (ROAR - a library of completed theses) and might be submitted to be published in psychology journals, used in presentations, reports or other methods with academics, or professionals in meetings/ conferences. A summary of the project results will be written up into a report after the submission of the student thesis in Summer 2022. If you asked to be sent a summary of the results, these will be sent to you on the contact information you agreed for these to be sent.

As a reminder, Once the project is completed, audio files will be deleted immediately, and all other anonymised files (i.e., files with only ID code numbers and no names) will be stored on the secure University server for a maximum of 3 years. After this, all files will be deleted. If files need to be transferred via email, this will only be done using the secure University/NHS email accounts and with password-protected files.

We hope that you have found the project interesting. If you would like additional information on talking therapies, please contact your GP or see the resources below.
If you would like to speak to me or my research supervisor about any aspect of the study or your participation, please contact us at:

M.O.L. Therapist and Researcher	**Research Project Supervisor**
Nicole ('Nicky') Gluckman	Dr Trishna Patel
Trainee Clinical Psychologist	Deputy Research Director, Professional
University of East London	Doctorate in Clinical Psychology
London E15 4LZ	University of East London, London E15 4LZ
u1945453@uel.ac.uk,	t.patel@uel.ac.uk,

Thanks again for taking part in this study.

Support Services

Please see below for a list of services from Mind UK (Mind UK, 2019) for support beyond your sessions with the University of East London.

Childline
0800 1111, childline.org.uk
Support for children and young people in the UK, including a free 24-hour helpline.

Papyrus HOPELINEUK
0800 068 41 41, 07786 209697 (text)
papyrus-uk.org
Confidential support for under-35s at risk of suicide and others who are concerned about them.

Hub of Hope
hubofhope.co.uk
A national database of mental health organisations from across Britain who offer mental health advice and support.

The Mix
0808 808 4994, 85258 (crisis messenger service, text THEMIX), themix.org.uk
Support and advice for under 25s, including a helpline, crisis messenger service and webchat.

On My Mind
annafreud.org/on-my-mind
Information for young people to make informed choices about their mental health and wellbeing.

Mencap
0808 808 1111, mencap.org.uk
Information and advice for people with a learning disability, families and carers.

Refuge
0808 200 0247, refuge.org.uk
Help and support for young people affected by domestic violence.

Youth Access
youthaccess.org.uk
Advice and counselling for young people, including details of free local services.

YoungMinds
85258 (crisis messenger service, text YM)
youngminds.org.uk
Improving the mental health of babies, children and young people. Information on medication for young people.

Samaritans
116 123 (freephone)
jo@samaritans.org, samaritans.org
Samaritans are open 24/7 for anyone who needs to talk.

Kooth
kooth.com
Counsellors available until 10pm every day. Free, safe and anonymous online counselling for young people. Check whether this is offered in your area.

Centrepoint
0808 800 0661, centrepoint.org.uk
Provides advice housing and support for young people aged 16-25 who are homeless or at risk of homelessness in England.

NHS Go
nhsgo.uk
NHS app with confidential health advice and support for 16–25 year olds.

Young Stonewall
0800 050 2020, youngstonewall.org.uk
Information and support for all young lesbian, gay, bi and trans people.

Appendix N: Study Flyer and Social Media Page

Study Flyer

BE KIND TO YOUR MIND

Join our online psychological wellbeing project

The M.O.L. Project: Free Psychological Wellbeing Support where YOU'RE in Control

Are you looking for...

A free and private online space to speak about the things that are important to you?

Someone to help you explore the challenges or problems you have been facing lately?

The choice of when and how often you speak to someone?

Help Others Like You!

If you are aged 16-19, U.K.-based and meet the project criteria (see our instagram page or email us for more details), you could be eligible for 12 weeks' worth of free therapy sessions.

By joining us on this project you'll be able to help us understand and improve the accessibility and success of M.O.L. therapy for young people.

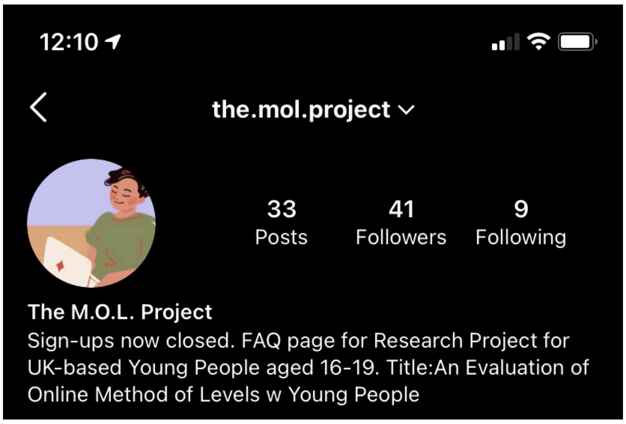
@the.mol.project

For further information please contact
Nicky Gluckman (Trainee Clinical Psychologist)
E: u1945453@uel.ac.uk

University of East London

Study Social Media Page

No copyrighted content was included on this page. All content drawn from Participant Information Statement or freely available online (e.g. from public tiktok or Instagram accounts) and content creators appropriately referenced/cited. Content included based on recommendations from consultations with young people regarding the principles of M.O.L. therapy (Conflict, control and reorganisation).

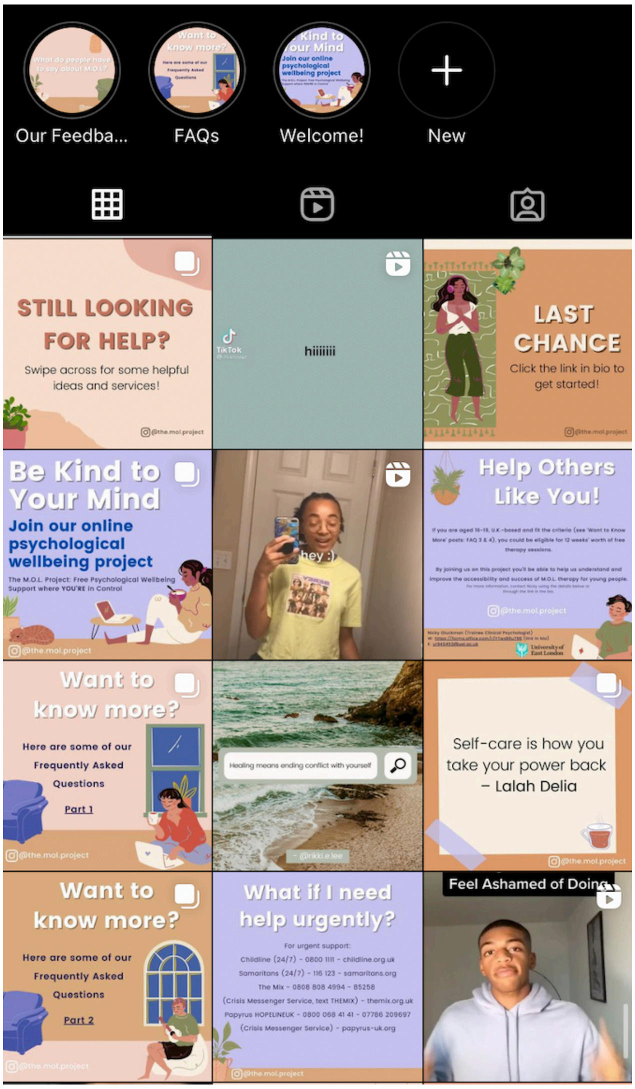


12:10

the.mol.project

33	41	9
Posts	Followers	Following

The M.O.L. Project
Sign-ups now closed. FAQ page for Research Project for UK-based Young People aged 16-19. Title:An Evaluation of Online Method of Levels w Young People



STILL LOOKING FOR HELP?
Swipe across for some helpful ideas and services!
@the.mol.project

LAST CHANCE
Click the link in bio to get started!
@the.mol.project

Be Kind to Your Mind
Join our online psychological wellbeing project
The M.O.L. Project: Free Psychological Wellbeing Support where YOU'RE in Control
@the.mol.project

Help Others Like You!
If you are aged 16-19, U.K.-based and fit the criteria (see 'Want to Know More' posts: FAQ 3 & 4), you could be eligible for 12 weeks' worth of free therapy sessions.
By joining us on this project you'll be able to help us understand and improve the accessibility and success of M.O.L. therapy for young people.
@the.mol.project

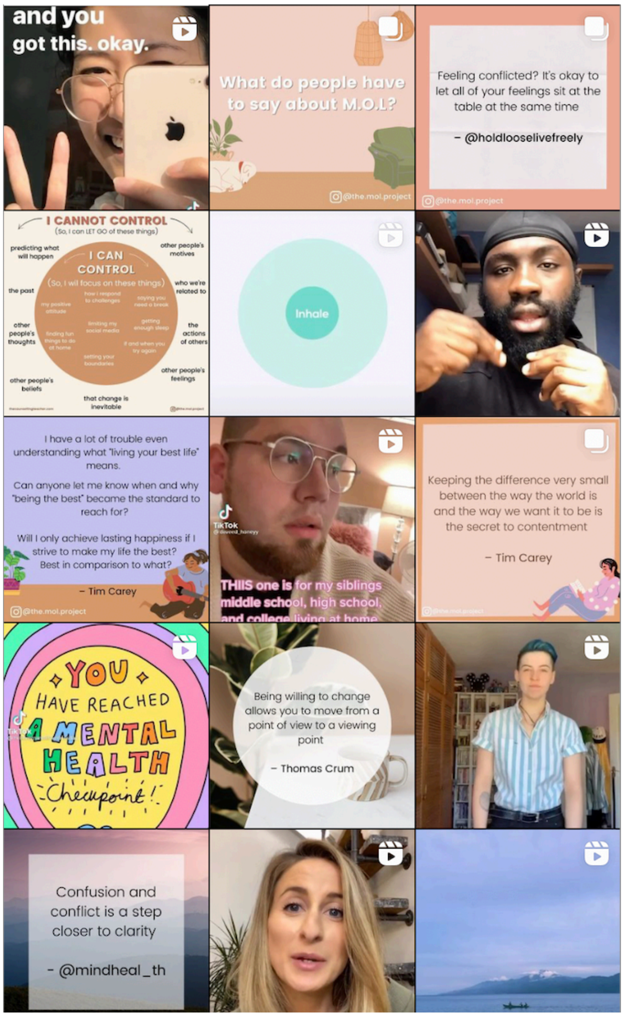
Want to know more?
Here are some of our Frequently Asked Questions
Part 1
@the.mol.project

Healing means ending conflict with yourself
- @rikki.e.lee

Self-care is how you take your power back
– Lalah Delia
@the.mol.project

Want to know more?
Here are some of our Frequently Asked Questions
Part 2
@the.mol.project

What if I need help urgently?
For urgent support:
Childline (24/7) - 0800 1111 - childline.org.uk
Samaritans (24/7) - 116 123 - samaritans.org
The Mix - 0808 808 4994 - 85258
(Crisis Messenger Service, text THEMIX) - themix.org.uk
Papyrus HOPELINEUK - 0800 068 41 41 - 07786 209697
(Crisis Messenger Service) - papyrus-uk.org
@the.mol.project



Feeling conflicted? It's okay to let all of your feelings sit at the table at the same time

– @holdlooselivefreely

I have a lot of trouble even understanding what "living your best life" means.

Can anyone let me know when and why "being the best" became the standard to reach for?

Will I only achieve lasting happiness if I strive to make my life the best? Best in comparison to what?

– Tim Carey

Keeping the difference very small between the way the world is and the way we want it to be is the secret to contentment

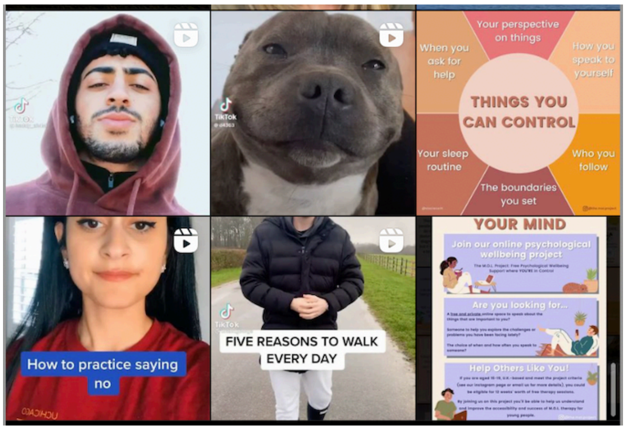
– Tim Carey

Being willing to change allows you to move from a point of view to a viewing point

– Thomas Crum

Confusion and conflict is a step closer to clarity

- @mindheal_th



Join our online psychological wellbeing project

The M.O.L Project: Free Psychological Wellbeing Support where YOU'RE in Control

Are you looking for...

A free and private online space to speak about the things that are important to you?

Someone to help you explore the challenges or problems you have been facing lately?

The choice of when and how often you speak to someone?

Help Others Like You!

If you are aged 16-19, U.K.-based and meet the project criteria (see our Instagram page or email us for more details), you could be eligible for 12 weeks' worth of free therapy sessions.

By joining us on this project you'll be able to help us understand and improve the accessibility and success of M.O.L therapy for young people.

Appendix O: Participant Demographics Form

Version 2: 12/03/2021

PARTICIPANT DEMOGRAPHICS FORM

An evaluation of online M.O.L. therapy with young people

Contact person: Nicole (‘Nicky’) Gluckman (MoL Therapist and Researcher)
Address: University of East London, University Way. London, E16 2RD
Email: u1945453@uel.ac.uk

All information provided in this document will be treated as strictly confidential.

Age:

☐ 16
☐ 17
☐ 18
☐ 19

What best describes your gender?

☐ Male
☐ Female
☐ Non-Binary
☐ I use another term (please describe)
☐ Unsure how to describe myself
☐ Prefer not to answer

Do you consider yourself to be transgender?

☐ Yes
☐ No
☐ Prefer not to answer

What best describes your preferred pronouns?

☐ Prefer not to answer

What specific term best describes your ethnicity?

When answering, please also specify which region best describes your ethnic heritage (e.g., ‘Black Caribbean’ or ‘White Irish’ or, if you identify as mixed heritage, ‘White and Pakistani’)

If you are unsure, write what you feel fits you best.

☐

What best describes your education or employment status?

☐ GCSEs
☐ International Baccalaureate
☐ AS/A Levels
☐ BTEC/CTEC Vocational Course
☐ Apprenticeship
☐ Employed Full-time
☐ Employed Part-time
☐ Self-employed
☐ Unemployed
☐ University Student (including part-time employment whilst studying)
☐ Homemaker
☐ Other
☐ Prefer not to answer

Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?

☐ Yes
☐ No
☐ Prefer not to answer

Have you ever looked for support for your mental health?

☐ Yes
☐ No
☐ Prefer not to answer

If yes, are you currently accessing support for your mental health?

☐ Yes
☐ No

In the last 12 months, have you accessed any of the following types of mental health support:

☐ NHS support in local community (e.g., through CAMHS or adult mental health services)
☐ Support from a school or university counsellor
☐ Support from other staff at school or university
☐ Private counselling or therapy in local community
☐ Support from a helpline or text service

☐ Support from an online service (e.g., The Mix, Childline, Big White Wall)
☐ Support through a local charity, drop-in centre or youth club
☐ Support from a local peer support group
☐ Inpatient care
☐ Other (please describe)

☐ No

Do you feel you have mental health difficulties?

☐ Yes
☐ No

If yes, how would you describe these difficulties:

Has a healthcare provider ever told you that you have mental health difficulties or provided you with a diagnosis?

If yes, please tick all that apply:

☐ Depression
☐ Anxiety
☐ Bipolar Disorder
☐ Psychosis
☐ Schizophrenia
☐ Personality Disorder
☐ Obsessive Compulsive Disorder
☐ Post Traumatic Stress Disorder
☐ Other (please describe)

Have you taken any medication for your mental health in the last 12 months?

☐ Yes
☐ No

If yes, are you currently taking any medication for your mental health?

☐ Yes
☐ No

Please describe what this medication is/was for:

Do you have, have you ever had, or has a healthcare provider ever told you that you have a brain injury (or Traumatic Brain Injury)?

☐ Yes
☐ No

Do you have or has a healthcare provider ever told you that you have a learning disability?

☐ Yes
☐ No

If yes, please write what best describes your learning disability

Are you currently using drugs to manage difficult emotions?

☐ Yes
☐ No

If yes, are you receiving professional support for this?

☐ Yes
☐ No

Are you currently using alcohol to manage difficult emotions?

☐ Yes
☐ No

If yes, are you receiving professional support for this?

☐ Yes
☐ No

Are you currently self-harming to manage difficult emotions?

☐ Yes
☐ No

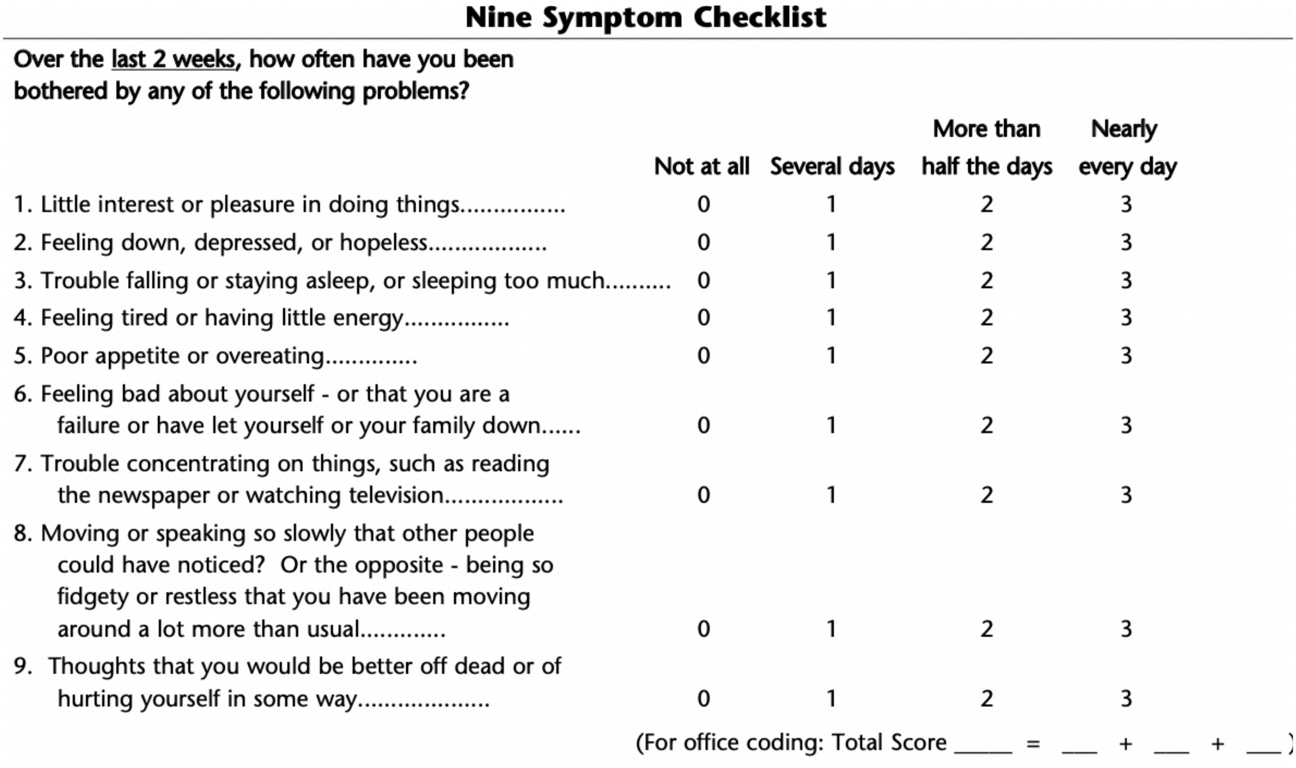
If yes, how frequently do you self-harm?

Are you receiving professional support for this?

☐ Yes
☐ No

Appendix P: Freely Available Outcome Measures

PHQ-9 (Kroenke & Spitzer, 2002)



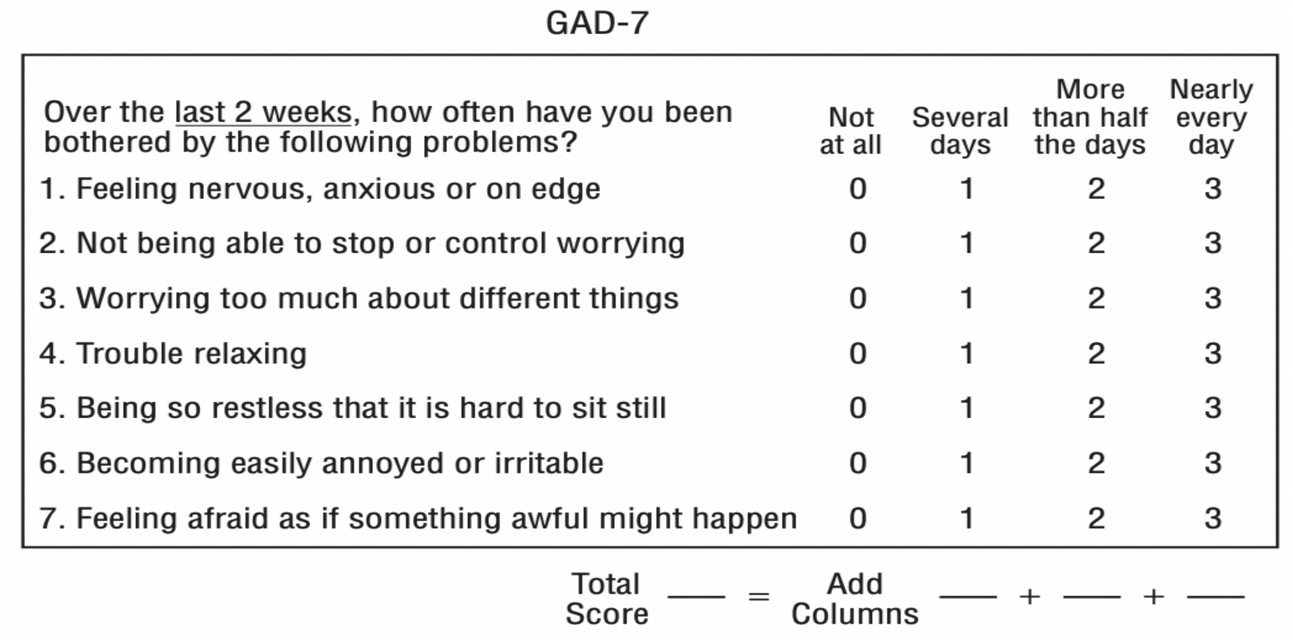
Nine Symptom Checklist

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things................	0	1	2	3
2. Feeling down, depressed, or hopeless.................	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much..........	0	1	2	3
4. Feeling tired or having little energy................	0	1	2	3
5. Poor appetite or overeating.............	0	1	2	3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down......	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.................	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual............	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way...................	0	1	2	3

(For office coding: Total Score _____ = ___ + ___ + ___)

GAD-7 (Spitzer et al., 2006)



GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total Score ___ = Add Columns ___ + ___ + ___

Outcome Rating Scale (Miller et al., 2003)

Outcome Rating Scale (ORS)

Name __________________________Age (Yrs):____ Gender______________
Session # ____ Date: __________________________
Who is filling out this form? Please check one: Self_______ Other_______
If other, what is your relationship to this person? ______________________________

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person, please fill out according to how you think he or she is doing.*

ATTENTION CLINICIAN: TO INSURE SCORING ACCURACY PRINT OUT THE MEASURE TO INSURE THE ITEM LINES ARE 10 CM IN LENGTH. ALTER THE FORM UNTIL THE LINES PRINT THE CORRECT LENGTH. THEN ERASE THIS MESSAGE.

Individually
(Personal well-being)

I--I

Interpersonally
(Family, close relationships)

I--I

Socially
(Work, school, friendships)

I--I

Overall
(General sense of well-being)

I--I

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Appendix Q: Feedback Questionnaire

Version 1: 12/03/2021

University of East London

Pioneering Futures Since 1898

PARTICIPANT FEEDBACK SHEET

An evaluation of online M.O.L. therapy with young people

Contact person: Nicole ('Nicky') Gluckman (M.O.L. Therapist and Researcher)
Address: University of East London, University Way. London, E16 2RD
Email: u1945453@uel.ac.uk

Thank you for participating in this research project so far. The aim of the project is to examine the usefulness and accessibility of online Method of Levels (M.O.L.) therapy. We also hope it will help us understand the usefulness of M.O.L. therapy with adolescents experiencing psychological distress.

Please fill out the following feedback form, so that your experiences and feedback can help us give advice to services and schools about improving the experiences and choices around therapy for young people, like you.

Let's think about if the following aspects were actually helpful to you. On a scale of 0-10 (Where 0 = 'Not At All Helpful' and 10 = "Very Helpful'), please rate the following:

	Rating (from 0-10)
Being able to book my own appointments for times/days that suited me	
Being able to book as many appointments as I wanted during the course of therapy	
Being able to finish sessions when I wanted	
Being able to choose the topic of conversation in sessions	
Being asked about what I was thinking or why I did particular actions	
Being asked questions rather than being given advice	
Breaking problems down	
Being able to attend appointments virtually	

Were there any other aspects of online M.O.L. that you found particularly ***helpful***?

☐ Yes
☐ No

If Yes, please describe

Were there any other aspects of online M.O.L. that you found particularly ***unhelpful***?

☐ Yes
☐ No

If Yes, please describe

What would improve online M.O.L. therapy for young people?

Have you ever had any form of psychological therapy in the past that involved speaking with someone (e.g. a therapist, counsellor, psychologist or other)?

☐ Yes
☐ No

If yes, how would you compare your previous therapy experience to your M.O.L. therapy experience? (e.g. What was the same and what was different?)

If your school offered online M.O.L., would you use it?
☐ Yes
☐ No

Would you recommend online M.O.L. to a friend?
☐ Yes
☐ No

Any other feedback about this study?
☐ Yes
☐ No

If Yes, please describe

Again, thank you for your participation in our project so far. We hope that you have found it interesting. You will shortly receive an email from us with information about completing the last two questionnaire packs for this study. However, if you wish to speak to us sooner, you can contact us at:

M.O.L. Therapist and Researcher
Nicole ('Nicky') Gluckman
Trainee Clinical Psychologist
University of East London
London E15 4LZ
u1945453@uel.ac.uk,

Research Project Supervisor
Dr Trishna Patel
Deputy Research Director
Professional Doctorate in Clinical Psychology
University of East London, London E15 4LZ
t.patel@uel.ac.uk,

Thanks again for your interest in the study.

Appendix R: MOL Session Evaluation Forms

MOL Session Evaluation – Other

Version 1: 01/08/2019

MOL Session Evaluation – Other

(Carey, T. A., & Tai, S. J.)

1. To what extent was the content of the session generated by the patient?

1 2 3 4 5 6 7 8 9 10
not at all completely

Examples:

2. To what extent did the therapist question rather than advise, suggest, or teach?

1 2 3 4 5 6 7 8 9 10
not at all totally

Examples:

3. To what extent did the therapist ask about disruptions?

1 2 3 4 5 6 7 8 9 10
not at all constantly

Examples:

4. To what extent did the therapist ask detailed and specific questions about the current topic of conversation?

1 2 3 4 5 6 7 8 9 10
not at all constantly

Examples:

5. To what extent did the therapist question rather than assume?

1 2 3 4 5 6 7 8 9 10
not at all extremely

Examples:

6. To what extent did the therapist ask about the patient's immediate experience?

1 2 3 4 5 6 7 8 9 10
not at all constantly

Examples:

7. To what extent did the therapist follow rather than lead the client?

1 2 3 4 5 6 7 8 9 10
not at all extremely

Examples:

8. To what extent did the therapist facilitate the client sustaining a focus in one or more areas?

1 2 3 4 5 6 7 8 9 10
not at all constantly

Examples:

9. Comments about the session:

10. Suggestions for improvement and development:

MOL Session Evaluation Revised – Self

Version 1: 01/08/2019

MOL Session Evaluation Revised – Self

(Carey, T. A., & Tai, S. J.)

1. To what extent was the content of the session generated by the patient?

1 2 3 4 5 6 7 8 9 10
not at all completely

2. To what extent did the therapist question rather than advise, suggest, or teach?

1 2 3 4 5 6 7 8 9 10
not at all totally

3. To what extent did the therapist ask about disruptions?

1 2 3 4 5 6 7 8 9 10
not at all constantly

4. To what extent did the therapist ask detailed and specific questions about the current topic of conversation?

1 2 3 4 5 6 7 8 9 10
not at all constantly

5. To what extent did the therapist question rather than assume?

1 2 3 4 5 6 7 8 9 10
not at all extremely

6. To what extent did the therapist ask about the patient's immediate experience?

1 2 3 4 5 6 7 8 9 10
not at all constantly

7. To what extent did the therapist follow rather than lead the client?

1 2 3 4 5 6 7 8 9 10
not at all extremely

8. To what extent did the therapist facilitate the client sustaining a focus in one or more areas?

1 2 3 4 5 6 7 8 9 10
not at all constantly

9. Comments about the session:

10. Suggestions for improvement and development:

Appendix S: Visual Analysis of Pre-intervention Scores

ORS

ID Code	Pre-intervention Week 1	Pre-intervention Week 2	Pre-intervention Week 3
104449	25.00	25.00	26.00
136137	25.20	23.50	16.00
202772	31.00	24.00	31.00
234099	21.00	28.00	28.00
299247	23.50	28.20	20.30
404921	12.50	18.00	20.50
152533	20.80	17.00	16.80
561361	29.00	30.00	31.00
533933	30.00	23.00	23.00
579971	22.50	31.00	27.00
588599	16.00	21.50	13.00
301305	20.00	15.00	29.00
625624	30.30	34.00	32.10
719799	31.50	29.00	32.00
667077	22.40	20.20	26.40
765003	27.00	27.00	31.00
799789	15.00	16.50	14.00
670870	25.00	26.00	28.00
822358	7.00	8.00	7.00

ROC (Reorganisation Subscale)

ID Code	Pre-intervention Week 1	Pre-intervention Week 2	Pre-intervention Week 3
104449	61.00	57.00	56.00
136137	43.00	51.00	43.00
202772	84.00	78.00	76.00
234099	80.00	89.00	74.00
299247	60.00	52.00	62.00
404921	55.00	64.00	57.00
152533	39.00	46.00	48.00
561361	60.00	55.00	57.00
533933	82.00	90.00	89.00
579971	74.00	75.00	79.00
588599	49.00	54.00	51.00
301305	50.00	58.00	49.00
625624	73.00	81.00	78.00
719799	82.00	75.00	90.00
667077	52.00	55.00	59.00
765003	81.00	77.00	84.00
799789	72.00	71.00	72.00
670870	63.00	68.00	70.00
822358	48.00	59.00	63.00

GAD-7

ID Code	Pre-intervention Week 1	Pre-intervention Week 2	Pre-intervention Week 3
104449	13.00	10.00	9.00
136137	7.00	10.00	15.00
202772	12.00	12.00	5.00
234099	11.00	13.00	17.00
299247	10.00	5.00	16.00
404921	16.00	12.00	9.00
152533	14.00	12.00	11.00
561361	4.00	5.00	4.00
533933	5.00	8.00	6.00
579971	13.00	12.00	14.00
588599	12.00	15.00	15.00
301305	7.00	8.00	7.00
625624	12.00	6.00	8.00
719799	7.00	4.00	5.00
667077	9.00	9.00	10.00
765003	5.00	5.00	2.00
799789	17.00	19.00	19.00
670870	4.00	4.00	4.00
822358	21.00	21.00	21.00

PHQ-9

ID Code	Pre-intervention Week 1	Pre-intervention Week 2	Pre-intervention Week 3
104449	19.00	6.00	5.00
136137	14.00	15.00	22.00
202772	9.00	9.00	6.00
234099	18.00	14.00	15.00
299247	6.00	6.00	9.00
404921	16.00	17.00	16.00
152533	16.00	15.00	13.00
561361	4.00	4.00	3.00
533933	7.00	6.00	3.00
579971	16.00	13.00	20.00
588599	12.00	9.00	15.00
301305	7.00	7.00	3.00
625624	5.00	6.00	7.00
719799	7.00	3.00	5.00
667077	13.00	13.00	11.00
765003	3.00	0.00	2.00
799789	27.00	27.00	27.00
670870	5.00	4.00	5.00
822358	21.00	23.00	24.00

Appendix T: Characteristics and Mental Health Information of Engaged Participants

Table T1

Demographic Characteristics of Engaged Participants (n=19)

Characteristics	Frequency n (%)
Age	2 (10.53)
16	0 (0.00)
17	3 (15.79)
18	14 (73.68)
19	2 (10.53)
Gender Identity	
Male	2 (10.53)
Female	17 (89.47)
Non-Binary	0 (0.00)
Another Term	0 (0.00)
Unsure how to describe myself	0 (0.00)
Prefer not to answer	0 (0.00)
Identifies as Transgender	
Yes	1 (5.26)
No	18 (94.74)
Ethnicity	
White or Other White	
White British	14 (73.68)
White Irish	1 (5.26)
Gypsy or Irish Traveller	0 (0.00)
Any other White background	
White European	2 (10.53)
Mixed or Multiple Ethnic Groups	0 (0.00)
Asian/Asian British	
Indian	0 (0.00)
Pakistani	1 (5.26)
Bangladeshi	0 (0.00)
Chinese	0 (0.00)

Any other Asian background	
Mixed Asian	1 (5.26)
Black, African, Caribbean or Black British	
Black Caribbean	0 (0.00)
Black African	0 (0.00)
Any other Black Background	0 (0.00)
Other ethnic group	0 (0.00)
Education or Employment Status	
GCSEs	0 (0.00)
International Baccalaureate	0 (0.00)
AS/A Levels	6 (31.58)
BTEC/CTEC Vocational Course	0 (0.00)
Apprenticeship	0 (0.00)
Employed Full-time	1 (5.26)
Employed Part-time	0 (0.00)
Self-employed	0 (0.00)
Unemployed	0 (0.00)
University Student (Including part-time employment whilst studying)	12 (63.16)
Homemaker	0 (0.00)
Other	0 (0.00)
Prefer not to answer	0 (0.00)
Health Difficulties or Disabilities	
Yes	3 (15.79)
No	16 (84.21)
Brain Injury	
Yes	0 (0.00)
No	19 (100.0)
Learning Difficulties/Disabilities	
Yes	1 (5.26)
No	18 (94.74)
Learning Difficulties/Disabilities Description	
Dyslexia and Dyspraxia	1 (100.00)

Table T2

Psychological Distress and Mental Health Support Information of Engaged Participants (n=19)

Mental Health Information	Frequency n (%)
Mental Health Support Sought (Past or Present)	
Yes	11 (57.89)
No	8 (42.11)
Prefer not to answer	0 (0.00)
Mental Health Support Sought (Current)	
Yes	2 (18.18)
No	9 (81.82)
Mental Health Support Services (Last 12 Months)	
NHS support in local community - e.g., through CAMHS or adult mental health services	1 (11.11)
Support from a school or university counsellor	1 (11.11)
Support from other staff at school or university	1 (11.11)
Private counselling or therapy in local community	2 (22.22)
Support from a helpline or text service	0 (0.00)
Support from an online service - e.g., The Mix, Childline, Big White Wall	0 (0.00)
Support through a local charity, drop-in centre or youth club	0 (0.00)
Support from a local peer support group	0 (0.00)
Inpatient care	0 (0.00)
Other - please describe	0 (0.00)
No	4 (44.44)
Feel they have Mental Health Difficulties	
Yes	17 (89.47)
No	2 (10.53)
Description of Mental Health Difficulties	
Depression Symptoms	2 (11.76)
Anxiety Symptoms	6 (35.29)

Mixed Anxiety and Depression Symptoms	6 (35.29)
Mixed Anxiety and Depression Symptoms, Trauma	2 (11.76)
Mixed Anxiety and Depression Symptoms, Eating Disorder	0 (0.00)
Depression Symptoms, Gender Dysphoria	1 (5.88)
Anorexia Nervosa	0 (0.00)
Formal Diagnosis	
Yes	6 (31.58)
No	13 (68.42)
Formal Diagnosis (Description)	
Depression	0 (0.00)
Anxiety	4 (66.67)
Bipolar Disorder	0 (0.00)
Psychosis	0 (0.00)
Schizophrenia	0 (0.00)
Personality Disorder	0 (0.00)
Obsessive Compulsive Disorder	0 (0.00)
Post-Traumatic Stress Disorder	0 (0.00)
Mixed Anxiety, Depression	1 (16.67)
Other	
Depression, Anxiety, Post Traumatic Stress Disorder	1 (16.67)
Anorexia Nervosa	0 (0.00)
Not Answered	0 (0.00)
Medication (Last 12 Months)	
Yes	4 (21.05)
No	15 (78.95)
Medication (Current)	
Yes	2 (50.00)
No	2 (50.00)
Medication (Current)	
Citalopram	2 (50.00)
Unsure of Name	2 (50.00)
N/A	0 (0.00)
Using Drugs to Manage Difficult Emotions	

Yes	0 (0.00)
No	6 (100.00)
Seeking Support for This	
Yes	0 (0.00)
No	0 (0.00)
N/A	6 (100.00)
Using Alcohol to Manage Difficult Emotions	
Yes	0 (0.00)
No	6 (100.00)
Seeking Support for This	
Yes	0 (0.00)
No	0 (0.00)
N/A	6 (100.00)
Using Self-Harm to Manage Difficult Emotions	
Yes	0 (0.00)
No	6 (100.00)
Seeking Support for This	
Yes	0 (0.00)
No	0 (0.00)
N/A	6 (100.00)

Appendix U: Characteristics and Mental Health Information of Non-Engaged Participants

Table U1

Demographic Characteristics of Non-Engaged Participants (n=6)

Characteristics	Frequency n (%)
Age	
16	0 (0.00)
17	0 (0.00)
18	1 (16.67)
19	5 (83.33)
Gender Identity	
Male	0 (0.00)
Female	6 (100.00)
Non-Binary	0 (0.00)
Another Term	0 (0.00)
Unsure how to describe myself	0 (0.00)
Prefer not to answer	0 (0.00)
Identifies as Transgender	
Yes	0 (0.00)
No	6 (100.00)
Ethnicity	
White or Other White	
White British	4 (66.67)
White Irish	0 (0.00)
Gypsy or Irish Traveller	0 (0.00)
Any other White background	0 (0.00)
Mixed or Multiple Ethnic Groups	0 (0.00)
Asian/Asian British	
Indian	0 (0.00)
Pakistani	1 (16.67)

Bangladeshi	0 (0.00)
Chinese	0 (0.00)
Any other Asian background	0 (0.00)
Black, African, Caribbean or Black British	
Black Caribbean	0 (0.00)
Black African	1 (16.67)
Any other Black Background	0 (0.00)
Other ethnic group	0 (0.00)
Education or Employment Status	
GCSEs	0 (0.00)
International Baccalaureate	0 (0.00)
AS/A Levels	1 (16.67)
BTEC/CTEC Vocational Course	0 (0.00)
Apprenticeship	0 (0.00)
Employed Full-time	0 (0.00)
Employed Part-time	0 (0.00)
Self-employed	0 (0.00)
Unemployed	0 (0.00)
University Student (Including part-time employment whilst studying)	5 (83.33)
Homemaker	0 (0.00)
Other	0 (0.00)
Prefer not to answer	0 (0.00)
Health Difficulties or Disabilities	
Yes	0 (0.00)
No	6 (100.00)
Brain Injury	
Yes	0 (0.00)
No	6 (100.00)
Learning Difficulties/Disabilities	
Yes	0 (0.00)
No	6 (100.00)

Table U2

Psychological Distress and Mental Health Support Information of Non-Engaged Participants (n=6)

Information	Frequency n (%)
Mental Health Support Sought (Past or Present)	
Yes	3 (50.00)
No	2 (33.33)
Prefer not to answer	1 (16.67)
Mental Health Support Sought (Current)	
Yes	0 (0.00)
No	3 (100.00)
Mental Health Support Services (Last 12 Months)	
NHS support in local community - e.g., through CAMHS or adult mental health services	0 (0.00)
Support from a school or university counsellor	1 (33.33)
Support from other staff at school or university	0 (0.00)
Private counselling or therapy in local community	0 (0.00)
Support from a helpline or text service	0 (0.00)
Support from an online service - e.g., The Mix, Childline, Big White Wall	0 (0.00)
Support through a local charity, drop-in centre or youth club	0 (0.00)
Support from a local peer support group	0 (0.00)
Inpatient care	0 (0.00)
Other - please describe	0 (0.00)
No	2 (66.67)
Feel they have Mental Health Difficulties	
Yes	5 (83.33)
No	1 (16.67)
Description of Mental Health Difficulties	
Depression Symptoms	0 (0.00)
Anxiety Symptoms	3 (60.00)

Mixed Anxiety and Depression Symptoms	0 (0.00)
Mixed Anxiety and Depression Symptoms, Trauma	0 (0.00)
Mixed Anxiety and Depression Symptoms, Eating Disorder	1 (20.00)
Depression Symptoms, Gender Dysphoria	0 (0.00)
Anorexia Nervosa	1 (20.00)
Formal Diagnosis	
Yes	1 (16.67)
No	5 (83.33)
Formal Diagnosis (Description)	
Depression	0 (0.00)
Anxiety	0 (0.00)
Bipolar Disorder	0 (0.00)
Psychosis	0 (0.00)
Schizophrenia	0 (0.00)
Personality Disorder	0 (0.00)
Obsessive Compulsive Disorder	0 (0.00)
Post-Traumatic Stress Disorder	0 (0.00)
Mixed Anxiety, Depression	0 (0.00)
Other	0 (0.00)
Depression, Anxiety, Post Traumatic Stress Disorder	0 (0.00)
Anorexia Nervosa	0 (0.00)
Not Answered	1 (100.00)
Medication (Last 12 Months)	
Yes	0 (0.00)
No	6 (100.00)
Medication (Current)	
Yes	0 (0.00)
No	6 (100.00)
Medication (Current)	
Citalopram	0 (0.00)
Other/Unsure	0 (0.00)
N/A	6 (100.00)
Using Drugs to Manage Difficult Emotions	

Yes	0 (0.00)
No	6 (100.00)
Seeking Support for This	
Yes	0 (0.00)
No	0 (0.00)
N/A	6 (100.00)
Using Alcohol to Manage Difficult Emotions	
Yes	0 (0.00)
No	6 (100.00)
Seeking Support for This	
Yes	0 (0.00)
No	0 (0.00)
N/A	6 (100.00)
Using Self-Harm to Manage Difficult Emotions	
Yes	0 (0.00)
No	6 (100.00)
Seeking Support for This	
Yes	0 (0.00)
No	0 (0.00)
N/A	6 (100.00)

Appendix V: Frequencies of Sessions Attended

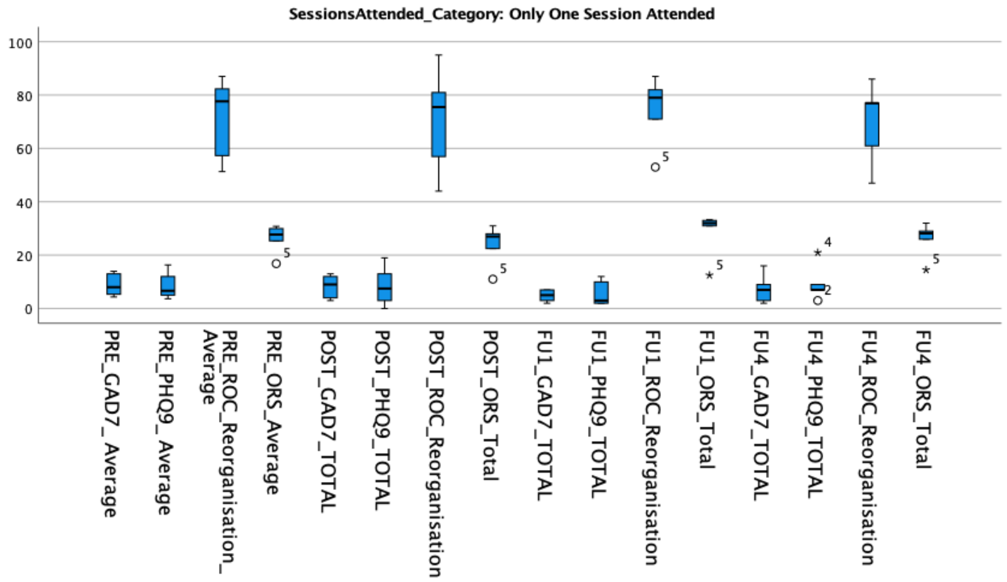
Table V1

Frequencies of sessions attended (n=19)

Number of Sessions Attended	Frequency n (%)
1	6 (31.58)
2	3 (15.79)
3	3 (15.79)
4	3 (15.79)
5	1 (5.26)
7	2 (10.53)
8	1 (5.26)

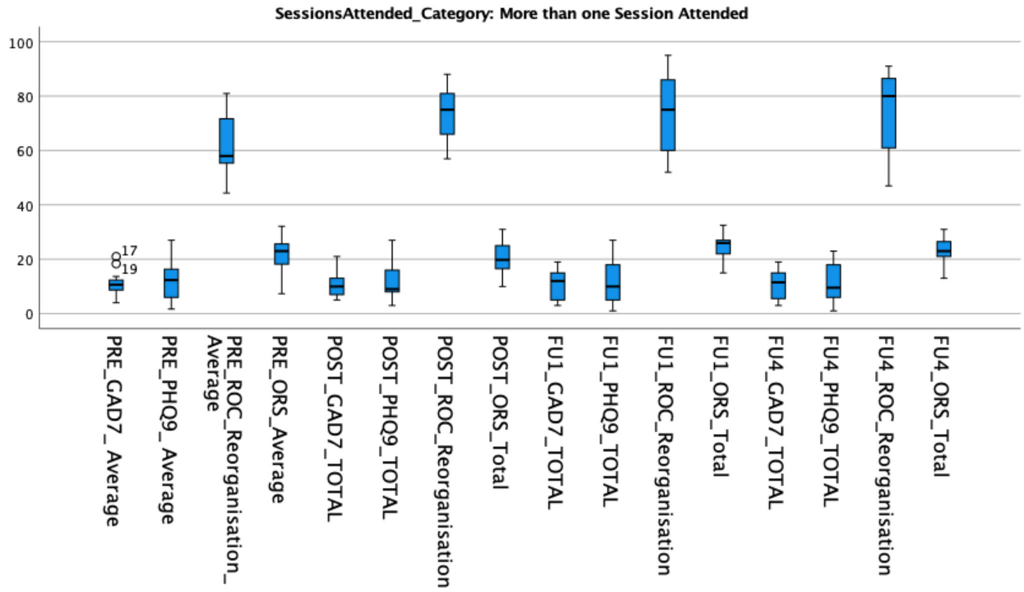
Appendix W: Tables and Figures for Parametric Assumptions of Mixed ANOVA

Figure W1



Box Plots of Data Distribution and Outliers for Individuals who Attended One Session

Figure W2



Box Plots of Data Distribution and Outliers for Individuals who Attended More than One Session

Table W1

Minimum and Maximum Z Scores for All Measures (Split by 'Number of Sessions Attended')

Group		N	Minimum	Maximum
Only one Session Attended	Zscore(PRE_GAD7_Average)	6	-1.28	0.80
	Zscore(PRE_PHQ9_Average)	6	-1.08	0.76
	Zscore(PRE_ROC_Reorganisation_Average)	6	-1.03	1.60
	Zscore(PRE_ORS_Average)	6	-1.04	1.19
	Zscore(POST_PHQ9_TOTAL)	6	-1.56	1.24
	Zscore(POST_GAD7_TOTAL)	6	-1.48	0.62
	Zscore(POST_ROC_Reorganisation)	6	-2.21	1.77
	Zscore(POST_ORS_Total)	6	-1.53	1.37
	Zscore(FU1_GAD7_TOTAL)	5	-1.25	-0.38
	Zscore(FU1_PHQ9_TOTAL)	5	-1.05	0.28
	Zscore(FU1_ROC_Reorganisation)	5	-1.51	0.93
	Zscore(FU1_ORS_Total)	5	-2.02	1.27
	Zscore(FU4_GAD7_TOTAL)	5	-1.42	1.12
	Zscore(FU4_PHQ9_TOTAL)	5	-1.19	1.53
	Zscore(FU4_ROC_Reorganisation)	5	-1.72	0.90
	Zscore(FU4_ORS_Total)	5	-1.64	1.47
More than One Session Attended	Zscore(PRE_GAD7_Average)	13	-1.35	2.31
	Zscore(PRE_PHQ9_Average)	13	-1.37	2.31
	Zscore(PRE_ROC_Reorganisation_Average)	13	-1.54	1.16
	Zscore(PRE_ORS_Average)	13	-2.56	1.40
	Zscore(POST_GAD7_TOTAL)	13	-1.06	2.29
	Zscore(POST_PHQ9_TOTAL)	13	-1.11	2.41
	Zscore(POST_ROC_Reorganisation)	13	-1.20	1.23
	Zscore(POST_ORS_Total)	13	-1.67	1.37
	Zscore(FU1_GAD7_TOTAL)	13	-1.07	1.71
	Zscore(FU1_PHQ9_TOTAL)	13	-1.19	2.29
	Zscore(FU1_ROC_Reorganisation)	13	-1.58	1.51
	Zscore(FU1_ORS_Total)	13	-1.63	1.14
	Zscore(FU4_GAD7_TOTAL)	12	-1.24	1.67
	Zscore(FU4_PHQ9_TOTAL)	12	-1.49	1.83
	Zscore(FU4_ROC_Reorganisation)	12	-1.72	1.23
	Zscore(FU4_ORS_Total)	12	-1.91	1.29

Table W2

Distribution Data for All Measures (Split by 'Number of Sessions Attended')

Group	Scale	M	SD	Min	Max	Skewness	Kurtosis	Shapiro-Wilk
Only one Session Attended	GAD-7							
	Pre-Intervention	8.78	4.09	4.33	14.00	0.33	-2.16[a]	0.37
	Post-Intervention	8.33	7.20	0.00	19.00	-0.15	-2.80[a]	0.12
	1-Week Follow-Up	4.80	2.28	2.00	7.00	-0.23	-2.51[a]	0.33
	4-Week Follow-Up	7.40	5.60	2.00	16.00	0.95	0.55	0.55
	PHQ-9							
	Pre-Intervention	8.39	4.89	3.67	16.33	0.97	-0.28	0.35
	Post-Intervention	8.33	4.50	3.00	13.00	0.42	-1.19	0.69
	1-Week Follow-Up	5.80	4.82	2.00	12.00	0.67	-2.73[a]	0.07
	4-Week Follow-Up	9.40	6.84	3.00	21.00	1.65	3.33[a]	0.13
	ROC (Reorganisation Subscale)							
	Pre-Intervention	72.22	14.45	51.33	87.00	-0.77	-1.42	0.25
	Post-Intervention	71.33	18.18	44.00	95.00	-0.44	-0.33	0.87
	1-Week Follow-Up	74.40	13.30	53.00	87.00	-1.29	1.55	0.42
	4-Week Follow-Up	69.60	15.52	47.00	86.00	-0.78	-0.57	0.54
	ORS							
	Pre-Intervention	26.42	5.11	16.83	30.83	-1.66	2.99[a]	0.13
	Post-Intervention	24.42	7.14	11.00	31.00	-1.68	3.06[a]	0.11
	1-Week Follow-Up	28.36	8.91	12.50	33.30	-2.18[a]	4.79[a]	0.00*
	4-Week Follow-Up	25.94	6.75	14.50	32.00	-1.68	3.22[a]	0.16

Group	Scale	M	SD	Min	Max	Skewness	Kurtosis	Shapiro-Wilk
More than One Session Attended	GAD-7							
	Pre-Intervention	10.97	4.87	4.00	21.00	0.59	0.49	0.48
	Post-Intervention	11.62	6.64	3.00	27.00	0.76	-0.07	0.42
	1-Week Follow-Up	10.85	5.84	3.00	19.00	0.11	-1.48	0.17
	4-Week Follow-Up	10.83	5.36	3.00	19.00	-0.17	-1.19	0.52
	PHQ-9							
	Pre-Intervention	12.36	7.46	1.67	27.00	0.49	-0.40	0.70
	Post-Intervention	10.85	4.86	5.00	21.00	1.03	0.97	0.30
	1-Week Follow-Up	11.46	7.87	1.00	27.00	0.53	-0.69	0.43
	4-Week Follow-Up	11.50	6.75	1.00	23.00	0.28	-1.04	0.47
	ROC (Reorganisation Subscale)							
	Pre-Intervention	62.05	12.42	44.33	81.00	0.33	-1.06	0.25
	Post-Intervention	72.77	10.35	57.00	88.00	-0.27	-1.26	0.39
	1-Week Follow-Up	73.85	14.71	52.00	95.00	-0.26	-1.27	0.36
	4-Week Follow-Up	73.92	15.17	47.00	91.00	-0.57	-1.20	0.14
	ORS							
	Pre-Intervention	21.95	6.41	7.33	32.13	-0.79	1.12	0.77
	Post-Intervention	20.24	6.66	10.00	31.00	-0.04	-0.85	0.84
	1-Week Follow-Up	24.12	4.97	15.00	32.50	-0.57	-0.15	0.16
	4-Week Follow-Up	22.84	5.14	13.00	31.00	-0.67	0.40	0.40

* Significant at $p<0.05$ level.

[a] Outside normality (±1.96) according to Field (2017) and George & Mallery (2021).

Appendix X: Mixed ANOVA Results

Table X1

Fixed-Effects ANOVA using the GAD-7 as the criterion

Predictor	df	F	Sig.	η_p^2
Between-subject effects				
Number of Sessions Attended	1	1.46[c]	0.25[c]	0.09
Error (Number of Sessions Attended)	15			
Within-subject effects				
Time	3	2.17[c]	0.11[c]	0.13
Time x Number of Sessions Attended	3	2.17[c]	0.10[c]	0.13
Error (Time)	45			

Note. * indicates significance at the $p<0.05$ level. [a] indicates Box's test of equality of covariance matrices was violated. [b] indicates Mauchly's test of sphericity was violated (and correction reported). [c] indicates one or more of Levene's test of equality of error variances was violated.

Table X2

Fixed-Effects ANOVA using the PHQ-9 as the criterion

Predictor	df	F	Sig.	η_p^2
Between-subject effects				
Number of Sessions Attended	1	0.71	0.41	0.05
Error (Number of Sessions Attended)	15			
Within-subject effects				
Time	3	1.49	0.23	0.09
Time x Number of Sessions Attended	3	0.92	0.44	0.06
Error (Time)	45			

Note. * indicates significance at the $p<0.05$ level. [a] indicates Box's test of equality of covariance matrices was violated. [b] indicates Mauchly's test of sphericity was violated (and correction reported). [c] indicates one or more of Levene's test of equality of error variances was violated.

Table X3

*Fixed-Effects ANOVA using the ROC '*goal conflict reorganisation' subscale *as the criterion*

Predictor	df	F	Sig.	η_p^2
Between-subject effects				
Number of Sessions Attended	1	0.00^{ac}	0.95^{ac}	0.00
Error (Number of Sessions Attended)	15			
Within-subject effects				
Time	3	3.23^{ac}	0.01^{*ac}	0.18
Time x Number of Sessions Attended	3	2.85^{ac}	0.05^{*ac}	0.16
Error (Time)	45			

Note. * indicates significance at the $p<0.05$ level. ^{a} indicates Box's test of equality of covariance matrices was violated. ^{b} indicates Mauchly's test of sphericity was violated (and correction reported). ^{c} indicates one or more of Levene's test of equality of error variances was violated.

Table X4

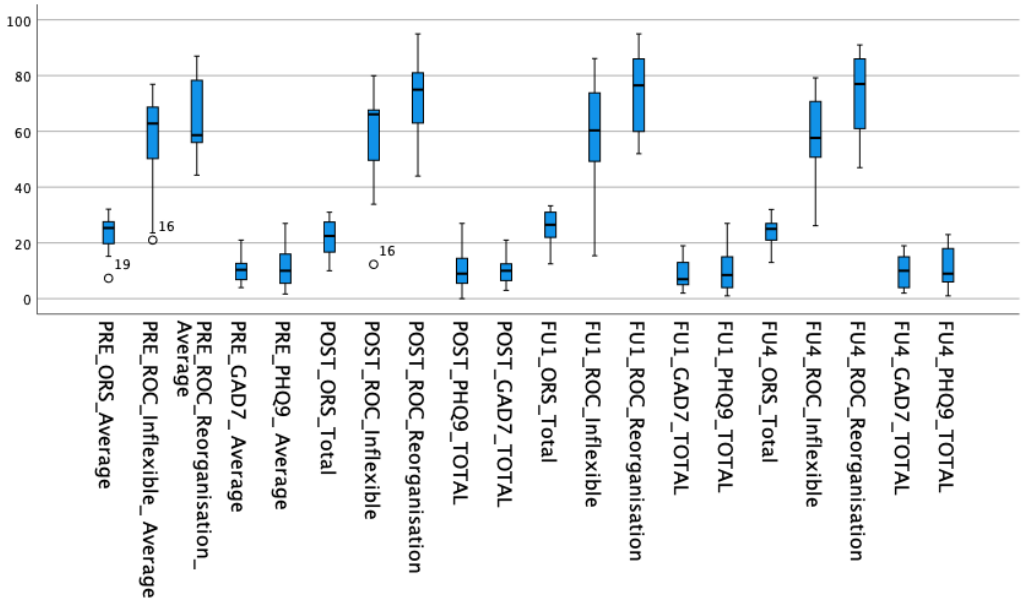
Fixed-Effects ANOVA using the ORS as the criterion

Predictor	df	F	Sig.	η_p^2
Between-subject effects				
Number of Sessions Attended	1	1.33	0.27	0.08
Error (Number of Sessions Attended)	15			
Within-subject effects				
Time	3^{b}	3.09^{b}	0.07^{b}	0.17
Time x Number of Sessions Attended	3^{b}	0.13^{b}	0.86^{b}	0.01
Error (Time)	45^{b}			

Note. * indicates significance at the $p<0.05$ level. ^{a} indicates Box's test of equality of covariance matrices was violated. ^{b} indicates Mauchly's test of sphericity was violated (and correction reported). ^{c} indicates one or more Levene's test of equality of error variances was violated.

Appendix Y: Tables and Figures for Parametric Assumptions of One-Way ANOVA

Figure Y1



Box Plots of Data Distribution and Outliers for All Measures

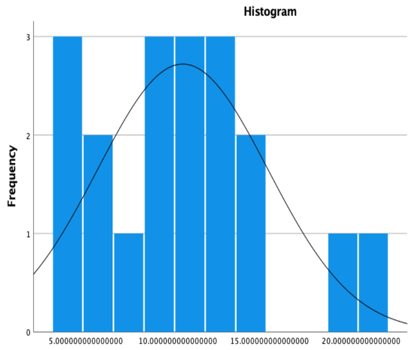
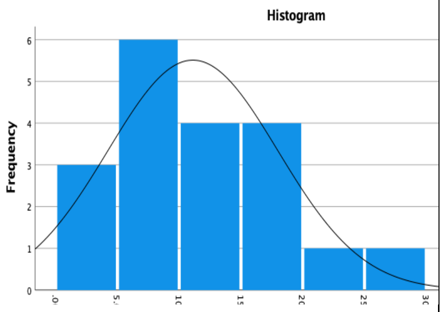
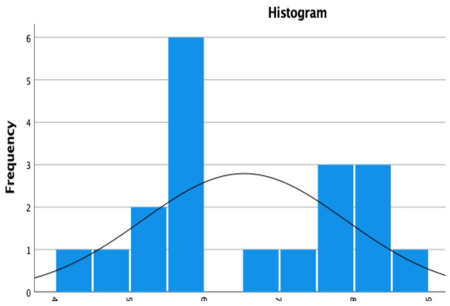
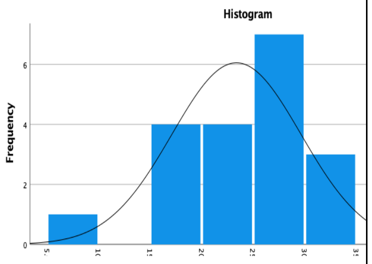
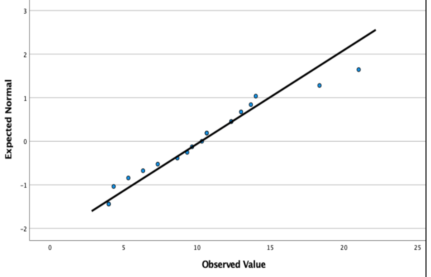
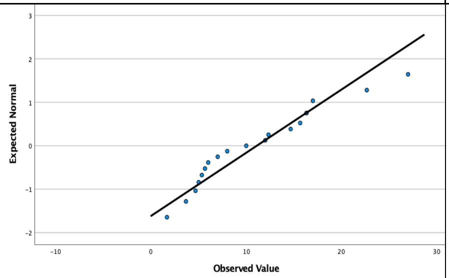
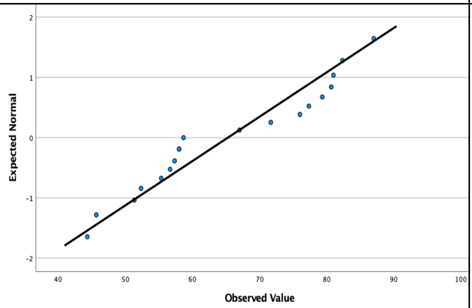
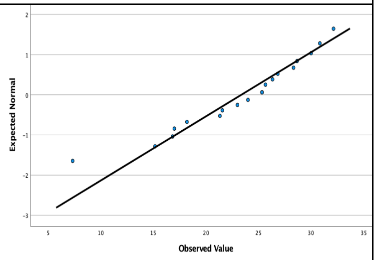
Table Y1

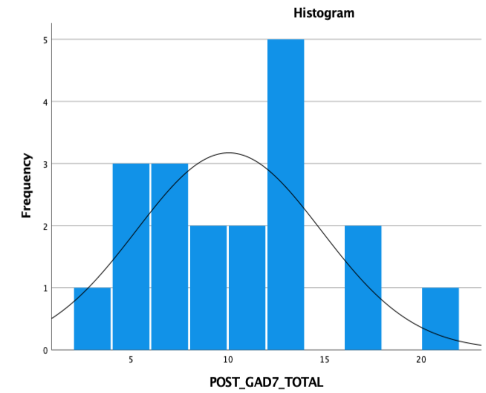
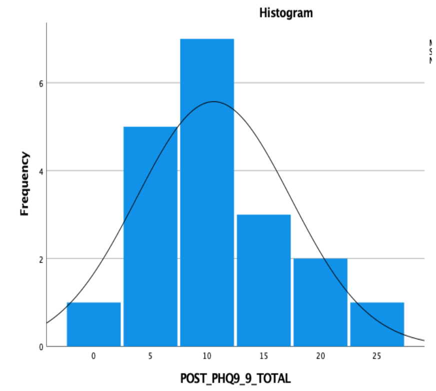
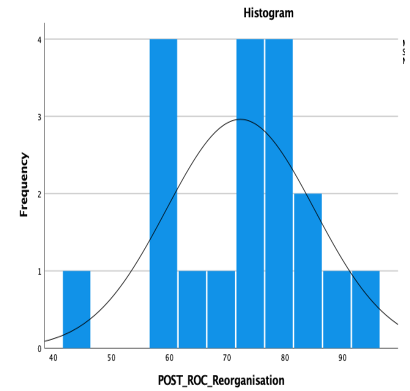
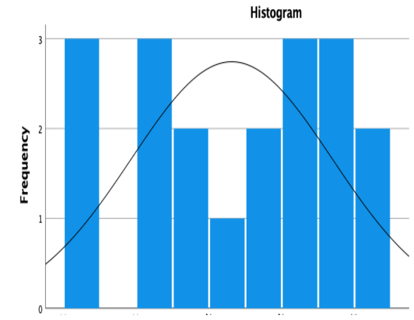
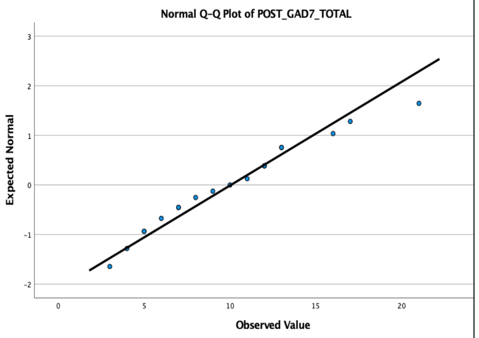
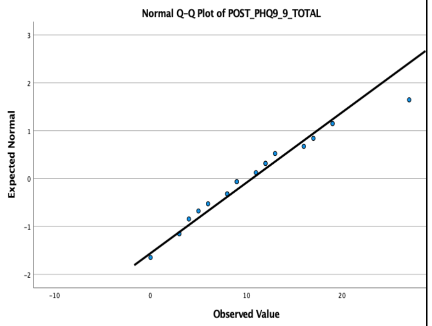
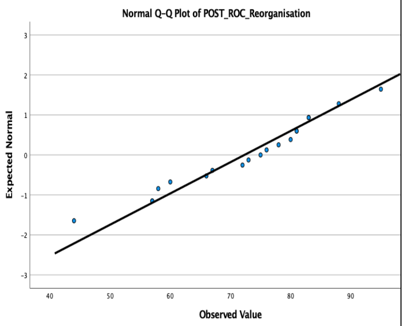
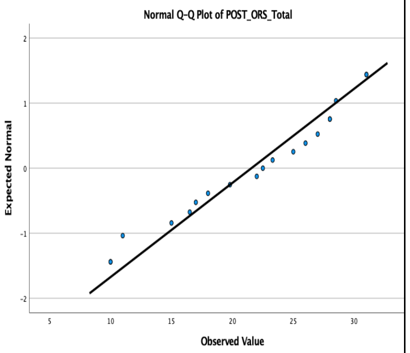
Minimum and Maximum Z Scores for All Measures

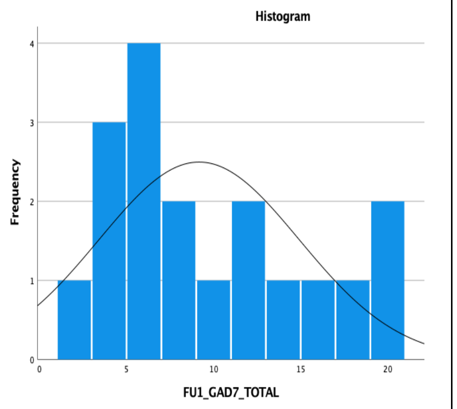
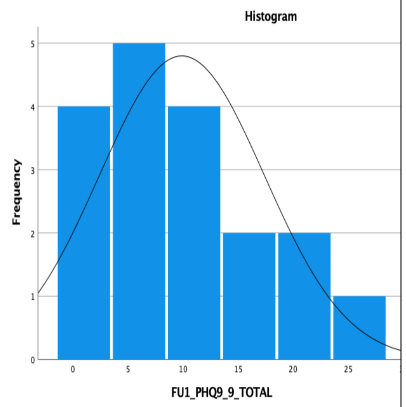
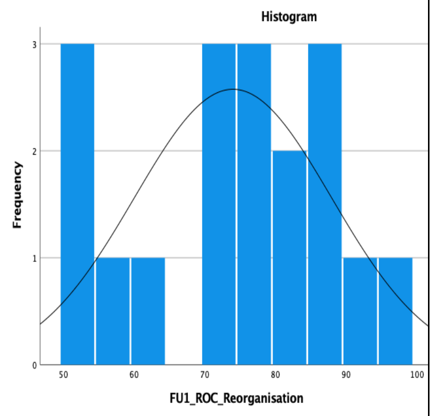
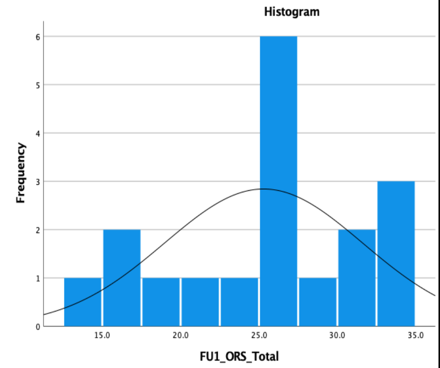
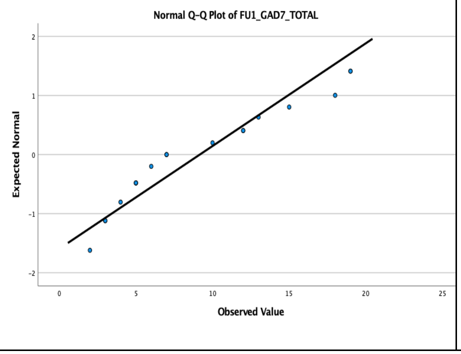
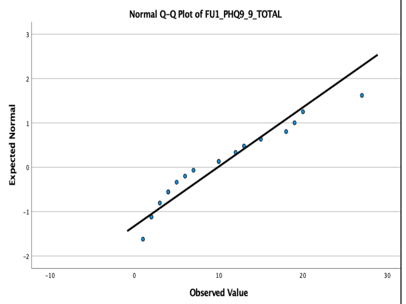
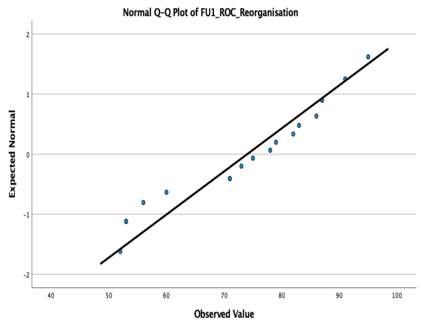
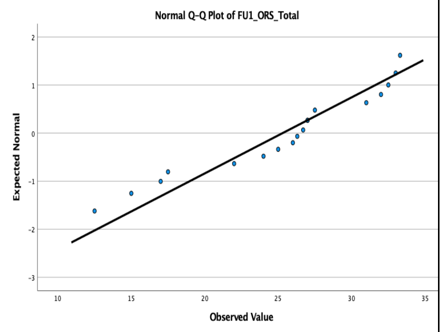
	N	Minimum	Maximum
Zscore(PRE_GAD7_Average)	19	-1.35	2.31
Zscore(PRE_PHQ9_Average)	19	-1.37	2.31
Zscore(PRE_ROC_Reorganisation_Average)	19	-1.54	1.60
Zscore(PRE_ORS_Average)	19	-2.56	1.40
Zscore(POST_PHQ9_TOTAL)	19	-1.56	2.41
Zscore(POST_GAD7_TOTAL)	19	-1.48	2.29
Zscore(POST_ROC_Reorganisation)	19	-2.21	1.77
Zscore(POST_ORS_Total)	19	-1.67	1.37
Zscore(FU1_GAD7_TOTAL)	18	-1.25	1.71
Zscore(FU1_PHQ9_TOTAL)	18	-1.19	2.29
Zscore(FU1_ROC_Reorganisation)	18	-1.58	1.51
Zscore(FU1_ORS_Total)	18	-2.02	1.27
Zscore(FU4_GAD7_TOTAL)	17	-1.42	1.67
Zscore(FU4_PHQ9_TOTAL)	17	-1.49	1.83
Zscore(FU4_ROC_Reorganisation)	17	-1.72	1.23
Zscore(FU4_ORS_Total)	17	-1.91	1.47

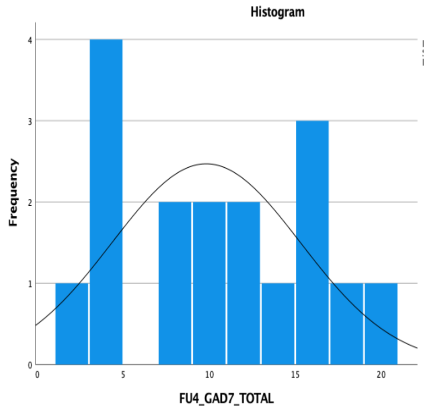
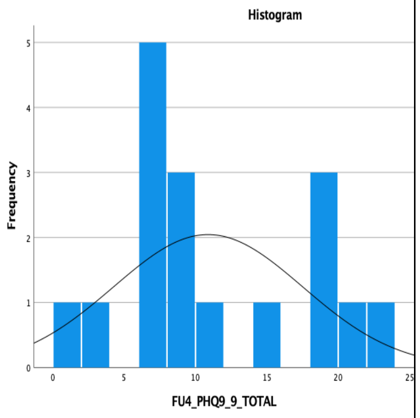
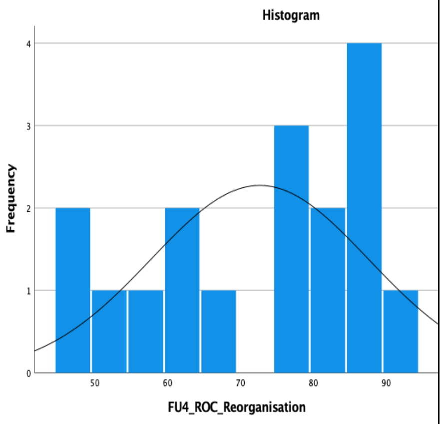
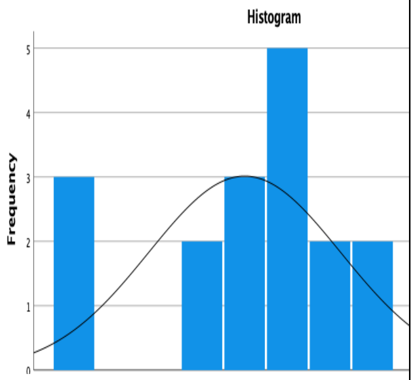
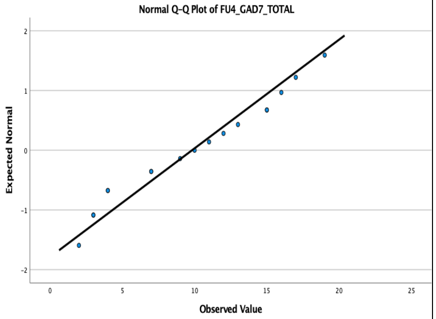
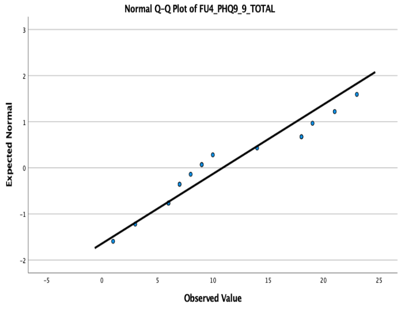
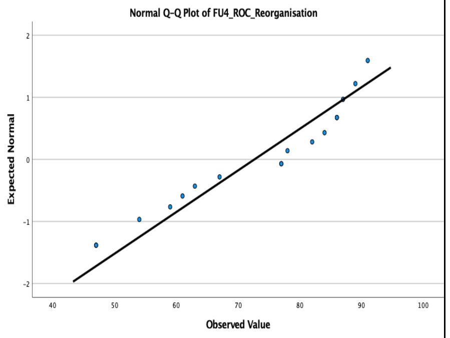
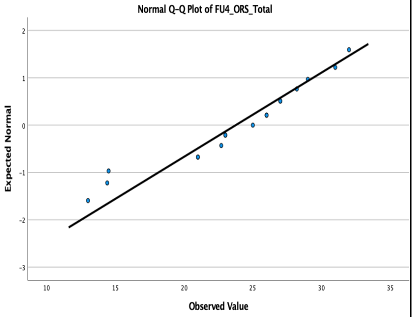
Table Y2

Normality Plots for All Measures

	GAD-7	PHQ-9	ROC ‘goal conflict reorganisation’ subscale	ORS
Pre-Intervention Average				
				

	GAD-7	PHQ-9	ROC ‘goal conflict reorganisation’ subscale	ORS
Post-Intervention				
				

	GAD-7	PHQ-9	ROC ‘goal conflict reorganisation’ subscale	ORS
1-Week Follow-Up				
				

	GAD-7	PHQ-9	ROC ‘goal conflict reorganisation’ subscale	ORS
4-Week Follow-Up				
				

Appendix Z: Feedback Data with Example Quotes

Table Z1

Similarities between Online MoL and Past Therapy (n=3)

Similarity Category	Example Quote	Frequency n (%)
Breaking Down Problems	"Talking about problems"	2 (66.67)
Control over Topic	"I choose what to talk about and if I want to change topics"	1 (33.33)

Table Z2

Differences between Online MoL and Past Therapy (n=9)

Difference Category	Example Quote	Frequency n (%)
Felt listened to	"In my previous experience, the counsellor didn't seem to hear or understand what I was saying… M.O.L. therapy definitely allowed me to express myself and feel heard"	3 (33.33)
Questions rather than advice	"MOL was better at asking questions and not just giving advice"	2 (22.22)
Less structure (meant increased uncertainty)	"M.O.L. is a lot less structured with less certainty (if that makes sense)"	1 (11.11)

More control, which felt tiring	“I think [MoL] is so patient-led and it can be exhausting...”	1 (11.11)
Helpful to explore disruptions	“Thing[s] I offhandedly say are questioned more with MOL and forces me to properly consider things that I may have compartmentalised…”	1 (11.11)
Appreciated control	“Felt… less pressure on making sessions in case life interfered”	1 (11.11)

Table Z3

Other Unhelpful Aspects of Online MoL (n=3)

Feedback Category	Example Quote	Frequency n (%)
No Advice Given	“Would have potentially liked a bit of advice”	2 (66.67)
No Focus or Discussion Topic Given	“Often I didn't know what I want to talk about [and] my mind would go blank”	1 (33.33)

Table Z4

Other Helpful Aspects of Online MoL (n=7)

Feedback Category	Example Quote	Frequency n (%)
Breaking Down Problems	"Thinking of problems in a more systematic way."	2 (28.57)
Being in Control	"The way… I was in control of the session and what we talked about."	2 (28.57)
Questions Asked (rather than advice given)	"Being asked questions about my problems"	1 (14.29)
Process Felt Comfortable	"I felt comfortable to open up more as it was mainly me talking."	1 (14.29)
Attention to Detail	"Attention to detail"	1 (14.29)