Change Mechanisms in Transdiagnostic Group Therapy for Children and Adolescent

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Abstract

Introduction: Group transdiagnostic cognitive behavioural therapy has recently gained interest and has potential as a treatment for children and adolescents. However, little is currently known about the mechanisms of change of group tCBT for children and adolescents, which would be important information to inform treatment protocols and enhance treatment efficacy. This study aimed to identify how therapists describe the mechanisms of change of transdiagnostic group therapy for children and adolescents via a qualitative research approach.

Methods: Four therapists agreed to be interviewed for this study. The average age of participants was 29.77 (*SD* = 1.92). Three of the participants identified as female. The average amount of work experience was 4.88 years (*SD* = 1.88), with an average of 4.13 years (*SD* = 2.56) of experience leading group therapy and 2.63 years (*SD* = 3.11) focusing on group therapy for children and adolescents. A semi-structured interview study was conducted, including 14 themes and 9 prompts. Data was collected from February 1st, 2025, to March 1st, 2025, and the interviews lasted between 31 minutes and 58 minutes (*M* = 40 min). The interviews were then analysed using the approach of applied thematic analysis.

Results: The analysis of the interviews revealed three main themes. The first subtheme considered therapist-related change (playful session design, the therapist's role in guiding and structuring the group, and building a therapeutic relationship), referring to what aspects the therapists saw as their responsibility in creating change in group tCBT for children and adolescents. Second was intra-personal change mechanisms (including developing empathy, self-insight, perceived peer support, relatedness and universality of experience, and hope), describing the mechanisms working within the individual patient. Lastly, interpersonal in-treatment change mechanisms (including corrective social experience, interpersonal connections, social learning, reality testing, setting goals and planning actions, and peer modelling) focused on change happening between the group members through the social contact established.

Conclusion: To conclude, this study gave insight into how therapists described the mechanisms of change of group tCBT for children and adolescents. Receiving peer support and feedback, developing a sense of hope, understanding the universality of their experiences and development of social skills were highlighted as important for change in group CBT for children and adolescents in previous research, and the same themes are represented in this study for the transdiagnostic setting. The uniqueness of group tCBT for children and adolescents lies in its explicit targeting of shared maintenance processes across different diagnoses, emphasizing

general change mechanisms rather than diagnosis-specific techniques. Understanding these processes can inform protocol development and enhance treatment outcomes in diverse clinical settings.

Keywords: Transdiagnostic Group Therapy, Children and Adolescents, Change Mechanisms, Applied Thematic Analysis

Introduction

Group therapy was recognized as a speciality by the American Psychology Association in 2018 (APA D49, 2023), and many benefits of the approach have been established for quite a while. Not only is it an effective treatment for several mental health issues, but it also is a source of social support, helping clients to change their perspective and feel less alone (Fogarty et al., 2019; Janiset al., 2021; Johnson, 2019; Mashinter, 2020; Sigman & Hassan, 2006). It can be useful to treat mood and anxiety disorders, but also, for example, eating disorders, schizophrenia, substance abuse disorders and panic disorders, as well as giving psychological relief to patients struggling with medical conditions such as breast cancer and chronic pain (Burlingame et al., 2013; Rosendahl et al., 2021). Therefore, group therapy can be an effective tool of treatment for a wide variety of issues. These studies, however, are considering an adult population. Children and adolescents, however, are at a different cognitive, behavioural, and emotional developmental state than adults, and socializing and interpersonal aspects are a larger factor for them (Shechtman, 2007). Therefore, children and adolescents should also be separately considered as a target group for group therapy. When looking at child and adolescent treatment, group therapy has proven itself to be successful in treating depression and anxiety (Bangun, 2022), decreasing anger and increasing assertiveness (Tavakoli & Mirghaemi, 2023), or improvement of externalized behavioural concerns (Arnold et al., 2024). Therefore, it does seem to be an effective treatment option for this population as well.

Research examining the effects of group therapy often considers samples where the groups are made up of individuals who all share a common diagnosis to be targeted. Specific diagnosis is even considered to be a significant moderator of outcome results, possibly because some conditions, such as eating disorders, profit more from the interpersonal learning, cohesion, and peer feedback aspects (Grenon et al., 2017; Rosendahl et al. 2021). In

clinical settings, such as psychiatric clinics, assisted living, or psychiatric daycare clinics, it might not be realistic for all group members to have the same diagnosis, as they often must treat many individuals with different diagnoses at the same time (Erickson et al., 2007; Norton & Philipp, 2008). Furthermore, the onset of a mental disorder during child or adolescent years (before the age of 20) increases the risk of developing other types of disorders (McGrath et al., 2020). So, while research can focus on these homogenous groups, real-world implementation often looks different, and children and adolescents struggling with mental health could be especially affected by comorbidity.

A new trend that is currently emerging to address this issue of treating multiple diagnoses at the same time is transdiagnostic cognitive behavioural therapy (tCBT). While the approach is still evolving, it is based on the idea that some mental disorders share common maintenance processes and characteristics that can be addressed by the same cognitive and behavioural intervention models (Joaquim et al., 2023). Currently, this includes a diverse range of treatments being either applied as “one size fits all”, addressing multiple disorders with a unified treatment or as “my size fits me” by tailoring the intervention to the specific problem(s) of the individual (Schaeuffele et al., 2021). When applied in group therapy, the tCBT approach is more efficient compared to waiting-list conditions, and at least as efficient as diagnosis-specific cognitive-behavioural group treatment (Joaquim et al., 2023). Next to addressing comorbidities, it is also beneficial in treating heterogeneous disorders, meaning those with a versatile symptom presentation such as major depressive disorder, generalised anxiety disorder, or obsessive-compulsive disorder, as it creates a more flexible treatment to approach those symptoms (Almeida & Marinho, 2021). Moreover, group tCBT seems to be effective regardless of possibly influential factors such as age, sex, and the level of education of a patient (González-Blanch et al., 2021), highlighting its potential for treating heterogenous groups of children and adolescents as well. Interestingly, a factor possibly resulting in greater effects is a higher severity of the disorder (González-Blanch et al., 2021), so perhaps

especially intensive treatment settings would benefit from this approach. Additionally, tCBT also increases the accessibility and dissemination of evidence-based interventions, as professionals will only have to study a single approach applicable to multiple pathologies (Almeida & Marinho, 2021). Lastly, the tCBT approach to group therapy is possibly more cost-efficient than treatment as usual, as it reduces required human resources during treatment as well as the health care utilization of individuals up to one year after treatment (Chapdelaine et al., 2023; Vasiliadis et al., 2024).

When it comes to group tCBT for adolescents and children, a recent meta-analysis by García-Escalera et al. (2017) points out that, while effectiveness on anxiety and depressive symptoms is evident for adults, there is a lack of research about it when it comes to the younger target group. Few studies have looked at this effectiveness; however, they show promising results. Group tCBT interventions have shown themselves to be effective when treating anxiety and headaches (Sharma et al., 2017), depression and anxiety rates (Chu et al., 2016) and decreasing peer problems and increasing pro-social behaviour (Melero et al., 2021). These examples show the efficacy of transdiagnostic treatments for a variety of issues. Furthermore, current research is also interested in the development of transdiagnostic treatment protocols for children and adolescents in group settings. Bilek & Ehrenreich-May (2012) evaluated the effectiveness of a protocol for children aged 7 to 12 for depressive and anxiety symptoms, geared at coping with emotions associated with negative affect and aiming to increase positive affect. They found that the group helped remission of anxiety disorder symptoms, as well as a reduction in overall severity of emotional disorders. Melero et al. (2021) worked with children aged 8 to 12 years using a protocol aimed at learning to manage emotions, detect and modify negative thoughts, relax, be exposed to anxiety-provoking situations, interact with others, and solve problems. They found that the group application of this protocol resulted in fewer peer problems and a tendency to increase prosocial behaviours at a one-year follow-up. Another available protocol is the *Cool Kids* manual, which focuses

on children with anxiety disorders and has multiple versions available to also address comorbidities with depressive disorders and autism spectrum disorders, as well as being adapted for preschool children, school-aged children, and adolescents (Ninan et al., 2019; Perini et al., 2013). This shows that there is interest in incorporating tCBT in a more efficient and structured way, as well as the diverse ways that transdiagnostic approaches can be applied. Even though the research on this topic is just beginning, there is clear interest developing in a transdiagnostic approach to child and adolescent group therapy.

Although little is known about the working mechanisms in group tCBT for children and adolescents, the working mechanisms of tCBT among adults and the working mechanisms of group therapy among children and adolescents have been examined to some extent. Looking at the adult population, transdiagnostic group therapy achieves changes when focused on negative affectivity, which is a symptom existing in a variety of diagnoses (Talkovsky & Norton, 2014). Bryde et al., (2021), who compared group cohesion in adult transdiagnostic and diagnosis-specific therapy groups, found that the transdiagnostic groups also identified cohesion as a "core healing factor". In the transdiagnostic groups, patients did not focus on diagnostic differences, but focused on their similarities, and they bonded over these experiences. Therefore, cohesion seems not only possible but also a core factor in these groups.

Focusing on traditional group CBT among children and adolescents, Nardi et al. (2017) evaluated the effectiveness of group CBT for adolescents with depression symptoms and found that the presence of peers was an important factor, as it provided a source of feedback and support, and allowed to practice new symptom-management skills, and additionally improved social-relational skills. Compared to group CBT with adults, a stronger emphasis in child and adolescent group therapy is placed on the therapeutic factors of developing an understanding of universality of the experience, a replication of the family

experience, the development of socializing techniques, instilling a sense of hope for change, and highlighting the importance of interpersonal relationships (Haen & Aronson, 2017). The development of social skills is suggested to be a unique factor to the groups of children and adolescents, as they are still in development, which is important to consider when administrating group therapy (Shechtman, 2007). When it comes to group tCBT, it is being criticised how little is known about the mechanisms for it regarding adolescents and children (Sharma et al., 2017; Taubner et al., 2024). It has been suggested that behavioural, cognitive and family-related mediators are of importance (Taubner et al., 2024). Cognitive mechanisms seem focus on negative thoughts and do not seem to differ greatly from concepts of adult psychotherapy. Regarding behavioural factors, some identified issues such as impulse control and engagement in therapy activities are viewed specifically adolescent issues. Lastly, family-related factors, such as family functioning and parenting skills, highlight the importance of family involvement in adolescent treatment. However, as of now there is little support for or consensus on central mechanisms of change of tCBT for children and adolescents (Taubner et al., 2024). Factors such as group cohesion and interpersonal factors, which are prominent in traditional group CBT, have not yet been thoroughly examined in tCBT contexts with younger populations, even though the differences in diagnosis could possibly affect these aspects differently in tCBT. Understanding the change mechanisms of group tCBT for children and adolescents is necessary to grasp which components of a treatment are relevant to its successful outcome, helping therapists to make informed decisions about which components to use, ensuring correct replication of interventions, as well as to understand the conditions or combinations in which a treatment should be used, or when it could be harmful (Tolin et al., 2023).

To summarize, group tCBT for children and adolescents has shown its potential to address issues such as depression and anxiety rates, decreasing peer-problems and increasing pro-social behaviour. It is a way of creating a flexible treatment to address comorbidity or

different disorders at the same time, which is a common occurrence in children and adolescents and the clinical setting. Support for its efficacy has been continuously emerging, and treatment protocols are being developed. However, little is currently known about the mechanisms of change of group tCBT among children and adolescents, which would be important information to inform treatment protocols and enhance treatment efficacy by illustrating which components and conditions make a treatment successful (Taubner et al., 2024; Tolin et al., 2023).

Aim

The present study aims to identify how therapists describe the mechanisms of change of transdiagnostic group therapy for children and adolescents. A qualitative approach will allow the collection of richer data than could be achieved otherwise. Other studies have used a qualitative approach to understand the ways that therapeutic processes and outcomes are related (Bryde et al., 2021), and therapist can provide practical, experiential knowledge as informed observers (Maxwell & Levitt, 2023). Especially invisible patterns could be discovered with qualitative methods, as the question is not only what is working, but for whom, when and why (Busetto et al., 2020). This is, to the researcher's knowledge, the first qualitative study to investigate the topic of transdiagnostic CBT change mechanisms for child and adolescent group therapy as described by therapists. The objective is to expand the understanding of change mechanisms for tCBT for children and adolescents as described by therapists and inform the future development of tCBT group protocols for a younger target group.

Methods

Participants

Participants were recruited via three different youth welfare institutions, which the researcher had previously established contacts to. The inclusion criteria were having working experience with conducting group tCBT with children and/or adolescents. Exclusion criteria was the non-providing or retraction of informed consent. Overall, 4 therapists consented to be interviewed within the scope of this project. Three of them held master's degrees in psychology and completed the post-master education for psychotherapists in Germany. One of them held a master's degree in social pedagogy and completed the post-master education for children and adolescent psychotherapists in Germany. These educations included training in group therapy. The average age of participants was 29.77 (*SD* = 1.92). Three of the participants identified as female. The average amount of work experience was 4.88 years (*SD* = 1.88), with an average of 4.13 years (*SD* = 2.56) of experience leading group therapy and 2.63 years (*SD* = 3.11) focusing on group therapy for children and adolescents. Two participants described their workplace as an intensive care residential group for children and adolescents, while the other two worked in outpatient daycare psychiatric clinics for children and adolescents. The specific demographic data can be found in Table 1.

Qualitative Measures

A semi-structured interview study was conducted. This form of interview allowed for the researcher some standardization of the question but also leaves room to address significant statements that might come up during the process (Adeoye-Olatunde & Olenik, 2021). The full interview consisted of 14 questions and 9 prompts (Appendix 1). The themes are summarised in Table 2.

Table 1

Socio-demographic data of participants N = 4

Participant ID	Age	Gender	General Work Experience	Experience leading group therapy	Experience leading group therapy for children and/or adolescents	Place of work	Following a protocol
P1	29	Female	4 ½ years	4 ½ years	1 year	Residential group	No
P2	28	Male	3 years	3 years	6 months	Residential group	No
P3	33	Female	8 years	8 years	8 years	Daycare clinic	No
P4	29	Female	4 years	1 year	1 year	Daycare clinic	No

The questions were created by the researcher based on the recent systematic review by Taubner et al. (2024). In their review, they identified six categories of mediators of psychotherapy for adolescents. The first three mediators that are often addressed are cognitive, behavioural and emotional mediators, which is in line with the classical change theory of CBT (Kennerley et al., 2017). The fourth and fifth mediators are family-related and relational mediators, which are the ones viewed at least partially age-specific for the target group. They address changes within the family of the patients, and their interpersonal development. Lastly, the sixth mediator addressed is therapy-related mechanisms, such as the therapeutic alliance, the duration of the treatment, or therapist's techniques (Taubner et al., 2024). To finish the interview, the interviewees are asked if they would like to add anything else that has not been covered yet, providing the freedom to find new topics as well.

Table 2

Interview categories and main themes

Category	Example item	Number of questions/prompts
General information	How old are you?	6
Cognitive	How do you address changes in thoughts or cognitions during the group therapy?	2
Family-related	What brings about change in family functioning?	2
Behavioural	What changes the behavioural components of patient's issues?	4
Therapy-related	How do you place the importance of therapy-related factors such as duration of treatment, therapeutic alliance, and therapists' techniques?	1
Relational	How are interpersonal changes happening?	3
Emotional	How do emotional issues of patients change?	3
Additional information	Are there any other domains that you perceive to be important for change?	2

Procedure

The ethics committee of the University of Twente, Faculty of Behavioural, Management, and Social Sciences (BMS) gave ethical approval for this study. The request number is 250065. Data was collected from February 1st, 2025, to March 1st, 2025. The semi-structured interview was designed to take around 30 to 45 minutes to complete, the interviews lasted between 31 minutes and 58 minutes (M = 40 min). Participants could choose to complete the interviews in German or English, all of them opted for German as it was their

native language. The interviews took place face-to-face, and the interviewees were allowed to choose a private environment that was most comfortable and convenient to them to complete the interview at, for which all of them chose their workspace. The researcher was equipped with a laptop to take field notes and a microphone to record the interview. The informed consent form was given to the interviewee beforehand in their preferred language (Appendix 2), so they could read through it in full, and they provided the signed form before the interview started.

The participants were walked through the structure of the interview and instructions were provided as detailed as the participant requested. The recording was started, and the researcher again informed the participant of their right to withdraw and assured of confidentiality and asked to give oral agreement again on the recording. Then, the interview was conducted. Afterwards, the participants were thanked for their participation, and it was made sure that they had all contact information should they have any further questions or wanted to withdraw from participation.

Data analysis

The first step conducted was transcribing the interviews using the software Amberscript. The transcripts were then read through and corrected by the researcher, which allowed for a process of familiarisation. Then the software ATLAS.ti 25 was used to allow examination of the data using applied thematic analysis. This approach uses inductive coding, starting with creating codes to interpret the data multiple times, and through the codes overarching themes should emerge (Guest et al., 2012). Therefore, the data was read through multiple times by the researcher and aspects relevant to the research question are marked with specific codes. The general information was not coded but used for participant descriptives. From this a coding scheme materialised, while the data was continuously analysed for reoccurring patterns. To avoid confirmation biases, the coding scheme was developed post-

hoc (Guest et al., 2012). This coding scheme was then reapplied to the interviews and adjusted. During this process, some codes were merged as they described similar processes, and some were deleted if they were considered to not be sufficiently supported throughout the interviews. The researcher alone developed the coding scheme; therefore, the coding was done repeatedly over multiple days to mitigate further bias (Castleberry & Nolen, 2018; Guest et al., 2012). After that, the codes were analysed for patterns that could be grouped in themes with regards to the research question. Overall, three themes were found. All quotes and themes were initially in German but were translated into English for this paper.

Results

The analysis of the interviews resulted in three main themes with different subthemes: The first subtheme considered therapist-related changes, followed by intra-personal change mechanisms and interpersonal change mechanisms. The full overview of the themes and subthemes can be found in Table 3.

Table 3

Codebook

Theme	Code (Number of Appearances)	Code description
Therapist-related changes	Playful Design (9)	Therapists include games or design the group in a playful way to motivate patients
	Therapist facilitates (13)	The therapist is seen as responsible for moderating the group, keep attention on the topic and make sure everyone participates as far as they can
	Therapeutic alliance (8)	Therapists describe how a therapeutic alliance in group therapy can affect change and how it should be applied
Intra-personal Change Mechanisms	Developing empathy (8)	Patients learn to develop empathy through witnessing other group members opening up, having to think about their situations

Table 3 - continued

Codebook

	Self-insight (12)	Patients learn to express their thoughts and emotions and experience by speaking them out loud in front of a group
	Receiving peer support (17)	Patients experience emotional validation and acceptance from other group members for their experiences
	Relatedness and universality of experiences (18)	Patients experience through the group that they are not alone with their problems because others also have similar problems
	Hope (10)	Patients realize that they can work on their problems, because other also have achieved results or because they get suggestions for solutions and feel relief and hope through this
Inter-personal in-treatment Change Mechanisms	Corrective social experience (9)	Patients realize through interactions in the group that things are different than they had previously assumed
	Interpersonal connections (16)	Group members feel connected to each other, understand each other and find similarities
	Social Learning (20)	Group members exchange thoughts with each other and learn appropriate social behaviour through this
	Reality testing (8)	Patients compare their assumptions about their reality to the things said or done by other group members and realize that things can be seen differently than they have assumed
	Setting goals and planning actions (15)	Patients get concrete suggestions about thoughts or behaviours from the group, or plan certain things together
	Peer Modelling (17)	Patients get to become role models for each other

Therapist-related changes

This theme refers to what aspects the therapists viewed as their own responsibility to bring change. It is made up of three subthemes: therapist facilitates, playful design and therapeutic alliance.

Therapist Facilitates

The first change mechanisms that therapists see laying in their hand is the moderation of the group, mostly as a prerequisite to imitate the change progress and focus on the content. In line with CBT principles, the therapist takes on an active and directive role, guiding the process and maintaining structure as a facilitator of cognitive and behavioural change. The therapists felt they were the ones creating the atmosphere for the group, keeping it a safe space for the patients to open up in, bringing in ideas, making sure everyone felt heard and has the opportunity to participate and keeping inappropriate things out of the conversation:

"I think it [therapeutic techniques] is very important. I think they need someone who- who structures- who gives it structure and instructs it and who can guide it, when it goes into themes that are not functional anymore or maybe moving away from the theme. [...] In the end it is important that someone takes care that the red threat is being kept." (P4)

This shows that the base of tCBT group therapy is creating an environment where cognitive and behavioural change is possible, and this is the therapist's responsibility. Further, this is viewed as a complex task, particularly within adolescent groups:

"[...] but I think that in this setting it is quite important that you create a good [...] atmosphere, that they all feel comfortable in the group, that they know they can trust that they won't be judged or laughed at [...] I find that this is a little challenging during the group, that you need to keep an overview. And especially with the teenagers that you need to set

boundaries when someone mentions something that isn't appropriate right now or that is judging." (P1)

What this shows is that achieving this setting for change is perceived by the therapist as a complex task, possibly more challenging than it would be in a one-on-one therapy session as there are more than one patient to keep in mind. They need to balance structure and flexibility, a key challenge in group tCBT. Working in the context of adolescents seemed to be considered to complicate the process even further, as they are more likely to test boundaries within the group. Further, the therapist also needs to adapt to the different disorder patterns they encounter in tCBT groups, adding another aspect to consider for them. By creating and maintaining a safe, structured environment, therapists enable deeper engagement for the group members, as well as applying intervention techniques. This foundational work allows other therapeutic mechanisms to function effectively.

Playful Design

Related to this, something the interviewed therapists mentioned consistently was the design of the group therapy session, specifically, that it is important to keep it playful when working with children and adolescents to achieve motivational changes. Each one of them mentioned that they usually start the group by playing a game with the patients, describing it as a strategy to initiate therapeutic engagement, addressing transdiagnostic issues such as low behavioural activation and emotional readiness for change:

"[The game is more important] for children than for teenagers. Like, so they see a certain allure to participate in the group and don't just have it saved as a negative thing, because it is an unpleasant situation for some to talk about your difficulties in front of others. And sometimes with the teenagers so they get a bit more active and a bit more awake and a bit to lighten the mood." (P3)

All interviewed therapists seemed to agree that a game helps to make the patients feel better about participating, loosening them up and creating a better mood overall. It also helps them settle down. Therefore, from a transdiagnostic standpoint, the game targets underlying processes such as emotional avoidance, social inhibition or low motivation. Furthermore, it can help to create group cohesion:

"I feel that it [the game] is really important, because- the start can be designed as a light topic. That means […] the patients have some time with each other, to find each other. It's a ritual, which is also really important, that they know exactly: I will go to group therapy, and it will go like this. Then at the same time- it strengthens the togetherness. […] they got to know each other better." (P4)

Therefore, including game aspects can be seen as a multi-layered change mechanism. For one, it is one of the tools used to create the atmosphere previously described as the basis for change. It also helps by creating group cohesion, shared rituals and fostering predictability, the latter two being especially important with child patients. Lastly, it seems to create motivational changes for the patients, helping them to see the group therapy in a more positive light and encouraging them to participate.

Therapeutic Alliance

The last mechanism the therapists saw themselves responsible for was the therapeutic alliance. It seems to be viewed as one of the most important prerequisites to create the previously described setting of safety needed for the patients to open themselves up to change. However, they seemed to be split on how it should be achieved. P2 and P3 viewed it as creating a tight bond of trust with every member of the group:

"I believe it's very important to the therapeutic alliance, how they view you as a therapist, that they have the impression that they feel a little save in the setting, and that they have the

impression that it everything they say isn't criticised. […] That's why I think it's important that we as therapist participate, […], that you slip in your own examples, so that they can get a certain feeling for the therapist as well. Especially when you only see them in a group setting, that you try to show a little extra interest in everyone, if that's possible somehow." (P3)

This approach reflects a belief that therapist modelling of openness and empathy reduces the transdiagnostic underlying mechanism of emotional avoidance. On the other hand, P1 and P4 did not view themselves to take such central roles. They believed that taking a step back prevents favouritism and fosters peer-to-peer interaction, which is crucial in group CBT:

"And I believe that therapeutic relationship is also important. […] But I wouldn't do an alliance, I wouldn't call it that, because I understand alliance as something special that you have with everyone in the group. […] I believe building a real alliance in group therapy isn't conducive, because it's supposed to be about everyone and that you should be neutral to them and should reflect to them that no one is getting more attention […], that you are neutral about every topic and problem and that everyone gets the same amount of time and importance." (P4)

By maintaining neutrality, the therapist facilitates interpersonal learning among group members, which can target common transdiagnostic CBT aspects, such as promoting empathy, reduce feelings of isolation, and challenge social beliefs. What emerges here is an agreement that a trusting relationship with the therapist is important to create changes. However, a disagreement seems to be about if this should be achieved by taking a more active role and bonding with each patient in the group individually, or if this means being as neutral as possible towards everyone so no one must feel left out, or fear being judged differently, possibly due to approaching different transdiagnostic aspects.

Intra-personal Change Mechanisms

This theme describes mechanisms working within the individual patient and is made up of the following codes: Developing empathy, self-insight, receiving peer support, relatedness and universality of experiences, and hope.

Developing Empathy

Something all therapists mentioned as an important factor for the patient was the increase of empathy for the others in the group. Over the course of group therapy, children and adolescents began to recognise and understand the emotional experiences of their peers, were able to increase their perspective-taking and respond in a sensitive manner:

"So, I believe that this also has a lot to do with starting to feel empathy, to think about the situation, so you can give advice, you have to be able to firstly understand, where is the other person? What is the topic? Why are they feeling like that? […] Then there's the question, how to I tell that to someone? Like, do I say, hey, you're stupid, why didn't you already do this and that? How do I talk to a person who's currently asking for help? How do I formulate that? How can I explain things which I think they could try out? Like, communication with each other, treating each other empathically." (P1)

Developing empathy increased the patient's relational skills, increasing constructive communication and bettering peer support. Furthermore, the ability to empathise was reported to also contribute to group cohesion, which therapists perceived as critical as well. According to the therapists, the development of empathy therefore directly affects shared transdiagnostic underlying struggles in social interaction and furthers the learning process of social skills, which is important for children and adolescents.

Self-Insight

Another mechanism highlighted by the therapists was the process of developing self-insight through verbalising personal difficulties within the group setting. They acknowledged that this is a difficult process for many patients, but it is helpful not only as an act of disclosure but also to create reflective awareness for the patient. Further, this process could be deepened by the input of group members asking questions:

"I believe a lot happens through a reflection process of the members. Like, some of them have a complex problem and through them talking about it they realize, oh yes, right, there's something there. And now I'm realizing while talking about it there are these and those connections that I haven't noticed before. […] Then I also find that the follow-up questions of the others are always helpful. […] And through that this reflection process is furthered." (P2)

The process of reflection seems to be described as twofold. The first part of putting problems into words is that it helps patients organise their internal states, promoting metacognitive processing and making cognitive restructuring possible. The interactive group component amplifies this process, helping to externalise and start a feedback loop. Self-insight reportedly targets core shared transdiagnostic processes such as rumination. For children and adolescents in particular, the peer feedback may carry unique weight due to heightened sensitivity to social evaluation.

Receiving Peer Support, Relatedness and Universality of Experiences, and Hope

The aspects of peer support, relatedness and universality of experiences, and hope can be grouped together as fostering a sense of connectedness within the group. First, patients can get emotional validation from their group peers, which was observed to be perceived as more credible or impactful than emotional validation from the therapist:

"From peers it's something different than from the therapist, that the feelings are reasonable and that they have an entitlement to them, then they can allow themselves to deal with the feelings more and act according to the feeling. And that the, the behaviour is supported, or they- the necessary- given the necessary motivation to have to change something about it, because their experience is confirmed and validated from multiple sides." (P4)

This form of horizontal validation is said to reduce self-stigma and foster emotional acceptance while challenging underlying maladaptive beliefs, a core transdiagnostic goal. Interestingly, P4 underlines that the validation means something different when coming from peers than when it comes from a therapist. Ther therapist indicated that, at times, the feedback from peers could be more believable and helpful to a patient than when it comes from a therapist, who takes on more of an authority role. It was stated that in the transdiagnostic setting, this meant that patients connected through common emotional challenges, such as anxiety, shame, or interpersonal difficulties:

"Certainly, I also believe that there is always a change of thought happening within patients. Soley that they maybe feel less alone and that the fundamental assumption I am alone with this, I am somehow particular, conspicuous or especially sensitive can be corrected." (P4)

Partly, it seemed to be held also as a form of cognitive restructuring for the patients. It is interesting that this sentiment was stressed even in the transdiagnostic setting. While patients do not necessarily share the same diagnosis, the effect was reportedly based on shared life experience and common humanity. The focus shifts from diagnosis-specific experiences to separating life experiences from the diagnosis and more towards a feeling of being understood regardless. Finally, these experiences led to increased hope and motivation for change. Witnessing the progress of peers, feeling emotionally supported, and realising that change was possible contributed to a shift in perceived self-efficacy:

"[…] it does make a difference to know, okay, others also have difficulties with this and then they can profit from how other have also gotten out of there, maybe become a bit more hopeful." (P3)

Therapists connected this hope to increase readiness for behavioural change, as it furthered their understanding of their problems. So, when collecting the experience relatedness and universality and having their experiences emotionally validated, patients felt relief and hope for change to be possible. This hope was further supported by seeing the success of the group members who they felt had had similar experiences. Interestingly, there is once again the proposal that interpersonal experiences within the group could enhance motivation more effectively than therapist-led instruction alone. These insights highlight how peer dynamics in group tCBT serve as both emotionally corrective and behaviourally activating.

Inter-personal In-treatment Change Mechanisms

This theme focused on change happening between the group members through the social contact established and included the codes corrective social experiences, interpersonal connections, social learning, reality testing, setting goals and planning action, and peer modelling.

Corrective Social Experiences and Reality Testing

Compared to emotional correction, the corrective social experiences made in group therapy described by the therapist seemed to focus on social relationship development. This revolved around relational learning and interpersonal skill development, fostering trust, perspective-taking, and the development of healthier relational schemas. For instance, one therapist emphasised that when adolescents shared personal experiences in the group and

were met with understanding rather than judgment, patients revised previously held expectations of rejection:

"They get strengthened through sharing personal things, that they are brave, sharing personal things. In the best case they'd then have a positive experience with it, positive experiences with relationships as well. Like, I can share something about myself, and it will be received well, nobody is laughing, or it doesn't get talked down upon. Like this opening yourself up and noticing, I am not alone with that. I think that's a huge factor." (P1)

Noticeably, she relates this effect back to the combating of the patient's assumption of being alone. Therefore, an assumption is made that the realisation of a patient that they are not alone and can be understood can also support their development of trust towards other people and build more stable relationships. The corrective relational experience reshapes interpersonal beliefs. Importantly, therapists suggested that even negative interactions could become therapeutic if processed constructively:

"We of course also had situations, where there were quite the quarrels in the therapy group [..], and them realizing that that's alright, too, that things like that are allowed to happen. I find that to be an important learning. That also belongs to interpersonal skills. That such a conflict is allowed to happen and that you can settle it, etc." (P1)

Both positive and negative social experiences during the group therapy therefore could have corrective effects on patients' assumptions about social relationships. This also shows that group therapy could influence a range of different social struggles children and adolescents may face. Interpersonal dysfunctions are stated to be be shared across various disorders and therefore targeted within the transdiagnostic approach. Further, this also leads to training perspective-taking and reality testing, facilitated through peer questioning and discussion. Patients were encouraged to examine their assumptions and reinterpret social events from alternative viewpoints:

"Asking the other what their thoughts are […] leads to some reality comparison now and then or creates a bit of a perspective change. […] so, they become a bit more aware of what happened cognitively, they maybe also become a bit more differentiated." (P1)

Cognitive restructuring through peer dialogue is viewed as key transdiagnostic CBT technique achieved in group settings. The patients would realise that it is possible to take another perspective of their situation though the suggestions of other group members, learning that how they view things might not be an objective reality, enhancing social insight and flexibility. Together, these corrective social experiences support behavioural and cognitive change through experiential learning in a real-life social environment. By having these corrective social experiences, patients can adjust their expectations and learn to assess future situations differently, as their fundamental assumptions are challenged. This is especially important for children and adolescents, who are still forming social identities and relational templates.

Interpersonal Connections and Social Learning

This leads to the next mechanism the often discussed by therapists, namely that they viewed change also happening through the interpersonal connections patients formed in the group:

"[…] because they opened themselves up, which was really hard for them […] they connected through a deeper friendship, because they realised, we get along on this level really well, because I have the same problems. Also, continuing to give each other support, beyond the group therapy setting they continued to strengthen and support each other." (P4)

The connections formed between the patients were ranked as being of high importance by the therapists. Patients were described as becoming a support system even outside of the setting of the group therapy, as they would develop a deep understanding for each other and

their struggles. All therapists also agreed that this group cohesion was possible in a transdiagnostic setting:

"But also, transdiagnostically certainly as well, I would say so, because there are many themes with family relationships, with friendships, with emotions like loneliness or something, that transcends diagnosis and are simply relevant to most of them." (P1)

Therefore, the patients were said to seek out their similarities, the struggles each of them faces despite differences in diagnosis and focus on these to build a connection to each other. A reduction in stereotypes or assumptions about each other was also often mentioned in this context. The peer support offered in these transdiagnostic groups was highlighted by all therapists as one of the most important change factors, as it functioned as reinforcers, enhancing group cohesion and motivating continued engagement. Furthermore, the therapists agreed that generating the social exchange between the patients was an important factor, once again highlighting the importance of learning socialising techniques in these groups. The group was seen as working best though patients having the desire to help each other, reflect each other's behaviour to each other and practice things in a safe environment. This social exchange would have a positive effect in client's commitment:

"I think that the group is different in different constellations, but the group itself is also an amplification, a reinforcer basically. Like, when I can tell them next week, I did that and that worked really well and then maybe the others are somewhat proud, happy for me or give positive feedback, that that is a big social reinforcement" (P1)

Once patients had invested in supporting one another, the therapist stated that they felt a sense of shared responsibility, which encouraged progress between sessions and reduced avoidance. They also are presumed by the therapists to become more sensitized to the problems of each other in order to help each other out.

Setting goals and planning action

Another mechanism of change identified by therapists involved the group's role in setting concrete behavioural goals and planning structured action. This process reflects core principles of behavioural activation. All therapists followed the structure that patients with a certain problem can directly request ideas, mostly regarding possible different thought patterns or behaviours, from the group:

"That they realize that they are responsible for their own action and can do something about it, that we collect concrete ideas, how they can change their behaviour. […] It depends on the topic a little, but sometimes they get some homework. Everyone practices that during the week and then we discuss it next week, how that went. Like setting concrete goals and then also knowing we will talk about that again. […] And other than that, collecting their own ideas and talk about what the others maybe have done already? To inspire, motivate each other a bit." (P3)

This goal-setting process supports the CBT process of experiential learning in which patients test out new behaviours in real-life situations and return to the group to reflect on the outcomes. The therapists also used the group exchange as a problem-solving unit. The important factor once again was that it comes from a group of peers. There also again was an aspect of social accountability towards the other group members to drive patients to complete the set tasks. Group tCBT was viewed as providing a unique opportunity for patients to engage in collaborative goal setting, action planning, and reflection, supported by peers who are said to serve as reinforcers. This process is viewed as facilitating concrete behavioural change and builds a sense of self-efficacy.

Peer Modelling

Lastly, when the patients collect these ideas together, it was also pointed out that some patients can take over role model functions for the others. The therapists stated that because they all have different life experiences, patients are exposed to peers who may demonstrate more adaptive coping strategies, interpersonal behaviours, or self-regulation skills. Through this process of vicarious learning, individuals may internalise new behavioural options by observing the successes of others:

"[…] be able to benefit from the learning experience of others, that you haven't collected yourself, but that you can copy those and maybe pick a role model. If you see someone who's really strong, always states their opinion and you wish that for yourself and then you can look, do I maybe want to copy some of that? And how can I use that as a role model function for myself?" (P4)

When collecting ideas and experiences from the group, the therapists found it profitable that others have a greater repertoire of experiences, skills, and strategies. Here, it is interesting that the differences between the patients are highlighted as beneficial. Each participant is viewed as bringing a unique lived experience, increasing the likelihood that others will find relevant and attainable role models. According to the therapists, in a transdiagnostic group, the diversity of backgrounds, symptoms, and coping styles becomes an asset.

Discussion

The purpose of this study was to evaluate the personal perspective of therapists on the change mechanisms of tCBT group therapy for children and adolescents. Based on interviews with four therapists working with children and adolescents who are conducting tCBT group therapy, three overarching themes were identified, namely therapist-related change, intra-

personal change mechanisms and inter-personal in-treatment change mechanisms. The results indicated that the mechanism described seemed to align closely with the change mechanisms of non-transdiagnostic group CBT for children and adolescents. Receiving peer support and feedback, developing a sense of hope, understanding the universality of their experiences and the development of social skills were highlighted as important for change in group CBT for children and adolescents in previous research, and the same themes could be found in this study for the transdiagnostic setting (Haen & Aronson, 2017; Nardi et al., 2017; Shechtman, 2007). The uniqueness of group tCBT for children and adolescents lies in its explicit targeting of shared maintenance processes across different diagnoses, emphasizing general change mechanisms rather than diagnosis-specific techniques. While many of the identified mechanisms are also present in traditional group CBT, tCBT integrates them into a unified framework that focuses on addressing common underlying processes through a combination of therapeutic mechanisms. Factors such as group cohesion, universality of experience, and peer support, actively create a safe and motivating environment where patients feel understood and encouraged to try new behaviours, which enables therapeutic actions and encourages engagement in new behaviours or thoughts. Other factors such as individualized goal setting or peer modeling translate these group-level processes into concrete behavioural and cognitive changes. For example, patients learn new coping strategies by observing peer models, receive immediate feedback, can practice social learning and reality testing, and can set flexible goals for themselves with the group's help. Thus, group tCBT fosters broader interpersonal and emotional development, making it a particularly interesting approach for children and adolescents with diverse symptoms.

An aspect that did not appear as a change mechanism was the recreation of the family experience. Usually, this is considered an age-specific aspect of group CBT for children and adolescents (Taubner et al., 2024). Taubner et al. (2024) note that family-related variables are among the most frequently studied mediators, yet these are often reported by parents rather

than therapists or adolescents themselves. This supports the idea that therapists might felt they were not able to sufficiently comment on changes in family-functioning due to lacking sufficient information or observational access to detect systemic family-related changes, as these might occur outside the therapy setting. Moreover, relational mediators, particularly those involving family functioning and parenting skills, are promising but under-investigated, often due to methodological challenges (Taubner et al., 2024). Many studies fail to incorporate multiple informants to detect such mediators. This aligns with the suggestion that therapist-only perspectives may not adequately capture family-related changes. To investigate these mechanisms of the family-related changes brought about by group tCBT for children and adolescents more effectively, future studies should include parents or other caregivers as participants.

Something that has been handled as a fundamental aspect of change in group therapy, in the transdiagnostic and non-transdiagnostic setting, was group cohesion (Bryde et al., 2021). It is understood as the foundation for all other group-related processes, which enables other change mechanisms to operate more effectively, such as interpersonal learning, peer feedback, and corrective social experiences. This also became apparent in this study, as the therapists highlighted that patients would find similarities between them and thus find relatedness, universality and peer support. However, in the study by Bryde et al. (2021), they suggested that patients would start to overlook their differences in the process thereby strengthening cohesion. They listed age, gender, occupation, severity of symptoms and “life stage” as the most notable differences to the patients, but that they would soon focus on characteristics that connected them, such as how their problems affected them and their lives, and suffering, distress and struggling with “the system”. In contrast, therapists in this study described differences such as how far along in their treatment they are, what coping skills they possess, how they interpret situations or some patients being more introverted or extroverted, and seemed to find advantage in them. They stated that aspects such as being role models to each other or providing feedback

and reality testing can beneficial instead of disruptive. Therefore, they perceived that change can sometimes happen more effectively if the differences between the group members become present, because it opens up a broader spectrum of perspectives for the patients, such as finding a different way to analyse a problem. When it comes to the composition of therapy groups for children and adolescents, Aichinger & Holl (2017) recommend keeping a mostly heterogenous group regarding age, as the children need to be able to match each other's developmental level to best complete therapeutic tasks. However, they note that interpersonal learning and learning from models does profit from balancing children with different symptoms, for example aggression vs. social inhibition. Generally, it is recommended to keep the therapeutic goal of a group in mind and achieve a balance of homogeneity and heterogeneity (Adler, 1995). This shows that there already is some recognition of the benefits of differences between group members. Therefore, tCBT may uniquely leverage both similarities and differences among group members to create a rich social learning environment. Further research regarding transdiagnostic group CBT for children and adolescents should therefore investigate which specific differences support progress rather than assuming all differences must be minimized in favour of cohesion and experienced relatedness.

Another aspect of relations within the group is the therape utic alliance. Therapeutic alliance in individual CBT is generally seen as different with children and adolescents. For one, their cognitive development is presumed to affect how they bond with their therapist (Fernandes, 2022; Zack et al., 2007). Additionally, because children and adolescents are often referred to therapy by their caregiver, the therapist is viewed as also having to negotiate an alliance with the caregiver as well as their child or adolescent client, which affects their bond (Zack et al., 2007). When looking at the child and adolescent group setting, there is an additional discussion about the relationship of and differentiation between therapeutic alliance and group cohesion (Lenzo et al., 2014). However, there is still evidence of therapeutic alliance being an important factor of treatment, as therapeutic alliance has been associated with more positive

outcomes in young adult group therapy (Lenzo et al., 2014), and the results of this study showed that the therapists viewed it as an important factor in creating a safe environment where change is possible. However, recently it has been criticized that therapeutic alliances are poorly defined and more complex in the context of a group setting because of the multi-faceted relationships that can appear in this context (Alldredge et al., 2021). There seems to be little research on how it progresses during the timeframe of the group therapy, also concerning ruptures and repair (Alldredge et al., 2021). This complexity also seems to be reflected in the disagreement that became apparent between the therapists in this study, as half of them regarded therapeutic alliance as a special connection to each individual group member, while the other ones regarded it as a trusting connection to the group as a whole while staying mostly neutral towards each member. In the context of the transdiagnostic setting, this becomes especially interesting because children and adolescents may present vastly different attachment styles based on their diagnosis (e.g. such as reactive attachment disorder and disinhibited social engagement disorder). It is already considered difficult for therapists to keep alliances with each group member (Lo Coco et al., 2022), and these diagnostic divergences might complicate the process further. To ensure that the therapeutic alliance can have advantageous effects on change, it would be valuable to further investigate how therapeutic alliances work in tCBT group settings with children and adolescents and how therapists can best approach it.

One behavioural issue seen in group therapy for children and adolescents, applicable in a transdiagnostic setting as well, is the hurdle of motivating clients to engage in the therapy activities (Taubner et al., 2024). The therapists in this study seemed to address this motivational concern via a more playful design, often starting the session with a game. This led to more engagement in the sessions, increasing motivation and fostering group cohesion, as well as opening possibilities for social learning. This idea seems to be related to constructs studied in the educational sciences. For example, Othman & Ching (2024) found that including board games to complement conventional teaching methods not only enhanced students' motivation

to engage with the learning materials but also heightened students' social engagement with each other. Further, something also often used in classrooms are energisers, which are short physical or mental playful activities used to activate students. These energisers have been theorized to increase on-task behaviour, lessen disruptive behaviours, enhance concentration, and foster positive group dynamics (Hasan et al., 2024; Raney et al., 2017). However, there seem to be no studies yet that further investigate the use of games in group therapy for children and adolescents as a complementary starting activity. It could be that this aspect is a change mechanism within itself through which patients increase motivation and learn appropriate social skills. However, it could also represent an intermediate outcome in which adherence and compliance of the patient is increased, which then leads to better therapy outcomes, which would mean it in itself would not be a change mechanism, but rather a therapeutic technique. Future research could focus on exploring how these games enhance motivation and encourage pro-social behaviour, which would also help improve the development of tCBT group protocols.

While this study considered a group tCBT approach, many of the change mechanisms discussed by the therapists are rooted in individual CBT. This includes changing cognitions and behaviours through reality testing, corrective cognitive and behavioural experiences or goal-setting processes (Kennerley et al., 2017). However, some of these change mechanisms are unique to the group setting. Yalom & Leszcz (2020) propose, alongside others, the development of socialising techniques and interpersonal learning as primary therapeutic factors of CBT group psychotherapy. For children and adolescents, peer feedback, the development of socialising techniques as well as social skills, and the highlighting the importance of interpersonal relationships are of even greater importance (Haen & Aronson, 2017; Nardi et al., 2017; Shechtman, 2007). These aspects are also reflected in the results of this study in the tCBT group setting. Further, social struggles are underlying aspects of many disorders, from anxiety and depressive disorders to conduct disorder. Therefore, group tCBT seems to be a considerable

setting for addressing these basic mechanisms in children and adolescents. Another factor suggested by Yalom & Leszcz (2020) is the instillation of hope. A recent study by Gallagher et al. (2020) investigated hope as a transdiagnostic change mechanism for anxiety disorder in CBT treatment and found that hope significantly promoted symptom changes and more positive outcomes. The results from this study indicate that the development of hope is also a relevant change mechanism in the context of tCBT group treatment for children and adolescents. Hope works as the interaction between identifying strategies to pursue a goal and feeling self-efficacy in completing these strategies, making the patient feel that they can reach their goals. To conclude, tCBT in the group setting can address distinctive underlying transdiagnostic factors and change mechanisms such as interpersonal growth and instillation of hope.

Strengths and Limitations

A strength of this study lies in its focus on a research field that has not been widely explored yet. Transdiagnostic approaches have only recently become of more interest, and research in this field remains spotty. Therefore, this study contributes to a better understanding of how this approach works and could be a basis for further research. Further, thematic analysis is a good approach for gaining a more in-depth understanding of a topic. It allows for building a complex view of a concept in a natural setting while allowing flexibility and identifying and analysing patterns (Castleberry & Nolen, 2018). This approach made it possible to answer the research question in a comprehensive and versatile manner. Lastly, including therapists from three different places of work and including one therapist who had a background in social pedagogy instead of clinical psychology likely ensured more diverse perspectives and allowed a richer view on how change mechanisms might process (Moser & Korstjens, 2018). Although explicit comparisons between backgrounds were not analysed in depth, having diversity within the background of the participants increases the potential of transferability of this research, meaning that the results became more likely to be extendable

to more diverse contexts of transdiagnostic group therapy for children and adolescents (Stalmeijer et al., 2024).

However, there are also limitations that need to be acknowledged. Firstly, the focus of this study only lies on the therapist's perspective. This choice was made due to the ethical difficulties of conducting research with children (Kirk, 2007), as these would have been beyond the scope this study could offer. However, the client's perspective on the change mechanisms would still be an important aspect to evaluate the complete picture. They might find aspects important that the therapists did not or were not as aware of and therefore did not mention. It would enrichen the understanding of what they appreciate in the transdiagnostic group therapy setting, as well as better the transferability (Stalmeijer et al., 2024). Further, the therapists might also be biased towards which mechanisms they reported. There has been evidence that therapists and clients rank different change mechanisms as important, such as therapists ranking the therapeutic bond higher (Tzur Bitan et al., 2022). Therefore, therapists might, for example, be biased to overestimate their own importance to the change mechanisms. Secondly, the analysis, including coding and interpretation, were done by only one researcher. This is not the recommended standard for this research approach, as it makes the analysis more prone to bias and decreases the consistency of the coding (Castleberry & Nolen, 2018). To mitigate this, the researcher acted according to the established advice for this situation by keeping detailed track of the decisions made during the coding process, aiming for continuous reflection of own bias, and making use of available supervision from more experienced researchers and exchange with peers. However, it still must be recognized that the coding and interpretation are likely to be more skewed and less consistent than it would have been if conducted by a team. Thirdly, the semi-structured interview approach can lead to certain bias. There was no possibility to pilot test the interview guide, which might have led to researcher bias based on previous knowledge and ambiguous or inappropriate leading questions (Kallio et al., 2016). Therefore, the questions posed could have had a

leading effect and caused the therapists to talk about aspects that they would not have mentioned on their own. Lastly, it must be mentioned that qualitative research approaches cannot aim at generalizability, considering the usual small sample size and the focus on the lived experience of the participants (Lim, 2024). Therefore, the results of this study cannot be generalized, only viewed in the lens of transferability as a nuanced insight to related contexts (Johnson et al., 2020; Stalmeijer et al., 2024). In this context, it is also important to acknowledge that none of the therapists stated that they follow a specific protocol for their groups. They reasoned that they all worked in settings were the patients stayed for a long time (several weeks up to a year for the daycare clinic, and several months to years for the residential group). The daycare clinic therapists further mentioned that they had a lot of rotation within the client group. While they mentioned using parts of protocols, they all felt that simply following a protocol was not fitting for their setting. Further, all therapists came from a setting where clients needed intense treatment due to high disorder severity. While there is some evidence that transdiagnostic treatments show greater effects for disorder of higher severity (González-Blanch et al., 2021), this affects the transferability of the results, especially regarding whether they also can be transferred to short-term protocol treatments.

Conclusion

To conclude, this study gave insight into how therapists described the mechanisms of change of group tCBT for children and adolescents. Overall, the mechanisms described seemed to be similar to the ones of non-transdiagnostic group therapy for children and adolescents. The aspect of group cohesion and homogeneity vs heterogeneity were discussed, as the therapists in this study did not view the differences between their patient as something to be overcome, but rather as useful. It was recommended to conduct further research regarding group tCBT for children and adolescents regarding which differences are helpful to the group progress while still maintain group cohesion. The aspect of therapeutic alliance

seemed to spark disagreement between the therapists in this study, revealing the complexity of this topic and the need for further investigation on how therapeutic alliances work in tCBT group settings with children and adolescents. Moreover, the effect of games as a start to the group session was discussed. Educational sciences have already studied the motivational and positive social effects of games and energizers on students, however, research regarding these effects in tCBT group settings for children and adolescents is still lacking. Lastly, the group setting of tCBT was suggested to have distinctive benefits in addressing underlying mechanisms of disorders for children and adolescents.

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Appendix 1: All Interview Questions (Englisch & German)

English:

1. Introduction & Informed Consent: *"Hi, my name is Ettje currently doing my master's thesis project at the University of Twente. For this, I am studying how therapists describe the mechanisms of change of transdiagnostic group therapy for children & adolescents. The questions I would like to talk about, concern your experience with adolescent group therapy and how you experienced change within them. Some questions might need you to reflect on your personal experiences or touch subjects you feel strongly about. Your participation in this study is strictly confidential, no names, places or other identifying information about you or people you talk about will be included. This interview will be recorded. This is simply to make sure that no important information is lost. The recording will be destroyed after finishing my thesis. If at any point in time during this interview, you feel like you want to stop, you may do so without any judgement. You also can feel free to ask questions at any time during the interview concerning any part of this study. If everything is understood, may we begin?"*
2. Demographic Questions
    a. How old are you?
    b. What gender do you identify with?
    c. How much job experience do you have as a therapist?
    d. How much job experience do you have with leading group therapy? Specifically for children and adolescents?
    e. What is your place of work? (Not the name, but description)
    f. Do you/your workplace follow a specific protocol for the group therapy?
3. Cognitive: How do you address changes in thoughts or cognitions during the group therapy?
    a. What brings about change in negative thoughts/dysfunctional attitudes or beliefs/metacognitive skills?
4. Family-related: How do you address family-related issues within group therapy?
    a. What brings about change in family functioning?
5. Behavioural: What changes the behavioural components of patient's issues?
    a. What is done to increase coping strategies?
    b. How do you go about motivational changes?
    c. How do you ensure engagement in therapy activities?
6. Therapy-related: How do you place the importance of therapy-related factors such as duration of treatment, therapeutic alliance, and therapists' techniques?
7. Relational: How are interpersonal changes happening?
    a. How are the patients influenced by each other?
    b. How do their interpersonal skills improve?
8. Emotional: How do emotional issues of patients change?
    a. How are the changes in emotion recognition, expression or regulation happening?
    b. How does the group therapy address feelings of loneliness?
9. Are there any other domains that you perceive to be important for change? Is there anything else you would like to add?

German:

1. Introduction & Informed Consent: *Hi, mein Name ist Ettje, und momentan schreibe ich meine Masterarbeit an der University of Twente. Ich untersuche wie Therapeuten die Veränderungsmechanism in transdiagnostischer Gruppentharpie für Kinder und Jugendliche beschreiben. Die Fragen, über die ich gerne sprechen würde, drehen sich um deine Erfahrungen mit Jugend-Gruppentherapie und wie du Veränderung in ihnen erfährst. Für einige Fragen musst du eventuell über deine persönlichen Erfahrungen reflektieren oder über Themen sprechen, über die du starke Gefühle hast. Deine Mitarbeit in dieser Studie ist streng vertraulich, keine Namen, Orte, oder andere identifizierbaren Details über dich oder Menschen, über die du redest, werden inbegriffen sein. Dieses Interview wird aufgezeichnet. Das wird getan damit keine wichtigen Informationen verloren gehen. Die Aufnahme wird zerstört, sobald ich meine Thesis fertig habe. Solltest du an irgendeinem Punkt während dieses Interviews aufhören wollen, darfst du dies ohne jegliches Urteil tun. Du darfst jederzeit während oder nach dem Interview Fragen zu jedem Teil dieser Studie stellen. Wenn alles verständlich ist, können wir anfangen?*
2. Demographic Questions
    g. Wie alt bist du?
    h. Mit welchem Geschlecht identifizierst du dich?
    i. Wie viel Arbeitserfahrung hast du als Therapeut*in?
    j. Wie viel Arbeisterfahrung hast du damit, Gruppentherapie zu leiten? Speziell für Kinder und Jugendliche?
    k. Was ist dein Arbeitsplatz? (Nicht der Name, aber eine Beschreibung)
    l. Folgst du/dein Arbeitsplatz einem bestimmten Protokoll für die Gruppentherapie?
3. Congitive: Wie besprichst du Veränderungen in Gedanken oder Kognitionen während Gruppentherapien?
    b. Was bewirkt Veränderung in negative Gedanken/dysfunktionalen Einstellungen oder Glaubenssätzen/metakognitiven Skills?
4. Family-related: Wie besprichst du Familien-Probleme in Gruppentharepie?
    b. Was bewirkt Veränderung in Familien-Funktionalität?
5. Behavioural: Was verändert den Verhaltens-Komponenten der Probleme der Patienten?
    d. Wie werden Bewältigungsstrategien (coping) verstärkt?
    e. Wie gehst du für Motivations-Veränderung vor?
    f. Wie stellst du Engagement in Therapie-Aktivitäten sicher
6. Therapy-related: Wie hoch stellst du die Wichtigkeit von therapie-bezognen Faktoren, wie zum Beispiel Länge der Therapie, therapeutische Allianz, oder die therapeutischen Techniken?
7. Relational: Wie passieren zwischenmenschliche Veränderungen?
    c. Wie beeinflussen sich Patienten gegenseitig?
    d. Wie verbessern sich ihre zwischenmenschlichen Fähigkeiten?
8. Emotional: Wie verändern sich die emotionalen Probleme der Patienten?
    c. Wie ergeben sich die Veränderungen im Erkennen, Ausdrücken und Regulieren der Emotionen?
    d. Wie bespricht Gruppentherapie Gefühle von Einsamkeit?
9. Gibt es noch andere Bereiche, die du für Veränderungen als wichtig empfindest? Gibt es noch irgendetwas, was du hinzufügen möchtest?

Appendix 2: Informed Consent Form English & German

English

Goal and Concept

For my master's degree program in positive clinical psychology and technology at the University of Twente, I am writing my master's thesis on the topic: "how therapists describe the mechanisms of change of transdiagnostic group therapy for children & adolescents?". For this, I must conduct interviews. Doing this, I will ask questions that are relevant to answer my research question. During this, I would like to make an audio recording. The recording will only be used for conducting my master's thesis. The recording will be transcribed, the transcript will only be read by me, my supervisors, and members of my thesis group. After finishing this course, the recording will be deleted. Your consent for participation and this recording is completely voluntary and can be withdrawn at any point during or after the interview.

You can withdraw from this study at any time by contacting me. I will confirm your withdrawal in writing and make sure that your recording and transcript will be deleted.

If you consent to the recording, the following is important:

- Before the interview begins, I will once again as for your consent to the recording. This oral consent will be recorded.
- Die audio recording will only be listened to by me and, in case of request, from my supervisor.
- The recording will be used solely for my master thesis.
- The recording will be deleted after six months at the latest.

Consent of the participant

I, the person signing, was informed of the audio recording. I have understood all information and give consent to a recording and the use of it by Ettje Gegenmantel.

Place, Date:

Signature:

Name:

Declaration of the student

I, the person signing, declare that I will be using the audio recording of the interview with the participant as described above. I will delete the recording after six months at the latest.

Place, Date:

Signature:

Name:

German

Ziel und Konzept

Für meinen Masterstudiengang positive klinische Psychologie und Technologie an der Universität Twente schreibe ich meine Masterarbeit mit dem Thema: „Wie beschreiben Therapeuten die Arbeitsmechanism von Veränderung durch transdiagnostische Gruppentherapie für Kinder und Jugendliche?“. Dafür muss ich Interviews führen. Hierbei werden Fragen gestellt, die für die Beantwortung der Studienfrage relevant sind. Während dieses Vorgangs möchte ich gerne eine Audio-Aufnahme machen. Die Aufnahme werden nur zur Erstellung der Masterarbeit verwendet. Die Aufnahmen werden transkribiert, das Transkript wir nur von mir, meinen Supervisoren und Gruppenmitgliedern gesehen. Nach Abschluss des Kurses werden die Aufnahmen gelöscht. Ihr Einverständnis, am Interview teil zu nehmen und die Aufnahme zu machen, erfolgt auf freiwilliger Basis und kann jederzeit während oder nach dem Interview zurückgezogen werden.

Sie können die Einwilligung jederzeit widerrufen, indem Sie mir dies mitteilen. Ich werde Ihnen dann den Entzug der Einwilligung schriftlich bestätigen und sicherstellen, dass die Aufnahmen und das Transkript gelöscht werden.

Wenn Sie sich mit der Aufnahme einverstanden erklären, ist Folgendes für Sie wichtig:

- Vor dem Interview werde ich noch einmal fragen, ob Sie Erlaubnis zur Aufnahme erteilen. Diese mündliche Erlaubnis wird dann mit aufgezeichnet.
- Die Tonaufnahme wird nur von mir, und im Fall einer Nachfrage von meinen Supervisoren angehört.
- Die Aufnahme wird ausschließlich für meine Masterarbeit verwendet.
- Die Aufnahme wird spätestens nach sechs Monaten gelöscht.

Einverständniserklärung des Partizipanten

Ich, der/die Unterzeichnete, wurde über die Aufnahme informiert. Ich habe alle Informationen verstanden und gebe die Erlaubnis für eine Tonaufnahme und deren Verwendung durch Ettje Gegenmantel.

Ort, Datum:

Unterschrift:

Name:

Erklärung des Studenten:

Ich, der/die Unterzeichnete, erkläre, dass ich die Tonaufzeichnung der Gespräche mit dem Partizipanten wie oben beschrieben, verwenden werde. Ich werde die Aufnahme spätestens nach sechs Monaten löschen.

Ort, Datum:

Unterschrift:

Name:

Appendix 3: Artificial Intelligence (AI) statement

During the preparation of this work, the I used ChatGPT, Scopus, Atlas.ti, Web of Science, Google Scholar, Science Direct, SAGE Publishing, Taylor & Francis, SpringerLink, Wiley Online Library, the University of Twente online library, Microsoft Word, and Mendeley Reference Manager to provide examples on how correctly conduct applied thematic analysis, how this analysis could benefit current research outcomes, analyse the collected interview data, evaluate the current literature in the field for the literature review, manage references, and check the flow, structure, grammar, spelling and cohesiveness of the research. After using these tool/services, I reviewed and edited the content as needed, taking full responsibility for the content of the work.