

The University of Hull

Communicating with Parents and Carers when an Adolescent Self-Harms: The Experience of School Staff

**being a thesis submitted in partial fulfilment of the requirement of the
degree of
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By

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Overview

This portfolio thesis is comprised of three parts;

Part one is a systematic literature review of the empirical research on school-based positive psychology interventions for adolescents. In total eight studies were included in the review. The quality of these studies was critically evaluated and a narrative synthesis of the collective findings is presented. The narrative synthesis also involves a critique of the implementation of the interventions and the methodological quality and strengths and limitations of these approaches. Findings are discussed with reference to existing literature on positive psychology interventions and in terms of clinical implications and future research.

Part two is an empirical study which explored the experiences of school staff who work with adolescents who self-harm and their families. An interpretive Phenomenological Analysis (IPA) approach was employed to explore the experiences of six members of school staff in five secondary schools England. Three superordinate and nine subordinate themes were identified which describe participants' experiences of communicating with parents. The themes are discussed in relation to existing literature on self-harm and in the context of the current political shift which advocates integrating mental health support in schools.

Part three comprises appendices of parts one and two. An epistemological statement and a reflective statement are included to provide additional context (appendices R & S).

Total word count: 30,183 (inclusive of tables, figures and references).

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Part One
Systematic Literature Review

This paper is written in the format ready for submission to The Oxford Review of Education.

See appendix A for submission guidelines.

Total word count: 8819 (inclusive of tables, figures and references).

**School-based positive psychology interventions for adolescents: A
systematic review of the quantitative research**

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School-based positive psychology interventions for adolescents: A systematic review of the quantitative research

Abstract

Growing interest in the Positive Psychology (PP) movement has resulted in increased research into the efficacy and application of interventions which are aligned with this paradigm. PP seeks to acknowledge and promote individual happiness and wellbeing rather than focus on managing or reducing perceived difficulties or pathology. Schools afford an ideal opportunity and location for delivering PP interventions (PPI's), however to date no systematic review of the research on school-based PPI's for adolescents has been carried out. This review collates the available quantitative research using a narrative synthesis approach to explore how PPI's are being applied in this population. Electronic databases were systematically searched for peer reviewed intervention studies. Eight studies of six interventions carried out in four countries were identified. There was a focus on values and strengths based approaches. All but one study showed change in the desired direction; however, the validity of studies was limited due to a lack of methodological rigour associated with school-based research.

Key words: school, positive psychology, intervention, adolescents,

Introduction

Children's mental health is a key concern for parents, educators and governments.

Reported levels of mental health difficulties in children are increasing with 13-20% of under 18's in the USA experiencing some form of mental health disorder in the last year (Centre of Disease Control and Prevention, 2013) with similar rates reported in the UK (Fonagy & Murphy, 2013). Historically, attention has focused primarily on reducing levels of mental distress, however, mental wellbeing and mental distress may not simply be two ends of the same continuum.

The dual factor model proposed by Greenspoon and Saklofske (2001) suggests that people can experience high levels of mental distress, while also reporting that they have high levels of wellbeing, indicating that human wellbeing and pathology may in fact be two distinct concepts. If this is the case then reducing mental distress will not automatically increase wellbeing, and vice versa; therefore both constructs deserve research attention.

Schools increasingly attend to not only academic achievement, but also to the psychological wellbeing of students (Oades, Robinsom & Green, 2011; Waters, 2011). Government programmes directed at supporting and educating children about emotional wellbeing have been implemented in a number of countries through programmes such as Social and Emotional Aspects of Learning (SEAL) in the UK (Hallam, 2009) and the Collaborative for Academic, Social and Emotional Learning (CASEL; Jones & Bouffard, 2012) in the USA, while Australia introduced the 'Wellbeing for Schools' website providing teachers and educational establishments with a wellbeing framework (Department of Education NSW, 2015).

Schools present an ideal opportunity for interventions to promote good mental health as children spend a large part of their day there. Schools also have the structure and

resources to implement this work. Childhood is a time of considerable cognitive and emotional development, with high levels of neuroplasticity (Kanwal, Jung & Zhang, 2016) and is a key time for acquiring and developing skills which will remain with an individual into adulthood. As well as the potential long-term benefits of promoting good mental health in pupils, wellbeing and school performance are linked (Suldo, Riley & Shaffer, 2006).

The importance of attending to child and adolescent wellbeing is accepted and PP has a lot to offer in this regard. The PP movement was initiated in 1998 by the American Psychological Association (APA) president, Martin Seligman, followed by an article by Seligman and Csikszentmihalyi (2000) in which it was argued that the discipline of psychology was too preoccupied with what is ‘wrong’, with its almost exclusive interest in human psychopathology and people’s negative experiences. Seligman and Csikszentmihalyi proposed that psychology should also emphasise human strengths and outlined the framework of PP, conceptualising PP as the science of positive subjective experiences, individual traits and positive institutions.

This resonated with psychologists and in the two decades following there has been an explosion in the theoretical exploration of PP and understanding of promoting human happiness. By 2013 more than 1336 peer reviewed articles on PP were published (Donaldson, Dollwet & Rao, 2015), which included many empirical tests of theories and interventions. In addition, the rate of publication accelerated suggesting increased interest in PP (Donaldson et al.,2015) and so this number has likely increased considerably since that review.

A range of PPI’s, including counting blessings, displaying gratitude, using personal strengths, and showing kindness have been developed (Seligman, Steen, Park & Peterson, 2005: Otake, Shimai, Tanaka-Matsumi, Otsui, & Frederickson, 2006). A

recent meta-analysis into the efficacy of PPI's in adults showed increased wellbeing and decreased symptoms of depression, with gains retained at six month follow up (Bolier, Haverman, Westerhof, Riper, Smit & Bohlmeijer, 2013).

Although there has been a swell in interest and enthusiasm for PP, criticisms have been levelled at the movement. Some of these relate to the conceptual framework of PP and the polarising of emotions and experiences as 'positive' or 'negative', which is regarded as simplistic and unhelpful (Lazarus, 2003). Beyond conceptual arguments, the lack of scientific rigour in the research is critiqued. Most literature on PP has been cross-sectional in design (Donaldson et al., 2015), which prevents causal attributions, and a lack of control groups limits scope for examining between-group and within group differences (Lazarus, 2003).

PP has since developed robustly, but its study in young people has lagged with only 16% of the empirical PP research involving children or adolescents under the age of 18 (Donaldson et al., 2015). In a selection of four school journals Froh, Huebner, Youssef and Conte (2011) found that only 27% of the articles had a positive focus. Froh et al., called for more equal attention towards positive wellbeing in schools.

PPI's have been incorporated into school curricula. Research at Geelong Grammar School (where whole school PP approaches have been adopted) show considerable good outcomes (Seligman, Ernst, Gillham, Reivich & Linkins, 2009). Several smaller scale studies and specific interventions have also been tested in schools (Chodkiewicz & Boyle, 2017). Shankland and Rosset (2017) reviewed brief school-based PP's, short-term interventions which could be delivered by teachers or school staff, covering mindfulness, gratitude, strengths and positive relationships. They concluded that teacher led PPI's can be effective.

Teachers may be a natural option for delivering programmes; however, external facilitators without the added teaching demands may also be a feasible option. Pupil -

staff relationships change considerably from primary school where children typically spend all day with a single teacher, to secondary school, where teachers tend to be specialised and students have contact with numerous teachers each day. Moreover, the developmental and support needs of young children are different to those of adolescents. There is no agreed age or biological marker for adolescence and definitions vary by culture (Patel, Flisher, Hetrick & McGorry, 2009). It is generally accepted to be the developmental stage between childhood and adulthood and many societies consider the onset of puberty to mark this transition from childhood to adolescence (Patel et al., 2009). The way in which adolescent research focusses on problems and risk factors may reflect and perpetuate the prevailing narratives and stereotype of the ‘difficult’ teenager (Topping, 2012). Examining work with adolescents from a PP perspective may expand and challenge this narrative.

Aims of this SLR

This systematic literature review aims to address the questions:

- Which empirically tested school-based PPI’s exist for adolescents?
- How are these PPI’s being applied?
- Are these PPI’s effective?

This SLR aims to review the available literature, evaluate the quality of the research and ascertain how PPI’s are being applied and whether they demonstrate efficacy.

Implications of the findings and suggestions for future research will be offered. This review includes interventions delivered by school staff or other professionals and focuses on only those interventions conceptualised by the authors as ‘Positive Psychology’ interventions. Although other interventions may be missed by this review, inclusion of those which self-identify as PP allows for evaluation of how the PP movement is being enacted in research, the extent to which this concept has infiltrated

research thinking in this area and how PP concepts are being applied by researchers aware of the movement. A systematic review protocol will be employed.

Methods

Search strategy

A search for school-based PPI review papers was carried out to ensure that this unique review would contribute to the existing literature. Two relevant reviews were identified, which provide valuable contributions but differ from the current review in a number of ways. Chodkiewicz and Boyle (2017) offered a broad reflection on school-based PPI's, while Shankland and Rosset (2017) reviewed short-term PPI's implemented by teachers. Neither review employed a systematic methodology or limited the review to studies which conceptualised interventions within a PP framework. This is therefore the only systematic review of its kind to the author's knowledge.

A systematic review of the available literature on school-based PPI's was carried out using electronic databases, including those from educational disciplines. Literature up to and including March 2018 was included with no start date cut-off. The following databases were searched; PsychINFO, Academic Search Premier, Education Research Complete, ERIC, CINAHL Complete and PsycARTICLES. The reference lists of included articles were also hand searched.

An initial scoping search used the terms 'school or school-based' AND 'adolescents or children' AND 'positive psychology interventions'. The terms 'adolescent or children' were removed as the use of 'school or school-based' meant that further specification was not required. Further search terms were identified and developed from the titles and keywords of the articles generated.

The final search terms 'school* or classroom* or education* or 'school-based' were entered to include articles with a focus on interventions which were carried out in

school. The term ‘positive psychology’ was entered with N5 ‘intervention* or treatment* or program* or strateg* or trial*’ to obtain articles with a specific PPI. The limiters ‘peer reviewed’ articles and ‘English language’ were applied.

An electronic search of databases returned 338 studies. 158 duplicates were removed.

Titles and abstracts were read and inclusion and exclusion criteria applied (see appendix B for rationale):

Inclusion criteria

- Published in a peer reviewed journal;
- English language;
- Participants who are secondary school age based on the British education system (i.e. aged 11-18). Where the sample bridges cut-offs (e.g. uses middle school samples) then the mean age of participants will be used;
- An active intervention;
- Empirical design using at least one standardised outcome measure (mixed designs to be included);
- An intervention which the authors conceptualise as a ‘positive psychology’;
- Intervention primarily aimed at promoting or developing an ability, skill or strength rather than reducing a behaviour or ‘pathology’ (in line with Sin & Lyubomirsky, 2009 definition of a PPI);
- Includes pupils who are in mainstream education;
- Any date;
- Any location.

Exclusion criteria

- Articles which are reviews, meta-analyses or meta-syntheses;

- Mean age of participants is under the age of 11 or over 18;
- Participants not in compulsory education;
- Intervention aimed at a specialist provision school.

157 further articles were rejected, 23 full articles were obtained. Of these full articles 16 were rejected and seven were included in the review. The reference lists of included articles were hand searched and one further article was included resulting in a total of eight articles for review. Table 1 shows included studies. Figure 1 illustrates the search procedure. See appendix C for details of studies excluded at the full article stage and rationale.

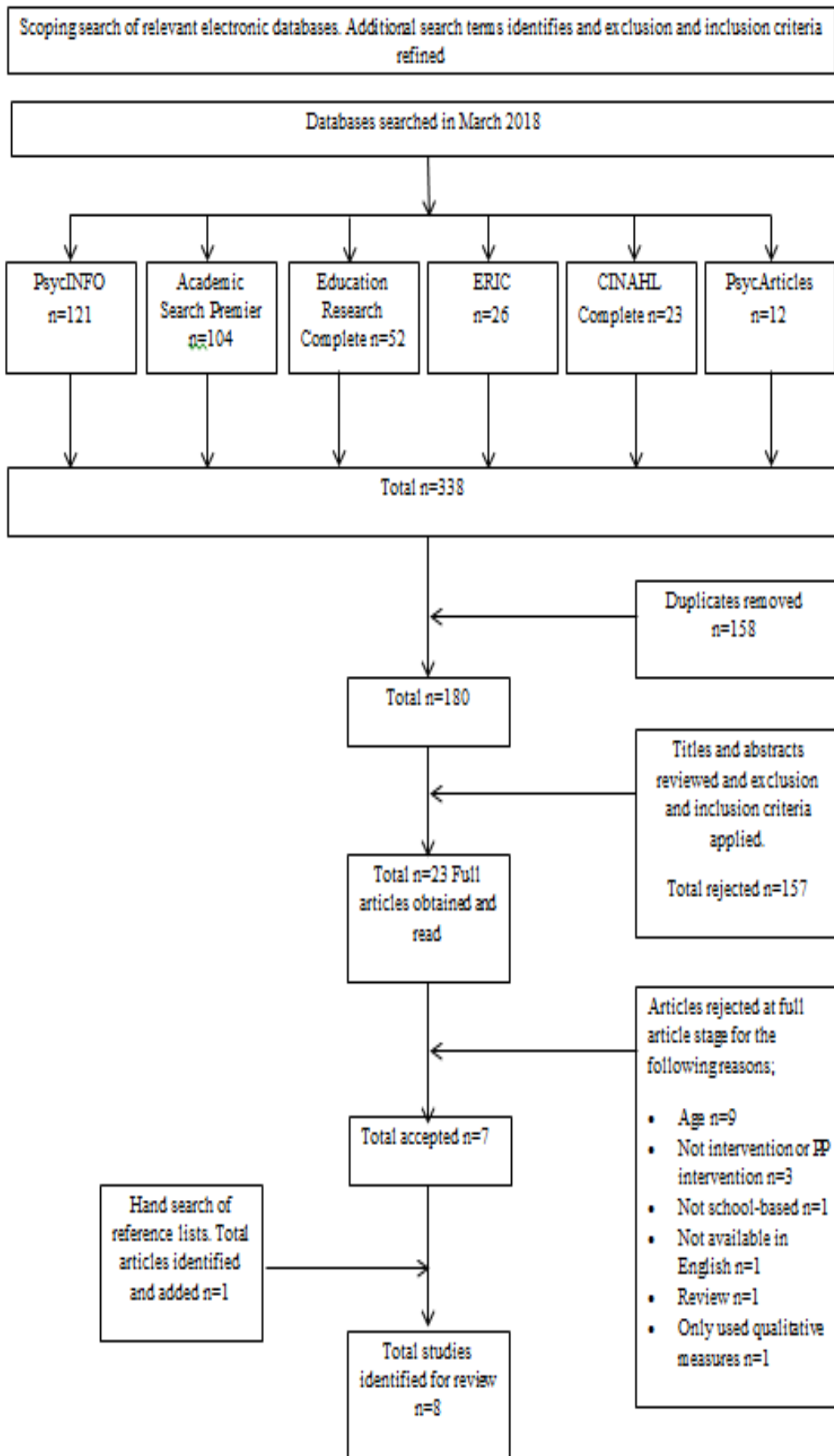


Figure 1. Prisma flow diagram of the review and selection process (Moher, Liberati, Tetzlaff, Altman, 2009).

Data extraction

Data extraction was completed using a specially developed pro-forma (appendix D).

Data Analysis

The sample of studies showed a high level of heterogeneity in terms of intervention and outcome measures, therefore a qualitative analysis, narrative synthesis (Popay, Roberts, Sowden, Petticrew, Arai, Rodgers, ... & Duffy, S. 2006), was employed to allow adequate exploration and description of the studies.

Quality assessment

Study quality was assessed using an adapted version of the Downs and Black (1998) checklist (appendix E). This was modified to better assess the quality of the studies in relation to the specific review question. Two questions; '**Are details provided about how the schools were selected?**' And '**Are sufficient details about the characteristics of the schools involved included?**' were added. One non-applicable question was removed.

Ratings were Yes or No and unable to determine. Yes scored 1, No or unable to determine were always scored 0. The option of 'partially' was added to some questions and scored .5 to allow greater discrimination of levels of detail. Studies scored out of 27 or 24 if they contained no follow-up. Quality percentages were calculated, and studies were ranked by quality (table 1). A random sample of papers were reviewed by another researcher. Inter-rater reliability was 88% suggesting high inter-rater reliability. Where there was disagreement about rating this was discussed and a rating agreed. No papers were excluded on the basis of quality.

Results

Overview

The search yielded eight studies which evaluated six PPI's. Two evaluated the 'Maytiv' (Hebrew for 'doing good') programme (Shoshani, Steinmetz & Kanat-Maymon, 2016; Shoshani & Steinmetz, 2014). Two examined the same manualised PPI, an initial version (Suldo, Savage & Mercer, 2014) and an expanded version which included a parent element and 'booster' sessions (Roth, Suldo & Ferron, 2017). One evaluated an online programme, Bite Back (Burckhardt, Manicavasagar, Batteram, Miller, Talbot & Lum, 2015), one 'Strong Minds' (Burckhardt, Manicavasagar, Batterham & Hadzi-Pavlovic., 2016), one iNEAR (Tunariu, Tribe, Frings & Albery, 2017), and one Strengths Gym (Proctor, Tsukayama, Wood, Maltby, Eades & Linley, 2011). Data quality ranged from 81.48% (Shoshani et al., 2006) to 52.01% (Proctor et al., 2011; Tunariu et al., 2017), giving a mean average quality rating for the sample of 69.66% (SD=11.87); suggesting an overall high level of quality. As the manualised programme does not have a name it will be referred to as MPPI 1 (Suldo et al., 2014) and MPPI 2 (Roth et al., 2017). Table 1 shows the main characteristics of the included studies

| Author + country | Intervention | Participant characteristics reported | Intervention details | Design + sample | Theoretical underpinnings | Outcome measures * | Results | Study quality (%) |
|--|--|---|---|--|--|--|---|-------------------|
| Burckhardt, Manicavasagar, Batterham, Miller, Talbot, & Lum (2015). Australia | Evaluated online PPI, 'Bite Back' to increase happiness and wellbeing. | n=310 Grades 7-12 Age Gender SES of school (high) | <i>Content:</i> 'Bite Back' workbook and website with interactive exercises. Interactive activities for gratitude, mindfulness, etc and information on 9 PP domains and ideas for these (gratitude, optimism, hope, flow, meaning, mindfulness, positive relationships, character strengths and healthy lifestyles). <i>Duration:</i> 6 hours over 4-6 week <i>Delivered by:</i> Facilitated by teachers. | RCT Pre/post-test design 4 independent schools. (2 Anglican girls' schools. 1 catholic boys' school and 1 Jewish co-educational school). | PP. | <ul style="list-style-type: none"> DASS-21 SLSS. SWEMWBS. | DASS-21 =N.S for depression, anxiety and stress and total score. SLSS =N.S SWEMWBS =N.S (scores of control group increased). | 77.08 |
| Burckhardt, Manicavasagar, Batterham, & Hadzi-Pavlovic (2016). Australia | Evaluated 'Strong minds' intervention. | n=221 year 10 & 11 Age Gender | <i>Content:</i> Introduction, values, committed action, utility of emotions, emotional avoidance and acceptance, thought fusion and diffusion, contact with present moment, contact with the present moment and observer self, applying Acceptance and Commitment Therapy (ACT), assertiveness (1), assertiveness (2), kindness, introduction to wellbeing, relationship between money and happiness; and physical exercise, social relationships, final session. <i>Duration:</i> 16 sessions x 30 minutes over 3 months. | RCT Pre/post-test design 1 independent Episcopalian school | PP ACT (Hayes, Strosahl & Wilson, 1999) | <ul style="list-style-type: none"> DASS-21 FS | DASS-21; When years 10 and 11 were examined together there was a statistically significant reduction in depression (large effect size), stress and DASS-21 total scores (medium effect size). Effect sizes are similar to CBT. FS=N.S (+ medium effect size only for yr 10). | 66.67 |

First 9 are ACT, final 7 are PP

Delivered by:

lead author (registered psychologist)

| | | | | | | | | |
|--|--|--|---|---|---|--|--|-------|
| Proctor, Tsukayama, Wood, Maltby, Eades & Linley (2011). | Evaluated 'Strengths Gym', | n=319 Years 8 and 9. Age Gender Data on ethnicity and SES not collected but population primarily Caucasian and lower to middle income. | <i>Content:</i> Measures and builds on character strengths under 6 virtues. Recognise unique individual strengths, develop them further and recognise strengths in others. Three levels for years 7, 8, 9. <i>Duration:</i> 24 lessons <i>Delivered by:</i> School staff | Pre-post test design 2 secondary school Teachers allocated classes to conditions | Character strengths. Values in Action - Inventory of strengths (VIA-IS; Peterson, 2006; Peterson & Seligman, 2004) | <ul style="list-style-type: none"> • SLSS. • PANAS. • RSE. | SLSS + PANAS; PA + NA= N.S. RSE= N.S. | 52.08 |
| Great Britain | | | | | | | | |
| Roth, Suldo, & Ferron (2017). | Evaluated expanded version of manualised PPI carried out by Suldo et al., (2014) | n=42 Age Gender Ethnicity SES | <i>Content:</i> <i>Teaches strategies to facilitate gratitude, kindness and character strengths, savouring, hope and optimism.</i> <i>Duration:</i> <i>Parent component; one meeting (1hr) & 10 written communications. Pupil component; 50 minutes/wk x 10 weeks & 2 follow-up sessions</i> | Longitudinal (follow-up at 5 and 7 weeks) 1 middle school Stratified random assignment at student level on SLSS scores. | Seligman's (2002) framework. Values in Action Inventory for youth (VIA- Youth; Park and Peterson, | <ul style="list-style-type: none"> • BMSLSS • SLSS • PANAS-C • BPM-Y | SLSS+ PANAS-C; PA+ NA- (PA maintained at 7 week follow-up) | 79.63 |
| U.S.A | | | | | | | | |

| | | | | | | | |
|--|---|--|---|---|--|---|-------|
| MPPI 2 | | | <i>Delivered by: lead author and 3 co-leaders (one psychologist and 3 doctoral students in school psychology)</i> | 2006) Hope theory (Snyder et al., 2005) | | BPM-Y=N.S. | |
| Shoshani, & Steinmetz (2014). Israel | Evaluated the Maytiv interventi on. Aims to promote adolescent mental health and well-being and determine whether efficacy differs by demograp hic factors | n=1038 7th -9th grade students Gender Ethnicity SES Teachers' details provided for religion, SES, marital status, and training experience. | <i>Content:</i> 1. Introduction 2. Educational change 3.permission to be human, 4. Positive emotions, 5. Gratitude, 6. Flow, 7. Beliefs to reality, 8. Goals, 9. Perfectionism, 10. Character strengths, 11. Mindfulness, 12. Focusing, 13. Relationships, 14. Kindness and compassion, 15. Tolerance. <i>Duration:</i> 1 school year 15 x 2 hour sessions fortnightly for staff and pupils + teacher training workshop <i>Delivered by:</i> Authors (2 CP's) to teachers, teachers to pupils | Longitudinal (follow-up at 1 year) 2 middle schools; matched 1 randomly assigned to intervention or control group. | Seligman's (2011) PERMA model. • BSI • RSE • GSES • SWLS • LOT-R | BSI – (small to moderate effect size) (decrease in GSI of BSI, depression symptoms, anxiety symptoms, and interpersonal sensitivity). Most educationally significant RSE+ (small to moderate effect size) GSES+ (moderate to high effect size) Optimism measured by LOT-R+ (small to moderate effect size) Control group BSI scores rose to above average. SWLS =N.S Effect of demographic characteristics = N.S | 77.78 |
| Shoshani, & Steinmetz & Kanat- Maymon | Evaluated the Maytiv interventi on. | n=2517 7 th to 9 th grade | <i>Content: As for 2014 study.</i> 1. Introduction 2. Educational change 3.permission to be human, 4. Positive emotions, 5. Gratitude, 6. Flow, 7. Beliefs | Longitudinal (follow-up at 8 months and 1 | Seligman's (2011) PERMA model of • SWLS. • PANAS. • Friends subscale of | SWB; SWLS =N.S. | 81.48 |

| | | | | | | | | |
|--------------------------------|---|---|---|---|---|--|---|-------|
| (2016). | on. | Age | to reality, 8. Goals, 9. Perfectionism, 10. Character strengths, 11. Mindfulness, 12. Focusing, 13. Relationships, 14. Kindness and compassion, 15. Tolerance. | year) | wellbeing (5 areas positive emotions, engagement, positive relationships, meaning, & achievement). | School Adjustment Report. | PANAS; PA+ (compared to control group which decreased). NA- (compared to control group which increased) | |
| Israel | To ascertain potential moderating effects of demographic variables. | Gender Socioeconomic status (SES) Religion Family status | <i>Duration:</i> 15 x 90 minute session fortnightly for staff and pupil + 2 introductory sessions for staff <i>Delivered by:</i> Authors (2 clinical psychologists) to teachers & teachers to pupil | 6 middle schools (70 classes) Classes randomised to intervention or control group. | | <ul style="list-style-type: none"> • School engagement survey. • Attendance • Achievement | Peer relations + School engagement + GPA + Attendance =N.S | |
| Suldo, Savage & Mercer (2014). | Evaluated manualised PPI to increase SWB. | n=55 Grades 6-8 Demographics chart included in article. | <i>Content:</i> <i>PPIs shown to work in adults were adapted to be developmentally appropriate for middle school children 10sessions.</i> <i>1.Introduction</i> <i>2&3. Positive emotions about past</i> <i>4-7. positive emotions in present</i> <i>8&9. Positive emotions about the future.</i> <i>10. Ending session</i> | Longitudinal (6 month follow-up) 1 middle school intervention group, 1 control. | Seligman's (2002) framework. Uses Values in Action Inventory for youth (VIA-Youth; Park and Peterson, 2006) Hope theory (Snyder et al., 2005) | <ul style="list-style-type: none"> • BMSLSS (for selection) • SLSS • PANAS-C • YSR | SLSS + PANAS = N.S YSR=N.S | 70.37 |
| USA | MPPI 1 | Age Gender SES Parental marital status Ethnicity | <i>Duration:</i> 10 weeks x 1 hr <i>Delivered by:</i> 6 School psychologists (first and second author and 4 doctoral student studying school psychology) | Randomly assigned to intervention or control group. | | | | |

| | | | | | | | | |
|--|----------------------------------|---|--|--|---|---|--|-------|
| Tunariu, Tribe, Frings & Albery (2017). Great Britain | Evaluated iNEAR programme. | n=354 years 7 and 8 Age Gender | <i>Content:</i> 1&2. <i>Self-concept and self-relatedness</i> 3&4. <i>Emotional regulation and relating to others</i> 5. <i>choice and option</i> 6. <i>responding with resilience</i> 7. <i>responding with resilience</i> <i>Duration:</i> 7 x 1 hr lessons <i>Delivered by:</i> Teachers | Longitudinal (not yet completed) 1 secondary school. Pupils randomly allocated to intervention or control group. | Draws on concepts of resilience and existential positive psychology. Prompted by government Prevent programme and need to avoid young people being radicalised. | <ul style="list-style-type: none"> • Environmental mastery and positive relationships subscales of the PWS • ODC • IUS-12 • WEMWBS. | Environmental mastery: + (higher in males in intervention) Positive relationships with others: + (for females in intervention). IUS-12 =N.S WEMWBS =NS ODC + (in females in intervention group) | 52.08 |
|--|----------------------------------|---|--|--|---|---|--|-------|

Table 1. Characteristics and details of articles included in review

*Full titles of abbreviated measures with references:

BMSLSS: Brief Multi-dimensional Students' Life Satisfaction Scale (Seligson Huebner, & Valois, 2003),
BPM-Y: Brief Problem Monitor-Youth (Achenbach, McConaughy, Ivanova, & Rescorla, 2011),
BSI: Brief Symptoms Inventory (Derogatis & Spencer, 1993),
DASS-21: Depression anxiety and Stress scale -short form (Lovibond & Lovibond, 1995),
Friends subscale of the school adjustment report (Conduct Problems Prevention Research Group [CPPRG], 2001),
FS: Flourishing scale (Diener Wirtz, Tov, Kim-Prieto, Choi, Oishi, & Biswas-Diener, 2010),
GSES: General Self-Efficacy Scale (Zeidner, Schwarzer & Jerusalem, 1993),
IUS-12: Intolerance of Uncertainty scale (Carleton, Norton & Asmundson, 2007),
LOT-R: Life Orientation Test-Revised (Scheier Carver & Bridges, 1994),
OCD: Openness to diversity and Challenge Scale (Pascarella, Edison, Nora, Hagedorn & Terenzini, 1996),
PANAS: Positive and Negative Affects Schedule (Watson, Clark & Tellegan, 1988),
PANAS-C: Positive and Negative Affect Scale for Children (Laurent et al., 1999),
PWS: The Psychological Wellbeing Scale (Ryff, 1989),
RSE: Rosenberg Self-Esteem Scale (Rosenberg, 1965),
School engagement survey (National Centre for School Engagement [NCSE], 2006),
SLSS: Student Life satisfaction scale (Huebner, 1991),
SWEMWBS: Short Warwick-Edinburgh Mental Well-being Scale (Tennant et al., 2007),
SWLS: Satisfaction with Life Scale (Diener, Emmons, Larson & Griffin, 1985),
WEMWBS: 14 items Warwick-Edinburgh Mental Well-being Scale (Tennant et al., 2007),
YSR: Youth Self-Report Form of the Child Behaviour Checklist (Achenbach & Rescorla, 2001).

Key:

- denotes reduction on measured variable
- + denotes increase on measures variable
- N.S denoted non-significant change on measured variable

Location

Studies were carried out in Australia (Burckhardt et al., 2015; Burckhardt et al., 2016), Israel (Shoshani et al., 2014; Shoshani et al., 2016), the USA (Suldo et al., 2014; Roth et al., 2017) and Great Britain (Proctor et al., 2011; Tunariu et al., 2017). Studies in Great Britain and Australia took place in secondary or high schools while those in Israel and the USA involved middle schools, reflecting the different national school structures. Schools in Australia were independent (fee paying schools) and reported higher than average SES of pupils. Other studies did not specify the source of school funding.

Recruitment

Sample selection varied in both approach and level of reporting. A weakness of the two lowest quality studies, Strengths Gym and iNEAR, and one average study MPPI 1, was the lack of information about the process of school selection. The six other studies

provided varying detail. Higher quality studies, both Maytiv studies and Bite Back, approached schools through letter distribution or contacting schools and they reported school inclusion criteria, with one reporting exclusion criteria. For Strong Minds and MPPI 2, schools approached the authors as they were interested in PP. There is a risk of selection bias in all studies as schools which approached authors or responded to invitations are likely more motivated and to have an interest in PP which may limit the external validity of findings.

Study design

All studies included control groups. Bite Back and Strong minds were Randomised Controlled Trials (RCT's). Strengths Gym was not randomised as teachers allocated classes to intervention or control groups but in the other five studies some form of randomisation was used. In all six non-RCT studies control groups received normal lessons and no active intervention. Only Bite Back attempted to blind all participants to the experimental condition. This blindness to alternate conditions was limited when both control and intervention groups took place in the same school and there was no control group intervention. Students in all studies completed self-report measures. It is possible that if students were aware of their test condition, this may have led to demand characteristics (Orne, 2009) therefore limiting internal validity.

Interventions ranged in duration from six hours delivered over four to six weeks for Bite Back, to 30 hours delivered over a full school year for Maytiv. Bite Back, Strong Minds and Strengths Gym used a pre/post intervention design and the other five studies were longitudinal, although iNEAR had not yet completed follow-up data collection. Length of follow-up ranged from seven weeks (MPPI 2) to one year (Maytiv 2014 and 2016). MPPI 2 included a parent component of a one hour psychoeducation session and a weekly communication letter.

Participants

The number of pupils involved in studies ranged from 42 in MPPI 2 to 2517 in Maytiv 2016. The age of pupils ranged from grade six (aged ten years) to grade 11 (aged 16 years). The lowest quality studies, Strengths Gym and iNEAR, did not report on school or detailed participant demographic variables beyond gender and age. iNEAR aimed to increase openness to diversity and so reporting on the diversity of the sample would have helped to contextualise this work. In the highest quality Maytiv studies greater detail was given about schools, students and staff implementing interventions.

Outcome measures

All studies were clear about their aims which were to evaluate the efficacy of the interventions to increase wellbeing

Wellbeing

A variety of measures were used but common to all was the use of specific measures of SWB to assess pupils' cognitive appraisals of life satisfaction using the WEMWBS, PWS, BMSLSS, SWLS, SLSS and FS. Four studies also measured pupils' appraisals of the affective aspect of their SWB using the PANAS or PANAS-C.

Several other instruments were used to measure: self-esteem, self-efficacy, optimism, openness to diversity and tolerance of uncertainty.

Psychopathology

Five studies measured symptoms of depression or anxiety or of psychopathology using the DASS-21, BSI, YSR or BPM-Y.

Only Maytiv 2014 measured effects on school life using the School Engagement Survey, Grade Point Average (GPA) and attendance levels. A strength across studies

was the use of standardised, validated measures normed for the participants' age. Where wording was altered, this was both minimal and authorised by the authors, so it is unlikely to have affected the measures' validity.

Theoretical basis of interventions

All studies were conceptualised by their authors as PPI's. However, there was considerable variation in the specifics of which additional theoretical underpinnings were incorporated. Maytiv is based on Seligman's PERMA model of happiness and wellbeing (Positive emotions, Engagement, Positive relationships, Meaning and Achievement) (Seligman, 2011).

Similarly the MPPI 1 and 2 used PPI's which have previously demonstrated efficacy adapted to be developmentally appropriate for middle school children. Values work is also incorporated with the Values in Action Inventory for Youth (VIA-Youth; Park & Peterson, 2006) and Hope theory (Snyder et al., 2005). 'Strengths Gym' draws upon the Values in Action Inventory of Strengths (VIA-IS; Peterson, 2006; Peterson & Seligman, 2004) and virtues. The iNEAR programme was developed in response to increasing concerns about radicalisation and a governmental 'prevent' strategy. It draws on theories of resilience and existential PP and encourages change in four areas; self-concept and self-relatedness, choice and options, emotional regulation and relating to others, responding with resilience. 'Strong Minds' incorporates elements of Acceptance and Commitment Therapy (ACT; Hayes, Strosahl & Wilson, 1999) and the authors describe clearly how frameworks were combined and knitted together where frameworks may conflict. 'Bite Back' used purely PP principles of gratitude, optimism, hope, flow, meaning, mindfulness, positive relationships, character strengths and healthy lifestyles.

The level of detail provided about the intervention content varied. The MPPI's 1 and 2 provide a full manual on request but reporting of content from other studies varied and was generally higher in the better quality studies.

Effectiveness of interventions

Teacher led

In Maytiv, Bite Back, iNEAR and Strengths Gym authors had no direct contact with students, but the level of ongoing involvement from the authors differed considerably. Maytiv was delivered to school staff each week by the authors and in parallel staff delivered it to pupils. They hoped teachers would incorporate PP elements into their own lives and model the principles to pupils. iNEAR provided staff training on the intervention and research at the start of the study but there was no ongoing involvement from the authors. 'Strengths Gym' and 'Bite Back' reported no involvement or training of school staff beyond the provision of materials.

Maytiv 2014 resulted in a statistically significant decrease in psychological distress, depression, anxiety and interpersonal sensitivity and an increase in self-esteem, self-efficacy and optimism from baseline to follow-up. In contrast the control group showed statistically significant increases in psychological distress, depression and anxiety and decreases in self-esteem and self-efficacy.

Maytiv 2016 involved a larger sample (70 classrooms from six schools). The intervention group showed a statistically significant increase in positive affect (PA), decrease in negative affect (NA) and increase in positive peer relationships. Again, changes were maintained at follow up. School engagement was increased and statistically significant improvements in GPA continued at time 3 and 4 follow-up. Neither Maytiv study resulted in a change in life satisfaction.

iNEAR was not effective at increasing SWB (both intervention and control group improved) or tolerance of uncertainty but did result in increased environmental mastery in males, and increased positive relationships with others and openness to diversity and challenge in females.

Of the two studies where staff delivering the programme received no training, the first, Strengths Gym, resulted in higher life satisfaction and PA, but no difference in NA or self-esteem. The second, Bite Back showed no effect on depression, anxiety or stress ratings (both intervention and control decreased), no significant effect on life satisfaction, and no change in flourishing, however the control group showed a statistically significant increase in flourishing. When pupil engagement was factored into analysis, highly engaged pupils in the control group showed a significant decrease in stress, while those in the 'Bite back' condition showed a small increase, with a decrease in life satisfaction. In summary 'Bite back' was not effective.

Author led studies

'Strong Minds' resulted in a statistically significant reduction in depression, stress and total DASS-21 scores. There was no overall effect on wellbeing but there was a statistically significant increase for year 10 but not year 11.

MPPI 1 showed increased life satisfaction maintained at six month follow-up. There were no statistically significant differences in PA, NA or emotional or behavioural problems. MPPI 2 resulted in increased life satisfaction and PA and reduced NA post intervention and gains in PA were maintained at seven week follow up.

Fidelity

There was greater variation in programme fidelity in teacher delivered interventions. In the two lowest quality studies fidelity was not reported (iNEAR) or was very low (Strengths Gym) with an average of 5.58 of 24 lessons being delivered (23.25%). In the

two high quality Maytiv studies which involved authors training teachers who taught pupils, fidelity was assessed by randomly checking classes or through reports at the end of the lesson. Full fidelity is reported by both.

Fidelity was high in all author led studies. Strong Minds sessions were audiotaped and the ACT (but not PP) component was coded. High fidelity to the model was reported. MPPI 1 reports 100% fidelity, PPI 2 reported 100% fidelity to the manual for the parent component and 98.4% for the pupil component.

Several studies reported low participation rates as parents did not wish for their children to take part (37.84% participation rate for MPPI 2) while in the MPPI 1 45% of parents did not return consent forms. This suggests a self-selection bias when an opt-in option is used. Possibly those who provided consent were qualitatively different from those who did not which limits the generalisability of findings. The reasons parents did not consent was not clear and could be considered in future studies. Some students in the MPPI 1 declined due to potential stigma.

Attrition was variably reported. In Maytiv (2016) 2517 pupils completed and only a modest 111 withdrew during the study, while 'Bite Back' had a high level of attrition and two of four schools involved withdrew.

Power

Only the MPPI 2 reported the statistical power of the study (low). It is likely that power in most studies was weak due to the nature of the samples and the matching and randomisation at class, grade and school levels.

Discussion

This review aimed to ascertain what school-based PPI's exist for adolescents, identify how they are being applied, and determine whether they are effective. Eight studies covering six PPI's across four countries were identified. All studies took place between 2011 and 2017 which suggests a small but growing international interest in developing empirically validated PPI's which can be used in schools for adolescents.

As expected all studies were underpinned by a PP framework. The aspects which studies focused on were broadly similar, with a clear interest in strengths and values-based work. Studies preferred measuring the cognitive component of SWB, with life satisfaction outcomes used by all eight studies. Four studies also measured the affective component of SWB. This is reflective of PP theory underpinning the programmes which suggest that wellbeing comprises of a cognitive appraisal and an affective experience (Diener, Lucas, Oishi, Snyder, & Lopez, 2002). Interestingly, although all studies stated their aim was to increase SWB, more than half also measured symptoms of anxiety, depression, stress or psychopathology. Perhaps this represents a move to think more holistically about the child, or a problem moving away from deficit or difficulty focussed models. The use of validated outcome measures appropriate to the study aims was a strength and increased internal validity.

Study findings were mixed. For the cognitive component of SWB only one teacher-led study, Strengths Gym, and two author led studies, both MPPI 1 and 2, demonstrated an increase in life satisfaction. MPPI 1 and 2 screened pupils and included only those pupils with scores of six or below on the BMSLSS (SWB). Screening pupils and offering PPI's to those with most scope for improvement may explain the greater increases in SWB, but it may also create issues of stigma and reluctance if PPI's are seen to be aimed specific pupils rather than having school wide application as was reported by some pupils who did not consent to take part.

With regard to the affective component of SWB, in the teacher led studies PA increased and NA decreased in Maytiv (2016) and PA increased in Strengths Gym. In the author led studies in MPPI 1 there was no change in PA or NA but in MPPI 2 PA increased and NA decreased. It appears that interventions were more able to bring about changes in affect ratings than cognitive appraisals of life satisfaction.

Psychopathology results were also mixed, with only two studies reporting reductions. Of the effective interventions one was teacher led (Maytiv 2014) and one author led (Strong minds). One possible reason that some interventions were not effective could be the use of none clinical samples where psychopathology were already comparable to the general population and therefore had less room for change.

Of the five studies which measured dimensions of psychopathology and SWB, two decreased psychopathology but did not increase SWB, and two increased SWB but did not decrease psychopathology. These differential effects support previous assertions that psychopathology and wellbeing are separate constructs (Greenspoon & Saklofske, 2001) and points to the need to consider both areas rather than assuming that change in one will facilitate change in another and this may explain why PPI's to promote wellbeing showed limited effectiveness at reducing psychopathology.

The difference in delivery may also have impacted efficacy. The more effective interventions were more intensive and longer in duration. Interventions delivered by teachers were typically shorter; Bite Back and iNEAR were 6 and 7 hours respectively, and had lower fidelity and adherence than the author led studies. These findings offer insight into practical challenges delivering school-based PPI's. The Maytiv style implementation with parallel programmes for staff and pupils is labour-intensive, but the closer links may have resulted in staff feeling more confident in programme delivery, and could account for better adherence and results. In contrast, the teacher-led

studies may present a more accurate representation of how interventions might be delivered if rolled out to school and so be more ecologically valid. Based on this review longer interventions delivered either by external agencies, or with in depth teachers involvement in the programme delivery, show better outcomes and adherence than short-term interventions which involve less adult facilitation. These would therefore be the preferable option for school-based intervention.

Studies were generally of a high quality but had a number of weaknesses. A clear limitation was in the quasi-experimental design employed in most studies. Most studies randomised classes or years but there was no blinding to experimental condition. This seemed to be due to a need to fit with school timetables and teacher availability, but meant that schools and teachers delivering the intervention were closely involved in this process. Use of wait list controls resulted in ambiguity: is the intervention effective in itself or is this a placebo effect of being part of a novel activity. None of the studies reported on extraneous variables such as other emotional wellbeing work in schools or whether participants received other external support which may have impacted intervention effectiveness.

The only study which reported no improvement, 'Bite Back', may provide clues to less effective aspects of interventions. In this online intervention two of the four schools dropped out with one reporting this was because pupils found the programme 'boring'. The authors speculate that the compulsory nature of the intervention may have also been a factor, although it was also the shortest intervention, at just six hours. Not only was the study ineffective but there was a paradoxical effect whereby those pupils who more actively engaged in the programme (completed more workbooks) showed decreases in life satisfaction. This is perhaps due to low investment in SWB and the minimal school involvement in the programme. This also highlights the need to be aware of possible

adverse effects. Only one study, Maytiv 2016 reported offering support to pupils following the intervention. Future studies should consider this as there is an ethical responsibility to ensure that any risks are considered and informed consent is gained in all research (Bulmer, 2001).

Cross cultural validity

The rates of mental health difficulties in young people appear to be broadly comparable in Israel and the USA (Shoshani et al, 2014), however, different cultural context and levels of religiosity means cross-cultural validity cannot be assumed. Reporting of religiosity varied. Studies in Australia and Israel were explicit about the use of faith schools but those in Great Britain or the USA did not report this information. PP concepts such as hope and gratitude are arguably familiar concepts in religious texts and thinking (Joseph, Alex Linley & Maltby, 2006) and so levels of existing familiarity with, and understanding of these concepts and their application, may be higher in those practising a faith. This could be considered in future studies when assessing external validity.

When considering the generalisability of any findings it is important to consider the possibly differing educational values and conceptions of childhood in the country in which any intervention was both designed and implemented. For example the Soshani et al., 2014 and 2016 studies took place in Israel. Israel's history has arguably resulted in a cultural emphasis on acculturation of young people and a greater focus on the values, beliefs and customs of Israeli culture, in addition to an emphasis on collectivism rather than individualism (Melhuish & Petrogiannis, 2006). This stands in contrast to a more western individualistic approach and inevitably will impact both the design and implementation of interventions. It may arguably also impact on what might be

considered to be a desired outcome as this will be social constructed within and through a given culture.

Systemic factors

Most studies were individualistic in their application and attempted to bring about individual change. Becker and Marecek (2008) criticised PP for ignoring wider socio-cultural factors and focusing on the individual, which is in line with the review findings. Perhaps this is reflective of the infancy of this body of research which is still laying the foundations for successful school-based PPI. The expansion of the MPPI 2 to include parents shows that systemic factors are being considered, reflecting an appreciation that a more systemic approach may be beneficial in PPI's. The Maytiv 2014 programme targeting the whole school resulted in a change of language as meetings were changed to 'strengths based meetings'. Bronfenbrenner's (1977) multilevel ecological systems theory provides a useful framework for considering how PPI's for adolescents are applied. The current work can be thought of as extending to the microsystem but in a fairly limited way. The challenge for researchers is that incorporating meso and macro systems brings in a large number of variables making the active element of the intervention harder to identify. As such it makes sense in a growing movement that such shortcomings are evident. Innovative research designs are required to enable the testing of more broadly applied interventions in an empirically sound way.

Future research

Future studies should seek to employ designs which allow for intervention comparisons or RCT's using PPI's compared to an active intervention from an alternate framework to determine the relative PPI impact. Controlling extraneous variables is difficult in school-based interventions. Using samples of classes within the same school may result

in contamination of conditions but can provide more closely matched samples, while matching schools avoids contamination but may result in more heterogeneous samples.

Staff and pupil interest and engagement needs consideration as previous research has demonstrated that people are more likely to adhere to PPI's when they enjoy it (Scheuller, 2010) and this was supported by the high attrition rate in the Bite Back intervention.

Fidelity and adherence to interventions may have impacted findings. It is possible that school staff experienced interventions as an extra task for which they had little time, had limited understanding, or did not feel able or motivated to implement. Low fidelity limits internal validity of studies but barriers to adherence and delivery need to be considered to develop usable interventions.

Limitations of the review

This systematic literature review provides a structured and detailed synthesis of the empirical research to date on school-based PPI's, but with some limitations. Due to the heterogeneity of interventions and samples it is not possible to conclusively determine efficacy. Recruitment methods and quasi-experimental designs, variable programme fidelity and adherence limit the internal and external validity of the studies and hence this review. Therefore these findings may serve to inform future research practices more than to directly guide the application of interventions. This is the first systematic reviews in this area, which is a strength.

Although objectivity was striven for throughout, the review is written from the perspective of a researcher with experience of the British educational system. This may have introduced bias in understanding school practices and the utility and potential

application of interventions. Finally, the inclusion of only peer reviewed articles means that informative but lower quality research may have been missed.

Conclusions

All studies in this review were carried out in the last seven years and it seems evident that there is increased interest in school-based PP for adolescents not only in the USA, where PP originated, but across the world. The nature of school-based interventions means that studies are typically quasi-experimental in design and so validity of findings is limited due to selection and limited controlling of extraneous variables. Despite these limitations studies are generally of a high quality and suggest that this is a promising area of research with much scope for development. Wellbeing is an important area of research and government priority (Department of Health, 2014). This review indicates that school-based PPI's can promote wellbeing in adolescents and that the best interventions are longer in duration and involve greater involvement from the authors which will necessitate investment from school and the government.

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*denotes reviewed studies.

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Part Two
Empirical paper

This paper is written in the format ready for submission to The Oxford Review of Education.

See appendix A for submission guidelines.

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Communicating with parents and carers when an adolescent self-harms: the experience of school staff.

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Communicating with parents and carers when an adolescent self-harms: the experience of school staff.

Abstract

This qualitative study explored how school staff experience communicating about adolescent self-harm (ASH) with pupils, staff and parents. Six participants currently working in secondary schools in England with experience of communicating with parents about ASH were recruited. Participants were interviewed using semi-structured interviews. These were analysed using Interpretive Phenomenological Analysis (IPA). Three superordinate themes: ‘involving parents’, ‘making sense of self-harm’ and ‘coping and solutions’ were identified as well as nine subordinate themes. The results are discussed in relation to the existing literature and clinical implications. Limitations of the study and potential areas for future research are highlighted.

Keywords: School staff, parents, adolescents, self-harm

Introduction

Self-harm

Self-harm (SH) has been described as ‘intentional self-poisoning or injury irrespective of the purpose of the act’ (National Institute for Clinical Excellence; NICE 2004 p203).

It describes the behavioural element, therefore suicidal intent may or may not be present. SH can include self-injury; such as cutting, burning, hanging, stabbing, inserting objects into the body, jumping from heights and jumping in front of vehicles, self-poisoning and swallowing poisonous substances or medicines. It can also include other risk-taking behaviours; drug use, smoking, over eating, food restriction, and promiscuity (Wood, 2009). Other terminology and definitions can be used which may indicate whether suicidal intent was involved, these include parasuicide, deliberate SH (DSH), non-suicidal self-injury (NSSI) and self-injury. The term SH, as used by the NICE, (2004) will be used throughout this article.

Prevalence and risk factors

SH prevalence rates vary from 16.2% in a UK sample (Hargus, Hawton & Rodham, 2009) to 46.5% in an anonymous survey carried out in the United States (Lloyd-Richardson, Perrine, Dierker & Kelley, 2007). It is clear that SH is particularly prevalent in adolescence, especially among females (Hawton, Rodham, Evans, Weatherall, 2002). In the long term, 39% of people who SH do so repeatedly, and are at increased risk of suicide (Zahl & Hawton, 2004). The majority of people who SH never use support services or engage in treatments that are available (Hawton, Saunders & O’Connor, 2012).

A variety of intrapersonal and interpersonal risk factors have been studied. Intrapersonal factors, such as emotional regulation and self-esteem, appear to have more of a role in

risk of onset, while interpersonal factors were associated with onset, maintenance and cessation (Hilt, Nock, Lloyd-Richardson, & Prinstein, 2008) indicating the importance of understanding the role of wider systemic factors in the whole course of ASH. While Hilt et al. (2008) suggests increased social support may reinforce ASH, adolescents themselves report that having someone they know to talk to, as opposed to external agencies, would prevent further SH (Fortune, Sinclair & Hawton, 2008). In addition, young people have also reported that unhelpful responses from others can actually result in further SH (Spandler, 1996). SH not only affects adolescent themselves, but also the wider family system. Parents report a range of emotions and reactions upon discovering ASH. These include disbelief, shock, anger, sadness, guilt and helplessness (Kelada, Whitlock, Hasking & Melvin, 2016). One of the key issues parents raise is concerns about stigma (Raphael, Clarke & Kumar, 2006).

It appears that help and support seeking behaviours in both adolescents and parents are affected by concerns about, and perceptions of stigmatising views of ASH (Raphael et al., 2006) which can reduce support seeking. Holding stigmatising attitudes and views has also been shown to affect the responses of some professionals (Law et al., 2009). This research has therefore been conceptualised and designed with an emphasis on considering stigma and its role.

Stigma

Stigma has been broadly defined as the application of a negative label to an individual because that individual deviates from what society considers acceptable (Goffman, 1963). Goffman identifies three areas which can attract stigma; physical disabilities, perceived differences in an individual's character, and 'tribal' differences such as being a different race or religion. Stigma consists of both cognitive and behavioural elements; stereotypes, prejudicial beliefs and discrimination (Corrigan & Bink, 2016). The stigma

which is attached to mental illness, and the associated negative discrimination, has been identified as a significant barrier to mental health treatment (Sartorius, 2002).

Public stigma

Public stigma describes how members of the general public hold stereotypical views about mental illness, and as a result behave in ways which are discriminatory towards individuals with mental health difficulties (Corrigan & Bink 2016). A theoretical framework of the application of public stigma was proposed by Corrigan, Markowitz, Watson, Rowan, and Kubiak, (2003). The ‘attribution model of public discrimination towards people with mental illness’ provides a socio-cognitive model of how stigma can be applied to individuals with mental illness. In this model, the public makes attributions about the causality of mental illness and the degree of responsibility and control that the individual has over it. This in turn leads to an emotional response which influences behaviour and can lead to avoidance, coercion, segregation or not helping. Other factors which influence helping or rejecting responses include familiarity with mental illness and beliefs about the dangers of it (Corrigan et al., 2003).

Courtesy stigma

Courtesy stigma can occur when society ‘blames’ another (usually the parent) for someone’s mental health difficulty, and it too can involve rejection, blame and avoidance (Goffman, 1963). Hence when considering mental health difficulties, it is important to consider not only the stigma which may be applied to the individual, but also that which may be applied to the wider systems around that individual, such as parents and other family members. Being aware of courtesy stigma may be particularly relevant in work with ASH given the role of parents in accessing informal and formal support.

Stigma and courtesy stigma in SH

Corrigan's model has been applied to mental illness generally, but has also been found to be applicable to SH. In a UK study of health professional students in their final years (studying medicine, nursing and clinical psychology) and non-health care professions (Physics) it was found that Corrigan et al's., (2003) public discrimination model could also be applied to those working with SH (Law, Rostill-Brookes & Goodman, 2009). The attributions that professionals made adversely affected the treatment received by people who self-harmed, and those professionals who reported that they felt people were responsible for their SH were more angry and reported being less willing to help. In adults who SH the experience of stigma can lead to reduced chance of further help seeking (Hunter, Chantler, Kapur, & Cooper, 2013). Experiences of psychosocial assessment were strongly influenced by perception of staff attitudes. Assessment was valued when staff legitimised, gave hope, and made aftercare plans. However, when individuals felt judged, ignored or hopeless they reported disengaging from services (Hunter et al., 2013).

The application of courtesy stigma in ASH specifically has not been studied, but parents report that concerns about stigma prevent initial help seeking (Raphael et al., 2006). When UK parents were asked to describe the emotional and practical impact of their child's SH many reported feelings of shame and embarrassment and so sought to hide it from others (Ferry et al., 2016). Parents were aware of wider stigmatising views about SH such as personal responsibility and worrying they would be blamed. Parents felt they could become isolated as they tried to hide their child's SH.

What beliefs do teachers and educators hold?

Clearly stigma is a primary concern for parents, but if this can be managed then schools are well placed to support parents with ASH for a number of reasons; SH is most

common in this age group, schools have access to most adolescents and school-based treatments and interventions may attract less stigma than specific mental health establishments (Shaffer & Gould, 2000). Schools are often the first to be aware of ASH as a result of student or peer disclosure, or because teachers themselves notice signs of SH, and are often the first to disclose ASH to parents or carers (Oldershaw, Richards, Simic & Schmidt, 2008). Therefore, although parents may actively avoid disclosing ASH, this may be negated in cases where teachers are involved in disclosure to parents, and presents an ideal opportunity to engage parents in a supportive relationship.

The approach school staff take can be crucial in helping parents to understand ASH and to support their child. Parents who report negative initial support from schools stated they were less likely to seek further support than those who have positive experiences (Oldershaw et al, 2008). There is little empirical evidence about the attitudes and knowledge of school staff towards ASH, although it is an emerging area of research interest. Of the limited research available most is quantitative and indicates teachers and school staff are uncertain about how to respond to ASH and would like clear guidelines on how to manage it (Berger Hasking & Reupert, 2014a; Berger, Haskin & Reupert, 2014b; Heath, Toste & Beetam, 2006).

There have been few qualitative explorations of teachers understanding and experiences of ASH, and these have focused exclusively on the teacher-student relationship.

Qualitative studies of teacher experiences of ASH in primary school pupils in England (Simm, Roen & Daiches, 2008), and secondary school pupils in England, (Best, 2006) Ireland (Dowling & Doyle, 2016) and Canada (Kenny, 2009) have explored how teachers experience and manage ASH. A systematic review suggested overarching perceptions are that SH in schools is often rendered 'invisible' and can be viewed as 'bad behaviour' (Evans & Hurrell, 2016).

Considering ASH only in this way limits understanding. To date no research has looked at how teachers or school staff understand ASH from a more systemic perspective, in particular how they make meaning of and experience the teacher-parent relationship. This study will be the first to explore this.

Evidence supports a systemic approach to child and adolescent wellbeing. High performing schools often demonstrate a number of characteristics, one of which is high levels of parent and community involvement. Where schools and families have better relationships, children do better academically, have better attendance and enjoy school more (Henderson & Mapp, 2002). In addition, positive relationships between parents and teachers during primary school is associated with more successful school outcomes (Dawson & Wymbs, 2016). Individual therapy combined with systemic approaches for family and support networks, including multisystemic therapy, has been suggested in working with adolescent SH (Carr, 2014).

How do school staff experience communicating with parents about ASH? Though we know that the quality of this experience can affect future help seeking by parents, there is a clear gap in knowledge about this experience from the perspective of school staff. The exploratory nature of this study means hypotheses cannot be made, however this study may highlight factors which might facilitate or hinder parent-school communication. If school staff are to communicate effectively with parents about ASH and foster an environment in which parents feel supported and able to continue to access support, then it is vital to understand this process from the perspective of the staff initiating the SH disclosure, as well as parents.

Rationale and Research Aims

This study aims to explore school staffs' beliefs about, and experiences of, communicating with parents about ASH. The findings of this study will have important

clinical implications. It is often school staff who initiate the first conversation a parent has about their child's SH. As such, their approach may be crucial in developing a supportive network which can work in an integrative, holistic way to support the adolescent. Understanding what, if any, role courtesy stigma might have would allow much needed theoretical understanding to be brought to the area of ASH.

Psychosocial interventions may be implemented through school based projects.

Supporting and including whole systems in this process may be required, and so this research will provide insights into potential challenges, and how this work can best be facilitated.

Finally this research hopes to lead to a deeper understanding of the systemic factors in working with ASH, which in turn may help to contextualise the behaviour within a broader theoretical framework. This research aims to increase understanding of the following:

1. How school staff think about systemic factors in ASH.
2. How do school staff feel about communicating with parents about ASH.
3. What have been school staffs' experience of communicating with parents about ASH.

Exploring the experiences of school staff could help services to support this work and utilise existing relationships and support systems in future work to support not only adolescents who SH but also those experiencing other mental health difficulties, and in wellbeing promotion work.

Method

Design

A qualitative methodology was employed to explore how staff working in UK secondary schools experience the systems which surround a pupil who has engaged in SH. In particular it sought to explore their experiences of communicating with parents or carers. Interpretative Phenomenological Analysis (IPA) was chosen for data analysis due to the explorative nature of the research question which was rooted in a desire to understand staffs' individual experiences. This research aim was complemented by an IPA approach which looks to make sense of how people interpret and give meaning to their experiences (Smith, Flowers & Larkin, 2009).

Measures

Six participants were recruited to take part in a semi-structured interview (Smith et al., 2009) (appendix H). Questions were designed to address the research question and to enable the participants to explore their personal experiences and to discuss what felt important to them in relation to the relevant areas. The questions were therefore open-ended with prompts if needed for clarification or to encourage the participant to provide additional information. Interview duration ranged in length from 40 minutes to 64 minutes.

Participants

Prior to the interview participants completed a demographic questionnaire (appendix I). The demographic questionnaires provided additional contextual information in which to understand participant experiences such as their age, qualifications, job roles, previous experience and training. This provided some information about the participant's wider context outside their educational role such as marital status and whether they have personal or family experience of SH.

Participants all worked in a pastoral role and two had additional teaching responsibilities. Ages ranged from 32-57 years. All were white British and married. All participants held level 4 qualifications or above. Years in current post ranged from one year to 12. Two participants had had training specifically on SH, one on mental health first aid, one on safeguarding (although it is likely all had this training as this is mandatory when working with children) and two did not answer this question.

| Ethnicity | Relationship status | Education level | Occupation/job title | Time in current role | Nature of work | Previous employment | Have you become aware of ASH in your current role | How did you become aware of the self-harm | Have you been in contact with families of adolescents who self-harm | Have you self-harmed | Do you know of family members who have self-harmed | Have you had any training on self-harm. If so what |
|---------------|---------------------|---------------------|--|-------------------------------|--|---|---|--|---|----------------------|--|---|
| White British | Married | Master's degree | Head teacher | 4 years | Education | recruitment | Yes | As a young teenager | Yes | No | No | Yes, mental health first aid. |
| White British | Married | Level 4 counselling | Student progress leader | 12 years | education | Teaching assistant, carer mental health | Yes | Student speaking up/friend informing | Yes | No | No | (Not answered) |
| White British | Married | Master's degree | Student support/student social worker | 3 years | One to one support, safeguarding and others | Charity project worker | Yes | Other students informing or student disclosing | Yes | No | No | CAMHS training, self-harm training |
| White British | Married | BA Hons | Pastoral manager | 1 year | Teaching assistant, pastoral care, communicating with parents and teachers | Sports coach | Yes | Staff and student disclosure | Yes | No | No | Safeguarding training |
| White British | Married | BA Hons | Academic coach | 5 years | Pastoral and academic support | Teaching assistant | Yes | Informed by parent, student or teacher | Yes | No | No | Yes –Self-harm course |
| White British | Married | Degree | Designated safeguarding lead (DSL) and teacher | DSL=5 years, teacher=35 years | | Head of House/head of geography | Yes | Disclosure, observations, friends and family | Yes | No | Yes | Nothing specifically self-harm but have safeguarding training |

Table 1. Participant demographics

Procedure

Ethical approval for the study was granted by the School of Health and Social Work Research Ethics Committee (appendix F). In the initial application the request specified that interviews would be conducted in person. Due to recruitment difficulties an application for an amendment was submitted in March 2018 to request approval to conduct interviews by telephone. This was approved (appendix G).

Recruitment

Initially schools within the Yorkshire and Humber region were approached by the researchers through direct communication with school admin teams and through known contacts within schools and were sent a poster (appendix K) and information sheet (appendix L). Posters were distributed on social media and a contact with Head Start, (a local agency which does work with schools around SH) also contacted schools with the same poster and information sheet. Participants either emailed the first author to express their interest in taking part, or contacts provided the first author with the email address of people who had expressed interest to them. Two attempts were made to contact people who had indicated interest in the study. If contact was not made, or the participant did not confirm that they would like to take part, then no further contact was made (recruitment protocol appendix M). Participants who indicated that they would like to take part were compared with the study inclusion and exclusion criteria. Where all inclusion criteria and none of the exclusion criteria were met then interviews were arranged.

| Inclusion | Exclusion |
|---|---|
| Experience of working within a secondary school in England | No experience of working in a secondary school in England |
| Fluent in English | Not a fluent English speaker |
| Full or part time member of school staff including teachers, head of year, pastoral staff, school nurse, school counsellor etc. | No direct experience of working with pupils who SH |
| Direct experience of communicating with parents about SH. | No direct experience of communicating with parents or carers about pupil SH |

Table 2. Participant inclusion and exclusion criteria

Interviews

Four face to face interviews took place. Three of these were carried out in the schools the participants worked in. One was conducted in the participant's home. Two further interviews were carried out over the phone on evenings when participants were at home. Participants were provided with information sheets (appendix L) at least 24 hours prior to the interview. At the interviews participants asked any questions and signed a consent form (appendix N). For telephone interviews participants were sent these one week before the interview and were asked to sign the consent form and complete the demographic sheets electronically or to post them back before the interview.

Participants were instructed to only share information they were happy to share and informed that they could withdraw from the study at any time up until data analysis. Confidentiality and its limitations were explained in the information sheet and verbally

before the interviews. No risks to participants or others were identified during data collection. Following the interviews participants were provided with a list of sources of support (Appendix O). No participants received any incentives or monetary payments for their participation.

Interviews were recorded on an encrypted laptop and were deleted after transcription.

All details which had the potential to lead to identification of participants, the schools or area they worked in, or pupils or their families or carers was anonymised or removed.

Participants were given numbers and all demographic sheets were stored securely.

Data analysis

Data was analysed using IPA. All transcripts were analysed by the first researcher and one full transcript was also checked by the second author. During the course of data analysis and write up the first researcher attended a qualitative research reflective practice groups and a section of data was analysed by the group. An annotated transcript can be found in appendix P.

Results

| Superordinate theme | Subordinate theme | Participant |
|----------------------|--|------------------------|
| Involving parents | 1. No-one wants to talk about it. | P1, P2, P3, P4, P5, P6 |
| | 2. Being a mediator. | P1, P2, P3, P5, P6 |
| | 3. The emotional impact. | P1, P2, P3, P4, P5, P6 |
| Making sense of SH | 1. 'They fall into two groups really'. | P1, P2, P3, P5, P6 |
| | 2. Every story is different. | P1, P2, P3, P5,P6 |
| | 3. Challenged perceptions | P1, P2, P3, P4, P5, P6 |
| Coping and solutions | 1. The importance of support. | P1, P2, P3, P4, P5, P6 |
| | 2. The role of teaching staff. | P1, P2, P3, P4, P6 |
| | 3. Feeling overwhelmed but maintaining hope. | P1, P2, P3, P5, P6 |

Table 3. Superordinate and subordinate themes

Three superordinate and nine subordinate themes were identified (table 3). There was a high degree of similarity in the ways that participants talked about their experiences. Sometimes it seemed as though participants wore two hats and moved from a professional explanation to a more personal understanding. This was partly evident in the changing use of the pronouns ‘we’ and ‘I’ throughout.

Superordinate theme one: Involving parents.

The first superordinate theme relates to how staff experienced initially involving parents. This typically involved initiating conversations and disclosing the child’s self-harm to parents. Staff talked about reluctance on their part to have these conversations and how they recognise this reluctance in pupils and parents too. They speculated this may be in part due to the taboo nature of SH which they believed to lead to parents to avoid talking to the school if they suspected SH. Staff saw themselves as having a mediating role and acknowledged the high levels of emotions which could be expressed by parents and pupils, and the need for them to manage this and remain professional, however they also spoke about the emotional impact on them personally.

Most participants found out about the SH from students or students’ friends and then phoned parents to invite them into school for a meeting.

Subordinate theme one: No one wants to talk about it

Participants discussed anticipatory anxiety about calling parents. P4, who had been in a pastoral role for the least amount of time, talked about expecting a hostile reaction.

‘I felt like maybe they would go ‘well who do you think you are to tell me what to do?’ So ... that was quite nerve wrecking’ P4 (249)

Participants typically waited until parents were in school before discussing the SH and were mindful about how they did this. They talked about a number of strong emotional

reactions from parents including shock, sadness and disbelief and there was a clear sense of uncertainty about what reaction there would be, which led to some apprehension:

'for me it's always take a deep breath how yeah how are you going to break this to that parent cos again it's not knowing their reaction so some people can be quite reluctant, you might be met with the aggression, again we've got to remember that they are possibly in shock and its oh my goodness, you know' P2 (185)

Staff talked about how hard these conversations with parents are and this difficulty talking about SH was also evident during the interviews in the way that participants spoke, and in an element of self-censure that occurred. At times it seemed difficult for them to find the appropriate words, evidenced by frequent delays and pauses and hesitation about using certain words like 'cutting' which seemed less acceptable.

*'I would say the most common one for me is definitely the erm (*long pause*) marking themselves' P2 (12)*

Staff said they believed that some parents already had an idea that there was something wrong, and they were surprised when they did not contact the school first, suggesting staff perceive some parental reluctance about having these conversations.

'if it was one of my kids I think I'd like to tell the teacher first but none of them did' P4 (273)

Staff also found some parents were reluctant to have further support and they speculated that this may be due to awareness of stigma and stereotypes, and the shame that they felt about their child self-harming:

'his parents were really high achievers and they wouldn't accept a referral to CAMHS because they were worried about the impact that would have on his career' P3 (391)

'I think people think if we ignore it it might go away [...] I think sometimes it's the stigma that goes to it' P2 (156)

Subordinate theme two: Being a mediator.

Participants were aware they had a clear role during SH disclosure. They talked about the need to carry out legal and safeguarding responsibilities and of their obligation to inform parents, but this was simultaneously a simple and complex process. In its simplest sense staff acknowledged that parents had to be informed, but the complexity lay in managing emotional reactions and maintaining the staff-pupil relationship when pupils also did not want to discuss the SH. They seemed to be placed metaphorically in a position between the child and the parent.

Participants were protective and expressed a wish to shield pupils from strong emotional reactions from parents:

'...I don't know sort of gave him the heads-up really so that he (Dad) could behave in a certain way, cos obviously we know that some parents react really really badly, some parents are gonna be upset and angry that their child's done that, but I think that the way we go about it is making sure that the conversation is had in a safe place' P3 (231).

Sometimes parental reactions were unhelpful, or intrusive. P3 felt pressed to share information about the pupil which pushed the boundaries of confidentiality:

'mum wanted to know everything and we kept saying 'it's confidential' P3 (299),

Staff were aware that pupils find these conversations difficult too and empathised with them:

'We we always have to again safeguarding, so we always always have to contact erm the family member, carer or anything to make them aware of why...Erm usually in in most cases for me the child initially is freaks out and is not happy with that' P2 (107)

They felt some pupils were relieved once parents knew, however, some described how this disclosure led to a breakdown of the teacher-pupil relationship.

'[the pupil said] 'if you tell my parents you're guna make me do this more' [that was] really difficult because...I knew ultimately we had to pass that on and we did, and we had to pass it on and the relationship broke down' P3 (209)

Subordinate theme three: Emotional impact

Participants often spoke from a professional, more neutral perspective, particularly at the start and after more emotional parts of the interviews, staff volunteered:

'we have a job to do' P3(214), 'I see that as part of my role' P1 (64)

As interviews progressed participants began to talk more from a personal perspective and about the range of felt emotions they experienced in addition to the worry:

'I think sometimes I feel quite helpless, erm and er helpless and then sometimes frustrated so er I suppose for me after that conversation on Friday [with a parent] I felt both helpless and really really worried and anxious [...] and I feel a huge sense of responsibility' P1 (314)

These feelings continued even outside work during holidays:

'worry, genuine worry [...] you'll read on the local news websites of whatever that someone has killed themselves, a young person and then I'm just, my anxiety just goes up and I think 'oh god what if it's one of the children I work with?' and so yeah worry for holidays and times I'm not there' P3 (447)

P2 also explicitly reflected that they would like to be able to stop thinking about it after leaving work, but that in reality this does not happen, indicating that separating professional and personal impact can be a challenge and is not clearly demarcated by simply physically leaving the workplace.

Participants discussed having to mask these emotions and maintain a calm, in control, professional stance in front of pupils and parents despite this being incongruent with their feelings.

*'But I think what I've got to do is hold it together for that parent or carer at that time and then it after it's that, *symbolises dropping something with hand/ letting go gesture* and you know might have a little cry to yourself or whatever, erm, but then you've got to get on and not show them and be positive moving forward' P2 (204)*

Some of this incongruence appeared to occur during the interviews as participants spoke from these two perspectives: both as a member of school staff who must understandably offer solutions, be professional and appear composed; but also as an individual impacted deeply by their pupils' distress.

Superordinate theme two: making sense of SH

Superordinate theme two details a sense making process that staff appeared to engage in. Initial descriptions polarised pupils into genuine 'self-harmers' who had 'reasons' and pupils who staff felt were influenced by peers and self-harmed as a way of identifying with a group. Participants all appeared to have gone through a process of deeper sense making whereby they had thought about the reasons and it appeared this exposure to SH directly had challenged the perceptions staff had about pupils and their families.

Subordinate theme one: 'They fall into two groups really'

Most participants categorised the pupils into two groups. Firstly, those with visible SH which was seen as being influenced by peers and friendship groups. Staff noticed 'pockets' of SH among groups and described it as a 'trend' or 'fashionable'. Although participants seemed uncomfortable using these terms, they spoke about this SH more easily and found it less worrying.

'they fall into two groups really, the ones who er, this sounds awful but [some pupils] making a really big fuss, often quite superficial cuts' P6 (75)

In contrast 'hidden' SH was perceived by staff as caused by 'internal pain' and there was fear attached to this SH.

'students that are doing it that are suffering internally and are not really telling anyone...and they are the ones that are more difficult as you are not aware of it until it becomes a bit more serious' P5 (75)

These pupils were thought to be more serious and there was a general feeling that something might be missed and a risk that a pupil might die.

'erm...er...er...to be honest there's a few that stand out and er...they are frightening and you know they frighten you and concern you about what could have been' P5 (275)

Subordinate theme two: 'every story is different' P5 (113)

Participants appeared to have a desire to move beyond these categorisations to attempt a deeper understanding of pupils' self-harming. P2 described a sense of bewilderment and a desperate attempt to find a reason for SH.

*'erm (*sigh*) immediately you know the first question you ask is why? er cos sometimes I think you're quite...you know it's like what ...what person SHs? How do we define that self-harmer and it could be anyone so it's why erm definitely why' P2 (69)*

Participants talked about *'unpicking it'*, *'digging'* and *'getting to the bottom of something'* in line with the secretive element of SH. Through this wondering staff had generated a range of explanations at all levels of the system; child, friends, school, parents and wider systemic factors such local employment levels and poverty were also cited:

'it might be the students erm self-esteem, it may be being bullied, it may be parents being separated. Erm for me one of those most extreme cases for me was erm a student that was in a very violent and controlling relationship with her boyfriend' P2 (41)

'there's benefit pressures, I think there's job pressures, I think there's lots of parents in (area) who er struggle find work[...]yeah poverty' P1 (114)

Participants saw SH was a way to manage the feelings which had resulted from any number of these factors:

'For the majority the reason for it is that they feel unable to cope with the pressures of whatever it is that they are dealing with whether it's to do with their home life, their school life, erm...academia, not having friends, there doesn't seem to be a rule for why a student would SH' P5 (80)

Subordinate theme three: challenged perceptions

It seemed that through their work, participants' ideas about who might SH had been challenged and had evolved over time. P4 was the most explicit in this and talked extensively about how at college they had developed and held views that SH is for attention and associated it with a particular group and *'emo culture'*, but that through exposure this view had changed.

'you'd have quite a lot of 'oh you're into this music, you dress in black so you probably hurt yourself' so there were a lot of labels and stereotypes for self-harm from what I've heard of from college, erm and I think that changed a lot' P4 (31).

Other participants were not explicit about how their views had developed, but this seemed apparent in which cases which were most salient in their minds. These were often ones where they were shocked and these pupils were not the people that they thought it would be. This was typically when children were from families where their parents were high achievers and supportive. When asked why they found a particular case shocking P2 commented:

'....I think for one most definitely the family was a very very well educated family a very well respected family. The girl was an A student who always skipped about school and as as jolly as anything and you just get the impression that the world is just so rosy, it's just so lovely, and I suppose from how they speak' P2 (314)*

It suggests that their beliefs have been challenged by these cases and there is something more shocking about SH occurring in 'those families' which suggest that on some levels there were previously held beliefs about children who SH and what families they are from. This added to the underlying fear as participants did not feel they could 'know' which pupils would SH.

Superordinate theme three - Coping and solutions

The final superordinate theme was about how staff coped with this work and the high emotional strain it could place on them. Staff talked about their role being somewhat isolated in the school and feeling that teaching staff were often very separate and that they often did not view mental health support as part of their work. Participants felt that teaching staff could offer a valuable contribution to the support and at times appeared

frustrated by the lack of involvement. Staff appeared to manage the emotional impact of their work by focussing on practical strategies and training needs.

Subordinate theme one: The importance of support

Four participants were employed solely in a pastoral role, two also carried out teaching. The pastoral teams were typically very small, between one and three people and there was a sense that the role of teaching staff and pastoral staff were very separate. Participants talked about the importance of support and supervision which was usually provided by other pastoral staff:

'It's really good to have other people to talk to about it so other professionals and people higher up' P4 (358)

However most felt woefully unsupported and highlighted a clear deficit in professional support:

'Nothing [support for staff] and that's where teaching is very very wrong really. There's nothing. I come home and have to talk to my husband or someone [...] there's no recognition that staff need the equivalent of supervision really. Staff dealing with this should have some sort of supervision' P6 (288)

Subordinate theme two: The role of teaching staff.

Participants saw teaching staff as well placed to support pupils due to their existing relationships:

'if you've struck a bond with a teacher its them that could be doing and helping' P4 (415)

but they felt frustrated that some teachers were reluctant to involve themselves with anything to do with emotional wellbeing:

'I'll be honest in that I think that a lot of form tutors and teachers automatically think 'this is safeguarding' and bat it over...they don't want to be held responsible if something does happen [...] they haven't necessarily got the time, but I don't think that it's about the time, I think it's about this sort of responsibility that this is quite serious'
P6 (238)

Participants initially gave sympathetic reasons for lack of teacher involvement such as it not being their role or being too busy and seemed hesitant to offer further explanation, but as conversations progressed participants offered other views and suggested that teaching staff are fearful of working with SH in pupils and any possible safeguarding risk.

Participants speculated about the possible attributions teaching staff might make about reasons for SH and alluded to stigma and possible stereotyped views among some.

'we still need to break those stereotypes with teachers as well' P2 (497)

'I would think a lot of them [staff] would think like I did when I first started 'oh look at me I need attention' P4 (593)

Participants valued the teaching staff and were keen to see them develop their support roles with extra training.

'it would be nice to develop their roles [teachers] if they are seeing them in form tutor...if they are comfortable with it' P6 (244)

Participants appeared frustrated with the lack of support from some teaching staff but were reluctant to verbalise this, often citing teachers' high workload but then elaborating later, although they seemed to feel that it might not be acceptable to say. When P3 discussed needing to breakdown stereotypes in teaching staff and teachers' avoidance of SH, they commented *'I can't believe I'm saying this on recorded*

interview' giving the impression that of censuring what was said. This self-censure seemed common across participants.

Subordinate theme three: Feeling overwhelmed but maintaining hope

Some participants felt isolated in their work which was possibly compounded by the lack of involvement of teaching colleagues and poor supervision. They talked about feeling overwhelmed by the responsibility and the shocking nature of the work:

'you are picking up the pieces from previous days and it's that cumulative thing really cos what you dealt with today won't go away, you haven't dealt with it today and that's the end of it so you get your new cases tomorrow but you've still got the fallout from the previous days' P6 (318)

The use of the word '*fallout*' brings to mind an explosion or accident and is particularly used in radioactive incidents suggesting that something is both dangerous in the moment but also that there is a lingering risk. This perhaps represents the participants' underlying feelings about this work or the impact on them.

Staff seemed to manage feeling overwhelmed by focussing on their role and the child:

'it's not about me it's about them' P3 (460)

There was a clear discourse of 'fixing' and 'solutions' as if there might be a simple answer. Staff discussed this from an organisational perspective and used 'we' and 'as a school' suggesting a cohesive team approach emphasising solution focused coping and signposting to other organisations.

Concluding the interviews, participants were asked what would help them in this work. Gaps, such as support and easier access to CAMHS, were mentioned alongside positive

actions they had taken such as posters, contact information, linking in with other agencies and giving staff and parents training and information.

'I think the most important thing is to make sure you have had as much training as you possibly can ...and just being aware of networks and support agencies' P5 (323)

This solution-focused stance suggests the adoption of a professional role helping participants to maintain hope and having the resources and ability to make a difference despite the complex emotional demands of the role. P1's final comment was that they love their job, P3 stated that they are making a difference and P2 talked about thriving in their pastoral role.

Discussion

This IPA study explored how school staff experience communicating with parents about ASH. Pastoral staff views could be conceptualised as falling under three superordinate themes 'Involving Parents', 'Making Sense of SH' and 'Coping and Solutions' with each superordinate theme comprising of three subthemes (Figure 1).

Involving parents

This was the first research to explore how pastoral staff experience talking to parents about ASH and it highlighted that taboos around SH impact this work. Pastoral staff finding out about SH experience anxiety due to concerns about potential parental reactions and awareness of the emotional impact that disclosing ASH may have on parents. Previous research from the perspective of parents suggests they feel shame and concern about stigma and they worry about being blamed for the SH (Raphael et al., 2016). This study indicates that pastoral staff recognised this reluctance and perceived some parents are avoidant of such conversations. Staff reported feeling frustrated that

parents did not share information about pupil SH with them, although they were also sympathetic to the possible reasons for this.

Legal obligations meant that parents were always informed about ASH and in all schools this was the responsibility of pastoral staff or head teachers. Staff were resolute about the need to inform parents but had experienced mixed reactions from pupils about the prospect of such conversations. Often pupils were considered relieved that this 'secret' could be talked about, but others seemed to use emotional threats to try to discourage disclosure. This chimes with Hawton et al., (2002) who found that pupils frequently worry that their SH will be perceived as attention seeking and so try to keep it hidden.

Staff in this study described mediating parental responses by preparing both parents and pupils for these conversations. This is in line with previous research suggesting guidance counsellors and teachers are well placed to support pupils and parents (Dowling & Doyle, 2016).

The strong emotional impact on staff was clear as staff talked about feeling helpless, frustrated and anxious. Staff discussed the impact remaining even after leaving work as they continued to worry about the safety of pupils and struggled to 'switch off', which is similar to Dowling and Doyle's (2016) findings. Staff however also described putting aside their emotional responses in the moment in order to carry out their work. Initial responses to SH have been shown to strongly impact future help seeking (Heath et al., 2011) and so this work is of great importance and, if handled well, will encourage further help-seeking and engagement from pupils and their families.

Making sense of SH

Staff initially categorised pupils into two groups; one where there was visible and less serious SH, and hidden SH which was perceived to be more serious and due to genuine internal pain. This distinction has been reported in numerous previous studies (Hargus et al., 2009). Adolescents themselves are aware of these perceptions and stereotypes. In particular they are aware of the belief that SH is a form of ‘attention seeking’ (Crouch & Wright, 2004).

However, staff moved on to develop a deeper understanding. In line with Bronfenbrenner’s (1977) multilevel ecological systems theory, staff understood reasons at the micro and meso level citing interpersonal difficulties, school, home and wider local issues such as employment and poverty.

These complex explanations were not explicitly blaming of parents. However, the subtheme ‘challenged perception’ indicates a belief among participants that certain families are less likely to have children who SH which perhaps belies an implicit judgement about the role of parents which could not be voiced. How staff make sense of the parental role was not explicitly explored although staff certainly did not exclusively see parents as ‘the reason’ for pupil SH and presented a more nuanced understanding.

Courtesy stigma, when someone, typically the parent, receives blame for someone’s mental health difficulty, can involve rejection, blame and avoidance (Goffman, 1963). Previous research suggests that parents believe that they will be blamed for their child’s SH (Raphael et al., 2016) but that finding is not borne out here. Staff may hold views about the role of parents, but they did not extend to explicit demonstrations of the behavioural element of courtesy stigma, namely rejection, blame or avoidance.

Coping and solutions

Participants felt that teaching staff could be helpful but there was a clear feeling of frustration that some 'avoided' self-harm. They wondered whether teaching staff held stereotyped views which could result in avoidance and suggested that this was due to perceived high risk. Corrigan's (2003) public attribution of stigma model suggests that the perception that these pupils are dangerous leads to an emotional response, resulting in different behaviours, in this case avoidance and withholding of help. It is not possible to know if other staff avoided pupil SH but the experience of participants is in line with previous research. Preliminary research indicates that school staff are willing to respond to ASH but are unsure how to and they call for increased training to feel more confident working with SH (Berger, Hasking & Reupert, 2014a; 2014b). Current findings echoed this request for more training for teaching staff and pastoral staff. Limited knowledge of SH is common in UK teachers (Best, 2006) and in two qualitative studies teachers discussed responding emotionally due to lack of training (Best, 2006; Simm, Roen & Daiches, 2010).

Stress and coping theory (Lazarus & Folkman, 1984) describes stress as a state in which the demands under which people are placed exceeds the resources available to deal with those demands. Individuals make a primary appraisal and considers what is at risk. Clearly for participants in this study the stakes are high and they mentioned concerns that pupils may die if SH escalated, or if there was suicidal intent which was not picked up on. Secondary appraisals then occur and the individual weighs up the resources available to them. Staff felt that what could be offered by them or the school is not always adequate, particularly with 'more serious' cases. According to coping theory people may then seek more information, which appears to be an approach adopted by staff who talked about the need for more training, a clear desire to find out what can be done and to seek out information. Seeking outside agencies, information, further

support and 'solutions' appears to enable pastoral staff to feel able to cope, despite the overwhelming pressure that they can be under.

However, this may have a negative effect on the way in pupils perceive school support. While for staff involving external agencies might increase feelings of support, Evans and Hurrell (2016) found that the way that schools escalate concerns to outside agencies can act as a barrier to disclosure and help-seeking by pupils.

Clinical implications

The emotional impact on staff and support required to do this work should not be underestimated. Staff currently do not receive the support required. While regular supervision was mentioned by all participants as crucial this is not routinely available. The importance of staff supervision in secondary schools is recognised (Huffman, 2014) to help staff develop and work effectively and this also may help staff to manage the anxiety and emotional impact of the work. The primary purpose of supervision is to ensure safe and effective care (British Psychological Society (BPS), 2014). Clinical psychologists are trained to offer supervision, indeed this forms an essential part of training and continued professional development. As such clinical psychologists would be well placed to offer the supervision required to support staff through individual and/or group supervision.

In addition, utilising other staff with existing relationships with pupils may also help to ease the burden on pastoral staff. Ongoing training is crucial to ensure that staff feel they have the resources to support pupils.

Though school policies and service frameworks may recommend SH is escalated to external agencies this may adversely affect future help-seeking and so local authorities and schools should consider whether increasing wellbeing provision in schools could be

a realistic alternative to involving external agencies providing staff receive adequate training and support (Best, 2004; Huffman, 2014).

Fostering staff relationships with parents from the time pupils start secondary school, and providing information about self-harm and difficulties pupils may have, as suggested by P6, may help to reduce the stigma and shame parents report (Raphael et al., 2006) and make later conversations easier to initiate.

Limitations

This research is limited in several ways. The use of qualitative methodology and small sample size means findings may not be generalisable in a broad sense. Self-selection bias means that those who volunteered to take part in the research may have had some commonality such as interest in self-harm about which the author is unaware.

The study was carried out in England and all participants and the author were British. As a result the experiences will have been informed by, and been understood, in the context of this culture and school system. IPA does not seek to make generalisations (Smith et al., 2009) but these findings and recommendations may be more readily applicable to this context. Further research should seek to explore this further.

Conclusions

Schools provide an ideal setting for supporting pupils who SH. As evident in interviews, staff are frequently made aware of SH and are well placed to mediate conversations between parents and pupils. They have both the access and the knowledge of the child and system to be able to manage this. At times staff feel overwhelmed by the SH both in terms of parental and child emotional reaction but also due to the sustained fear inherent in working with risk. Attention is typically paid to the relationship between the child and school or child and family. The school-family relationship is often overlooked but

is crucial to support pupils adequately (Prilleltensky, Nelson & Pierson, 2001). The way in which parents perceive the school and the way in which the school perceives the parents will impact such interactions, but the importance of these relationships should not be underestimated as schools and family have a 'bidirectional, reciprocal influence over each other' (Sheridan, Warnes, Cowan, Schemm & Clarke, 2004, p.11).

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Part Three: Appendices

Appendix A- Guidelines for authors for the systematic literature review and empirical paper

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Updated 24-05-2018

Appendix B - Systematic literature review inclusion and exclusion criteria and rationale.

| Inclusion criteria | Rationale |
|---|---|
| Published in a peer reviewed journal | To ensure high quality articles |
| English Language | To enable reviewer to understand and analyse the article |
| Includes participants who are secondary school age based on the British education system (i.e. aged 11-18) | To enable comparisons between interventions aimed at children at the same developmental level chronologically. |
| Includes an active intervention | |
| Empirical design and includes at least one standardised quantitative outcome measure (mixed designs to be included) | To enable evaluation of efficacy of intervention. |
| Uses an intervention which the authors conceptualise as a 'positive psychology' intervention | To enable evaluation of the body of work which is intentionally adhering to a positive psychology approach |
| Intervention is primarily aimed at promoting a or developing an ability, skill or strength rather than reducing a behaviour or 'pathology' (in line with Sin and Lyubomirsky (2009) definition of positive psychology interventions). | To ensure the approach is based on generally accepted positive psychology principle. |
| Intervention aimed at pupils who are in mainstream education. | Students in specialist provision or further education may have additional characteristics which makes comparisons less reliable |
| Any date | So that changes over time or in positive psychology interventions may be considered. |
| Any location | Interventions in any country will be included so that comparisons can be made. |
| Exclusion criteria | Rationale |
| Article which are reviews, meta-analyses or meta-syntheses | To maintain manageability and clarity of the data and individual studies. |
| Participants under the age of 11 or over 18. Where the sample bridges cut-offs the mean age of participants will be used. | To ensure that the samples are comparable to British secondary school age. |

| | |
|--|--|
| Participants are not in compulsory education | Those who enter into optional further education may have different characteristics than those who do not (eg SES, academic ability) therefore this sample may not be comparable with mainstream compulsory education. |
| Intervention aimed at specialist provision schools | Review aim to look at interventions designed for implementation in mainstream educational institutes. |

Appendix C- Studies excluded at full article stage and rationale

| Number: | Study title: Citation: | Reason for exclusion: |
|---------|---|---|
| 1 | <p>A positive psychology approach to tackling bullying in secondary schools: A comparative evaluation.</p> <p>Richards, A., Rivers, I., & Akhurst, J. (2008). A positive psychology approach to tackling bullying in secondary schools: A comparative evaluation. <i>Educational and Child Psychology</i>.</p> | Focus on reducing bullying. |
| 2 | <p>An Internet-based positive psychology program: Strategies to improve effectiveness and engagement.</p> <p>Redzic, N. M., Taylor, K., Chang, V., Trockel, M., Shorter, A., & Taylor, C. B. (2014). An Internet-based positive psychology program: Strategies to improve effectiveness and engagement. <i>The Journal of Positive Psychology</i>, 9(6), 494-501.</p> | Looking at improving the online program and student satisfaction with it. |
| 3 | <p>Developing student wellbeing and resilience using a group process.</p> <p>Chessor, D. (2008). Developing student wellbeing and resilience using a group process. <i>Educational and Child Psychology</i> 25(2), pp 82-90</p> | Only used qualitative measures. |
| 4 | <p>Effectiveness of group intervention based on positive psychology in reducing symptoms of depression and anxiety and increasing life satisfaction in adolescent girls.</p> <p>Jabbari, M., Shahidi, S., & Mootabi, F. (2015). Effectiveness of group intervention based on positive psychology in reducing symptoms of depression and anxiety and increasing life satisfaction in adolescent girls. <i>Iranian Journal of Psychiatry and Clinical Psychology</i>, 20(4), 296-287.</p> | Full article not available in English (only abstract). |
| 5 | <p>Effectiveness of self focused intervention for enhancing students' well-being.</p> <p>Singh, K., & Choubisa, R. (2009). Effectiveness of self focused intervention for enhancing students' well-being. <i>Journal of the Indian Academy of Applied Psychology</i>, 35(Special issue), 23-32.</p> | Sample aged 19-24. |
| 6 | <p>Effects of the Best Possible Self Activity on Subjective Well-Being and Depressive Symptoms.</p> <p>Liau, A. K., Neihart, M. F., Teo, C. T., & Lo, C. H. (2016). Effects of the best possible self activity on subjective well-being and depressive symptoms. <i>The Asia-Pacific Education Researcher</i>, 25(3), 473-481.</p> | Sample aged 16-23 and in higher education institute. |

| | | |
|----|---|---|
| 7 | <p>Establishing the effectiveness of a gratitude diary intervention on children's sense of school belonging.</p> <p>Diebel, T., Woodcock, C., Cooper, C., & Brignell, C. (2016). Establishing the effectiveness of a gratitude diary intervention on children's sense of school belonging. <i>Educational & Child Psychology</i>, 33(2), 117-129.</p> | Primary school |
| 8 | <p>Feasibility and effectiveness of a web-based positive psychology program for youth mental health: Randomized controlled trial.</p> <p>Manicavasagar, V., Horswood, D., Burckhardt, R., Lum, A., Hadzi-Pavlovic, D., & Parker, G. (2014). Feasibility and effectiveness of a web-based positive psychology program for youth mental health: randomized controlled trial. <i>Journal of medical Internet research</i>, 16(6).</p> | Not school-based (study advertised through schools and other organisations) |
| 9 | <p>Happy thoughts: Enhancing well-being in the classroom with a positive events diary.</p> <p>Carter, P. J., Hore, B., McGarrigle, L., Edwards, M., Doeg, G., Oakes, R., ... & Parkinson, J. A. (2018). Happy thoughts: Enhancing well-being in the classroom with a positive events diary. <i>The Journal of Positive Psychology</i>, 13(2), 110-121.</p> | Primary school |
| 10 | <p>Increasing Elementary School Students' Subjective Well-Being through a Classwide Positive Psychology Intervention: Results of a Pilot Study.</p> <p>Suldo, S. M., Hearon, B. V., Bander, B., McCullough, M., Garofano, J., Roth, R. A., & Tan, S. Y. (2015). Increasing elementary school students' subjective well-being through a classwide positive psychology intervention: Results of a pilot study. <i>Contemporary School Psychology</i>, 19(4), 300-311.</p> | Primary school |
| 11 | <p>Integrating a relaxation response-based curriculum into a public high school in Massachusetts.</p> <p>Foret, M. M., Scult, M., Wilcher, M., Chudnofsky, R., Malloy, L., Hasheminejad, N., & Park, E. R. (2012). Integrating a relaxation response-based curriculum into a public high school in Massachusetts. <i>Journal of adolescence</i>, 35(2), 325-332.</p> | Not defined as a positive psychology intervention |
| 12 | <p>Positive education for young children: Effects of a positive psychology intervention for preschool children on subjective well being and learning behaviors.</p> <p>Shoshani, A., & Slone, M. (2017). Positive Education for Young Children: Effects of a Positive Psychology Intervention for Preschool Children on Subjective Well Being and Learning Behaviors. <i>Frontiers in psychology</i>, 8, 1866.</p> | Preschool children |
| 13 | <p>Positive Education: Positive Psychology and Classroom</p> | Review. |

| | | |
|----|--|-------------------|
| | <p>Interventions</p> <p>Seligman, M. E., Ernst, R. M., Gillham, J., Reivich, K., & Linkins, M. (2009). Positive education: Positive psychology and classroom interventions. <i>Oxford review of education</i>, 35(3), 293-311.</p> | |
| 14 | <p>Positive psychology in education for sustainable development at a primary-education institution</p> <p>Ampuero, D. A., Miranda, C., & Goyen, S. (2015). Positive psychology in education for sustainable development at a primary-education institution. <i>Local Environment</i>, 20(7), 745-763.</p> | Primary school |
| 15 | <p>Positive Psychology Intervention to Alleviate Child Depression and Increase Life Satisfaction.</p> <p>Kwok, S. Y., Gu, M., & Kit, K. T. K. (2016). Positive psychology intervention to alleviate child depression and increase life satisfaction: A randomized clinical trial. <i>Research on social work practice</i>, 26(4), 350-361.</p> | Primary school. |
| 16 | <p>The Efficacy of Positive Psychology Interventions to Increase Well-Being and the Role of Mental Imagery Ability.</p> <p>Odou, N., & Vella-Brodrick, D. A. (2013). The efficacy of positive psychology interventions to increase well-being and the role of mental imagery ability. <i>Social Indicators Research</i>, 110(1), 111-129.</p> | Sample aged 18-74 |

Appendix D – Data extraction sheet

| | |
|--|--|
| <p>Journal title and author(s)</p> <p>Citation</p> | |
| <p>Study details</p> <p><i>Research questions/aims</i></p> <p><i>Location</i></p> <p><i>Design</i></p> <p><i>Control group and type</i></p> | |
| <p>Sample size</p> <p>Intervention group</p> <p>Control group</p> | |
| <p>Participant Characteristics</p> <p><i>Age (school years and Mean age of sample)</i></p> <p><i>Gender</i></p> <p><i>Ethnicity</i></p> <p><i>Socio-economic background</i></p> | |
| <p>Intervention</p> <p><i>Duration</i></p> <p><i>Delivery by</i></p> <p><i>Follow up</i></p> <p><i>Adherence/dropout</i></p> | |
| <p>Recruitment</p> <p><i>Recruitment (optional/compulsory)</i></p> <p><i>Inclusion/exclusion criteria (targeted sample?)</i></p> | |
| <p>Measures</p> <p><i>Qualitative measures</i></p> <p><i>Quantitative measures</i></p> | |

| | |
|---|--|
| <p><i>Who completed measures (self-report, parent, teacher)</i></p> <p><i>When measured (pre and post?)</i></p> | |
| <p>Results</p> <p><i>Statistical tests used</i></p> | |
| <p>Main Findings</p> | |
| <p>Conclusions</p> <p><i>Clinical Implications</i></p> <p><i>Limitations:</i></p> | |

Appendix E - Quality checklist

| Reporting | | Burckhardt, Manicavasagar, Batterham, Miller, Talbot & Lum (2015) | Burckhardt, Manicavasagar, Batterham, & Hadzi-Pavlovic (2016). | Proctor, Tsukayama, Wood, Maltby, Eades & Linley (2011). | Roth, Suldo, & Ferron (2017). | Shoshani, & Steinmetz (2014). | Shoshani, Steinmetz & Kanat-Maymon (2016). | Suldo, Savage & Mercer (2014). | Tunariu, Tribe, Frings & Albery (2017). |
|--|--|---|--|--|-------------------------------|-------------------------------|--|--------------------------------|---|
| 1. Is the hypothesis/aim/objective of the study clearly described? | Yes=1 No=0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 2. Are the main outcomes to be measured clearly described in the introduction or methods section? If the main outcomes are first mentioned in the results section, the question should be answered no. | Yes=1 No=0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 3. Are details provided about how schools were selected? This score should be 1 where any inclusion and exclusion criteria are reported. | Yes=1 Partially=.5 No=0 Unable to determine=0 | 1 ⁱ | .5 ⁱⁱ | 0 | .5 ⁱⁱⁱ | 1 | 1 ^{iv} | 0 | 0 |
| 4. Are sufficient details about the characteristics of the schools involved included? Are demographics such as SES of the catchment, school size, location, funding, religiosity included? | Yes=1 Partially=.5 No=0 | .5 ^v | .5 ^{vi} | .5 ^{vii} | 0 | 1 ^{viii} | 1 ^{ix} | 0 | 0 |
| 5. Are the characteristics of the participants included in the study clearly described? In cohort studies and trials, inclusion and/or exclusion criteria should be reported. In case-control studies, a case-definition and the source for controls should be provided. | Yes=1 Partially = .5 No=0 | .5 ^x | .5 ^{xi} | .5 ^{xii} | 1 ^{xiii} | 1 ^{xiv} | 1 ^{xv} | 1 ^{xvi} | .5 ^{xvii} |
| 6. Are the interventions of interest clearly described? Treatments and placebo (where relevant) that are to be compared should be clearly described. | Yes=1 No=0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 7. Are the distributions of principle confounders in each group of participants to be compared clearly described? A list of principle confounders is provided. | Yes=1 Partially=.5 No=0 | .5 | .5 | .5 | 1 | 1 | 1 | 1 | 0 ^{xviii} |

| | | | | | | | | | |
|--|-----------------|------------------|-----|-----|-------------------|--------------------|-------------------|------------------|-------------------|
| 8. Are the main findings of the study clearly described? Simple outcome data (including denominators and numerators) should be reported for all major findings so that the reader can check the major analyses and conclusions. (This question does not cover statistical tests that are considered below). | Yes=1 No=0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 9. Does the study provide estimates of the random variability in the data for the main outcomes? In non-normally distributed data, the inter-quartile range of results should be reported. In normally distributed data, the standard error, standard deviation, or confidence intervals should be reported. If the distribution of data is not described, it must be assumed that the estimates used were appropriate and the question should be answered yes. | Yes=1 No=0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 10. Have all important adverse events that may be a consequence of the intervention been reported? This should be answered yes if the study demonstrates that there was a comprehensive attempt to measure adverse events. | Yes=1 No=0 | 0 | 0 | 0 | 0 | 0 | 1 ^{xix} | 0 | 0 |
| 11. Have the characteristics of participants lost to follow-up been described? This should be answered yes where there were no losses to follow-up or where losses to follow-up were so small that findings would be unaffected by their inclusion. This should be answered no when a study does not report the numbers of participants lost to follow-up. | Yes = 1 No=0 | n/a | n/a | n/a | 1 | 1 | 1 | 1 | n/a ^{xx} |
| 12. Have actual probability values been reported (e.g. 0.035 rather than <0.05) for the main outcomes, except where the probability value is <0.001? If no <i>p</i> values are presented, the question should be answered 'no'. If <i>p</i> values presented and there is a mixture of reporting (some presented as < or > specific figures, some as equality, e.g. <i>p</i> = 0.034), question should be answered as yes. | Yes=1 No=0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| External validity All the following criteria attempt to address the representativeness of the findings of the study and whether they may be generalised to the population from which the study subjects were derived. | | | | | | | | | |
| 13. Were the subjects asked to participate in the | Yes=1 | 0 ^{xxi} | 0 | 0 | 1 ^{xxii} | 1 ^{xxiii} | 1 ^{xxiv} | 1 ^{xxv} | 0 |

| | | | | | | | | | |
|--|---|-----|-----|-----|---|---|---|---|-----|
| <p>study representative of the entire population from which they were recruited? The study must identify the source population for participants and describe how the participants were selected. Participants would be representative if they comprised the entire source population, an unselected sample of consecutive participants or random sample. Random sampling is only feasible where a list of all members of the relevant population exists. Where a study does not report the proportion of the source population from which the participants are derived, the question should be answered as unable to determine.</p> | No=0 Unable to determine=0 | | | | | | | | |
| <p>14. Were those subjects who were prepared to participate representative of the entire population from which they were recruited? The proportion of those asked and agreed to participate should be stated. Validation that the sample was representative would include demonstrating that the distribution of the main confounding factors was the same in the study sample and the source population</p> | Yes=1 No=0 Unable to determine =0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 |
| Internal Validity –bias | | | | | | | | | |
| <p>15. Was an attempt made to blind study subjects to the intervention they had received? For studies where the participants would have no way of knowing which intervention they received this would be answered yes.</p> | Yes=1 No=0 Unable to determine =0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| <p>16. Was an attempt made to blind those measuring the main outcomes of the intervention?</p> | Yes=1 No=0 Unable to determine=0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| <p>17. If any of the results of the study were based in “data dredging”, was this made clear? Any analyses that had not been planned at the outset of the study should be clearly indicated. If no retrospective unplanned subgroup analyses were reported, then answer yes.</p> | Yes=1 No=0 Unable to determine=0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| <p>18. In trials and cohort studies, do the analyses adjust for different lengths of follow-up of participants, or in case-control studies, is the time</p> | Yes =1 No=0 Unable to | n/a | n/a | n/a | 1 | 1 | 1 | 1 | n/a |

| | | | | | | | | | |
|--|--|-------------------|---------------------|---------------------|-------------------|-------------------|-------------------|--------------------|---|
| <p>period between the intervention and outcome the same for cases and controls?</p> <p>Where follow up was the same for all study participants, the answer should be yes. If different lengths of follow up were adjusted, for example by survival analysis, the answer should be yes. Studies where differences in follow-up are ignored should be answered no.</p> | determine =0 | | | | | | | | |
| <p>19. Were the statistical tests used to assess the main outcomes appropriate?</p> <p>The statistical tests used must be appropriate to the data. For example non-parametric methods should be used for small sample sizes. Where little statistical analysis has been undertaken but where there is no evidence of bias, the question should be answered yes. If the distribution of the data (normal or not) is not described it must be assumed that the estimates used were appropriate and the question should be answered yes.</p> | Yes =1 No=0 Unable to determine=0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| <p>20. Was compliance with the intervention checked ?</p> | Yes =1 No=0 Unable to determine=0 | 1 ^{xxvi} | 1 ^{xxvii} | 1 ^{xxviii} | 1 ^{xxix} | 1 ^{xxx} | 1 ^{xxxi} | 1 ^{xxxii} | 0 |
| <p>21. Were the main outcome measures used accurate (valid and reliable)?</p> <p>For studies where the main outcome measures are clearly described, the question should be answered yes. For studies that refer to other work or demonstrates the outcome measures are accurate, the question should be answered yes.</p> | Yes =1 No=0 Unable to determine =0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Internal Validity-Confounding (selection bias) | | | | | | | | | |
| <p>22. Were the participants in different intervention groups (trials and cohort studies) or were the cases and controls (case-control studies) recruited from the same population?</p> <p>For example, participants for all comparison groups should be selected from the same hospital. The question should be answered “unable to determine” for cohort and case studies where there is no information concerning the source of participants</p> | Yes=1 No=0 Unable to determine=0 | 1 | 0 ^{xxxiii} | 0 ^{xxxiv} | 1 | 0 ^{xxxv} | 1 | 1 | 1 |

| | | | | | | | | | |
|---|---|--------------------|---------------------|----------------------|------------------------|------------------|------------------|------------------|--------------------|
| included in the study. | | | | | | | | | |
| 23. Were study participants in different intervention groups (trials and cohort studies) or were cases and controls (case-control studies) recruited over the same period of time? For a study which does not specify a time period over which participants were recruited, the question should be answered “unable to determine”. | Yes=1 No=0 Unable to determine =0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 24. Were participants randomised to intervention groups? Studies that state that participants were randomised should be answered yes except where method of randomisation would not ensure random allocation. For example, alternate allocation would score 0 because it is predictable. | Yes=1 No=0 Unable to determine=0 | 1 ^{xxxvi} | 1 ^{xxxvii} | 0 ^{xxxviii} | 1 ^{xxxix} | 1 ^{xl} | 1 ^{xli} | 1 | 1 |
| 25. Was the randomised intervention assignment concealed from both participants and staff until recruitment was complete and irrevocable? All nonrandomized studies should be answered no. if assignment was concealed from participants but not from staff, it should be answered no. ^{xlii} | Yes=1 No=0 Unable to determine =0 | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 |
| 26. Were loses of participants to follow-up taken into account? If the number of participants lost to follow-up are not reported, the question should be answered as “unable to determine”. If the proportion lost to follow-up was too small to affect the main findings, the question should be answered yes. | Yes=1 No=0 Unable to determine=0 | n/a | n/a | n/a | 1 | 1 | 1 | 1 | n/a |
| Power | | | | | | | | | |
| 27. Was a sample size or power calculation done? | Yes=1 No=0 Unable to determine=0 | 0 | 0 ^{xliii} | 0 | 1 ^{xliiv} | 0 | 0 | 0 | 0 |
| | | 18.5/24 =77.01% | 15/24=62.5% | 12.5/24=52.01 % | 22.5/27 =83.33 % | 21/27=77. 78% | 22/27=81.48 % | 19/27=7 0.37% | 12.5/24=5 2.08% |

Adapted from Downs. S.H. & Black. N. (1998). The feasibility of creating a checklist for the assessment of the methodological quality both of randomised and non-randomised studies of health care interventions. *Journal of Epidemiology and Community health*, 52 (6), 377-84. **Footnotes at end of document**

Appendix F – Ethics approval letter

Ethics form removed for final version.

Appendix G - Ethics amendment approval letter

Ethics amendment approval letter removed for final version.

Ethics amendment approval letter removed for final version.

Appendix H - Semi-structured interview schedule

Interview schedule

Participants' understanding and interpretation of SH

1. What do you understand by term SH?
2. How do you find out about SH in pupils?
P: what do you think/feel when you find out?
P: what do you do?
3. What do you think are the reasons for it?
P: how do pupils explain it? **P** what do you think are the reasons?

Experiences with parents

4. Can you tell me about your experiences of talking to parents about ASH?
P: what are your thoughts/feelings before, during and after?
P: can you think of an example?
5. How do you think parents feel talking to you about this?
P: how do they react?
P: why do you think that they react in that way?
6. What do you think parents think about SH?
7. What do you think they think are the reasons for it?

Experiences with other school staff

8. At your work place who else is involved when an adolescent SHs?
9. What do you think other staff member think about SH?
P-What do you think they think are the reasons for it?
10. What has it been like working with other staff when an adolescent SHs?

Barriers and facilitators

11. What do you think has helped when working with pupils who SH and their parents?
12. What do you think has been unhelpful when working with pupils who SH and their parents?

Appendix I - Demographic questionnaire

Demographic information sheet

Please tick

1. What is your age in years?

.....

2. Are you male or female?

Male Female Prefer not to say

3. Which ethnic group describes you best?

- | | |
|---|--|
| <input type="checkbox"/> White British | <input type="checkbox"/> Other Asian background |
| <input type="checkbox"/> Other White background | <input type="checkbox"/> Black Caribbean and White |
| <input type="checkbox"/> Black British | <input type="checkbox"/> Black African and White |
| <input type="checkbox"/> Black African | <input type="checkbox"/> Asian and White |
| <input type="checkbox"/> Black Caribbean | <input type="checkbox"/> Other Dual Heritage |
| <input type="checkbox"/> Other Black background | <input type="checkbox"/> Chinese |
| <input type="checkbox"/> Indian | <input type="checkbox"/> Traveller |
| <input type="checkbox"/> Pakistani | <input type="checkbox"/> Bangladeshi |
| <input type="checkbox"/> Other Ethnic Group | <input type="checkbox"/> Prefer not to say |

4. Which relationship status describes you best?

- Single In a relationship Married Separated Divorced other
 Prefer not to say

5. What is your highest level of education?

.....

6. What is your current occupation?

.....

7. How long have you been in this role?

.....

8. What is the nature of your work?

.....
.....

9. What jobs have you had before your current one?

.....
.....

10. At work have you become aware of adolescents who self-harm?

.....

11. How did you become aware of the self-harm?

.....

12. Have you been in contact with families of adolescents who self-harm?

Yes No

13. Have you ever self-harmed?

Yes No Prefer not to say

14. Do you know of family members who have self-harmed?

Yes No Prefer not to say

15. Have you had any training on self-harm and if so what training was this?

.....
.....

Thank you for completing this questionnaire.

Appendix J - Participant inclusion and exclusion criteria and rationale

| Inclusion criteria | Rationale |
|---|--|
| Published in a peer reviewed journal | To ensure high quality articles |
| English Language | To enable reviewer to understand and analyse the article |
| Includes participants who are secondary school age based on the British education system (ie aged 11-18) | To enable comparisons between interventions aimed at children at the same developmental level chronologically. |
| Includes an active intervention | |
| Empirical design and included at least one standardised quantitative outcome measure (mixed designs to be included) | To enable evaluation of efficacy of intervention. |
| Uses an intervention which the authors conceptualise as a 'positive psychology' intervention | To enable evaluation of the body of work which is intentionally adhering to a positive psychology approach |
| Intervention is primarily aimed at promoting a or developing an ability, skill or strength rather than reducing a behaviour or 'pathology' (in line with Sin and Lyubomirsky (2009) definition of positive psychology interventions). | To ensure the approach is based on generally accepted positive psychology principle. |
| Intervention aimed at pupils who are in mainstream education. | Students in specialist provision or further education may have additional characteristics which makes comparisons less reliable |
| Any date | So that changes over time or in positive psychology interventions may be considered. |
| Any location | Interventions in any country will be included so that comparisons can be made. |
| Exclusion criteria | Rationale |
| Articles which are reviews, meta-analyses or meta-syntheses | To maintain manageability and clarity of the data and individual studies. |
| Participants are under the age of 11 or over 18. Where the sample bridges cut-offs the mean age of participants will be used. | To ensure that the samples are comparable to British secondary school age. |
| Participants are not in compulsory education | Those who enter into optional further education may have different characteristics than those who do not (eg SES, academic ability) therefore this sample may not be comparable with mainstream compulsory education. |
| Intervention aimed at specialist provision schools | Review aim to look at interventions designed for implementation in mainstream educational institutes. |

Appendix K - Study advert poster

Date:09/10/17
Version number:2



School staff experiences of adolescent self-harm



Hello, my name is Jayne and I am carrying out a research project as part of the Doctorate in Clinical Psychology course at the University of Hull. My study is into self-harm in secondary school pupils and I am particularly interested in the views of school staff as there is very little research into this area.

I would like to talk to any current or past members of school staff (including teachers, pastoral managers, school nurses, support staff etc) who have had contact with a student who has self-harmed and who has spoken to parents about it. The self-harm does not need to have occurred in the school, only that the member of staff is aware of it and has spoken to parents/carers about it. This may have been due to parents contacting the school, or the school contacting parents.

I would like to hear more about what this has been like for staff and to find out more about their experiences.

This study may be published in an academic journal and presented at conferences. It is hoped that this will be an interesting and useful study which will lead to a greater understanding of the topic of adolescent self-harm from the perspective of staff, so that services may better support staff and schools to manage it.

Could you tell me about your experiences?

Taking part in this research will involve initially speaking on the phone to check that you have enough information about the study and are happy to take part. We would then meet at a convenient location for a single 1:1 informal interview, which usually takes around an hour, where we would talk about your experiences of working with self-harm.

All information will be confidential and anonymous subject to relevant safeguarding policy and legislation.

If you are interested in taking part and would like more information, have questions, or would like to clarify anything, please get in touch by email J.E.Millward@2015.hull.ac.uk or by text or call (if unanswered please leave a message and I will get back to you). There is no obligation to take part and you are free to withdraw your interest or participation at any time.

Thank you for your interest.

Appendix L - Participant information sheet



Date: 09/10/17
Version Number: 2

Participant Information Sheet

Title of the study: School staff experiences of adolescent self-harm and talking to parents about this.

You are invited to take part in a study exploring school staff experiences of adolescent self-harm. So that you are able to decide whether or not to take part we would like to explain a little about the research and what it will involve. Please ask the researcher any questions that you may have about the study or your involvement.

What is the purpose of the study?

Individuals exist as part of larger systems, for example the family system, school system or social systems. School staff are an important part of an adolescent's system and research suggests that pupil wellbeing can be improved when they feel supported by the people around them, such as friends, teachers and parents. Adolescent self-harm is increasing and school staff are often the first to become aware of it. Research exists into the experiences of adolescents and parents, however there is very little research into the perspectives of school staff. This study aims to explore the experiences school staff when working with self-harm. It is hoped that through this research we will find out more about self-harm from the perspective of staff themselves to increase understanding of the system around the adolescent who self-harms.

Why have I been invited?

We are asking people who have worked in secondary schools and have spoken to parents about adolescent self-harm to share their experiences.

What will I have to do?

If you are interested in taking part and sharing your experiences you will be invited to take part in a one to one interview with the researcher. This interview will be arranged at a time and place that is convenient for you. The interview will take place privately and can be away from the school setting to ensure full confidentiality.

During the interview the researcher will ask you questions about your experiences of working with people when adolescent self-harm occurs. They will ask about your experiences and what you think might have helped or hindered this work. The interview will be audio recorded.

What will happen to the recording?

The recording of the interview will be stored electronically. The researcher you speak to will be the only person who will have access to it. They will listen to this recording and transcribe the interview. The transcribed interview will be anonymous (so people will not be able to identify you or anyone else from it) and this will be stored securely. After the interview has been transcribed, the recording will be destroyed.

Date: 09/10/17
Version Number: 2

Do I have to take part and what if I change my mind?

You do not have to take part in the study, participation is completely voluntary. If you do decide to take part you will be asked to sign a consent form to indicate that you agree to take part. Even when you have given consent to take part you are still free to withdraw from the study at any time and for any reason up until the time when the data is analysed. You will not need to give any reason for changing your mind and withdrawing from the study.

Will other people know what I have said?

When talking to the researcher you may talk about or mention things which you do not want other people to know about. Everything that you say to the researcher and during the interview will be anonymous and confidential. Data that is not anonymous, such as consent forms which may have your name on, will be stored at the University of Hull separately from the interview recording and the transcribed interview.

In some instances it may be necessary to break confidentiality, for example if you tell the researcher something which they think puts you or someone else at risk. If this were to happen, the researcher would discuss this with you first before any actions were taken, but the researcher may need to tell someone else first without asking you.

What will happen to the results of the study?

The results of the study will be written up and form part of the researcher's thesis. It may be submitted for publication in an academic journal or be presented at conferences. Direct quotes may be used in the write up of the study but these will be anonymous. All personal details will be removed and there will be no information which will identify you.

Who is organizing and funding the study?

The researcher is a trainee on the Doctorate in Clinical Psychology programme at the University of Hull and is employed by Humber NHS Foundation Trust. The study is part of her doctoral research project. The Research expenses are paid by the University of Hull.

Who has reviewed the study?

This study has been reviewed and approved by the School of Health and Social Work Research Ethics Committee at the University of Hull.

What is there is a problem?

If you have any questions about the study you can contact the researcher, Jayne Millward on 07576828208 and she will try to answer any questions. If you still have further questions and would like to speak to someone else you can contact the research supervisor (details below) or the Associate Dean for Research, Faculty of Health and Social Care, University of Hull, Cottingham Road, Hull, HU6 7RX. 01482 463 342.

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Expenses and payments

Your participation in this study is entirely voluntary and there will be no payment for taking part. However, should you wish to come to the University of Hull for the interview, you will be reimbursed for any travel expenses.

Are there any disadvantages or risks to taking part in the study?

The study will require up to 60 minutes of your time. Some people can find it upsetting to talk about their experiences and the interview may bring to mind some things which you may find difficult about your work. However, if this does happen to you the researcher can give you details of organisations which can offer support for you to consider.

Are there any possible benefits to taking part in the study?

Although you will not be paid for your participation in the study, many people say that they find it useful to talk about their experiences. It is hoped that the information gained from school staff in this study will help to contribute to a greater understanding of how school staff can be supported to work with adolescent self-harm. This may help to improve future service provision, training and support for school staff in the future.

I am interested in taking part in the study and would like further information

If you are interested in participating, you can contact the researcher via the following contact details:

Researcher **Jayne Millward**
Doctorate Programme in Clinical Psychology
Aire building, University of Hull
Cottingham Road
Hull
HU6 7RX

Telephone: _____ (please leave a message if the call is not answered and the researcher will get back to you)

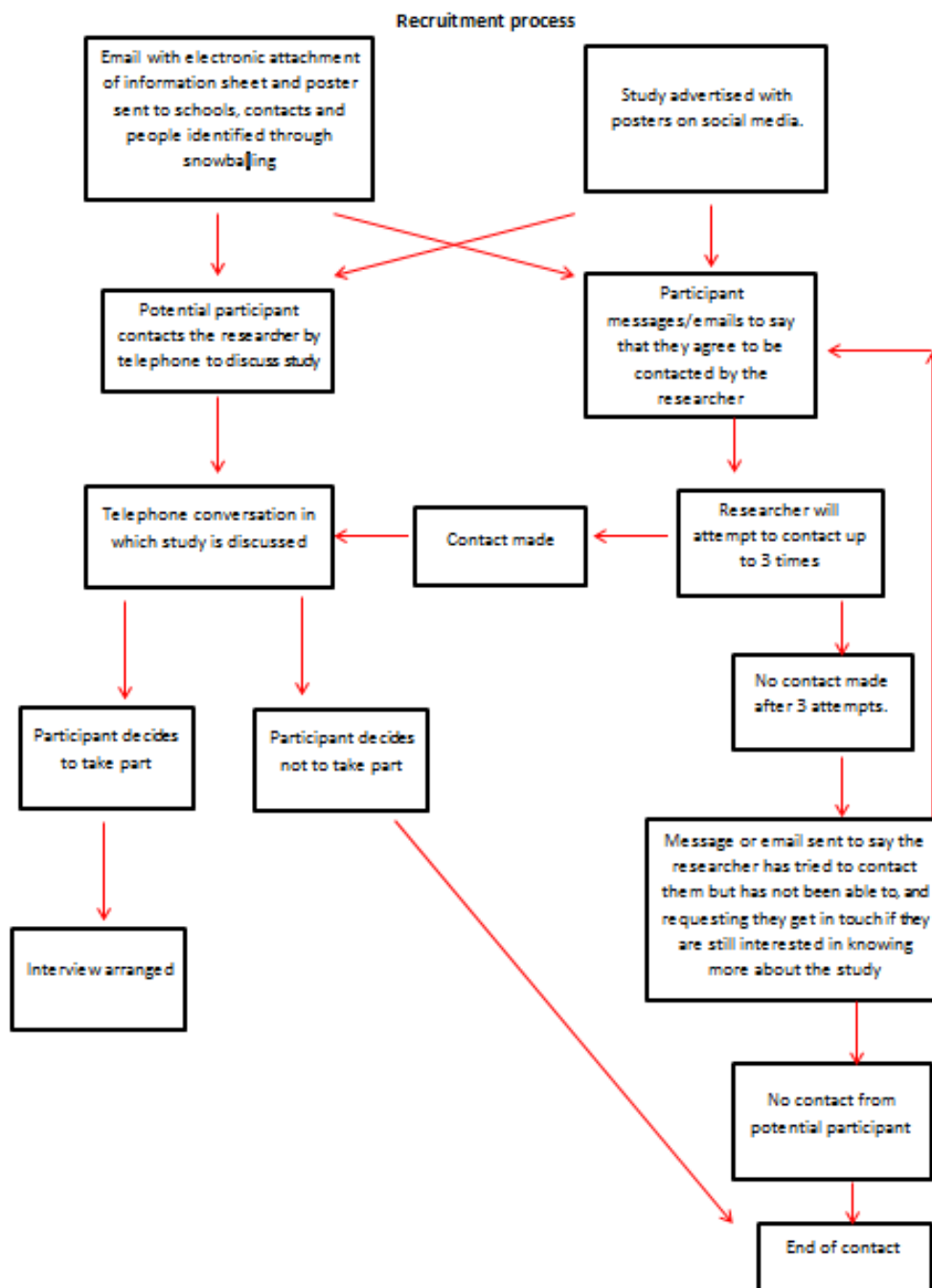
Email: J.E.Millward@2015.hull.ac.uk

This research project is being supervised by:

Dr Annette Schlösser
Doctorate Programme in Clinical Psychology
Aire Building, Room 129, University of Hull
Cottingham Road
Hull
HU6 7RX
E-mail: a.schlösser@hull.ac.uk

Thank you very much for your interest

Appendix M - Recruitment protocol



Appendix N -Participant consent form

CONSENT FORM

Title of Project: School staff experiences of adolescent self-harm and talking to parents about this.

Name of Researcher: Jayne Millward

Please initial boxes

1. I confirm that I have read and understand the information

sheet for the above study. I have had the chance to think about the information, ask questions, and have had these answered.

2. I understand that taking part is voluntary and that I am free to withdraw at any time without giving a reason up to the point of the data being analysed. This will not affect my role or relationship with colleagues.

3. I understand that some of the data collected during the research may be looked at by individuals from the University of Hull, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.

4. I confirm that direct quotes from the interview may be used in future publications or conferences and understand that they will be anonymized and will not breach confidentiality.

5. I agree to take part in the interview and understand that it will be recorded.

Name of participant

Date

Signature

| | | |
|----------------------------------|-------|-----------|
| _____ | _____ | _____ |
| - | | - |
| Name of person taking consent | Date | Signature |
| _____ | _____ | _____ |
| - | - | - |

Appendix O - Participant sources of support sheet

Version 1



Sources of support

Thank you for taking part in this study and for talking to me about your experiences. If after talking to me you would like any further support there are a number of organisations that can offer support to individuals who self-harm, their friends and families.

Samaritans – call 116 123 (open 24 hours a day), email: jo@samaritans.org or visit your local Samaritans branch

Mind – National organisation call 0300 123 3393 or text 86463 (9am-6pm on weekdays)

Or locally

Hull and East Yorkshire Mind

Wellington House
108 Beverley Road
Hull
HU3 1YA
Tel: 01482 240200
Info line: 01482 240133
Fax: 01482 336878
Email: info@heyhound.org.uk

Harmless – email info@harmless.org.uk

National Self Harm Network forums

YoungMinds Parents Helpline – call 0808 802 5544 (9.30-4pm on weekdays)

Your school and G.P may also be able to offer advice about what services are available locally.

Appendix P - Example of data analysis (P5 pages 8-11)

| Exploratory comments | P5 original transcript | Emergent themes |
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| <p>Parents contacted immediately-seen as important?</p> <p>GP immediately (sense of urgency) GP-medical model</p> <p>Speak to child first</p> <p>Pupils are normally relieved that parents will be told</p> <p>Pupils relief that they can talk about their problems. 'something wrong in their life' SH has enabled a conversation as they contact about the SH but this opens up conversations about what is wrong.</p> <p>Empathy with the teenagers and how difficult it is to start conversations.</p> <p><u>What kind of responses do you usually get from parents?</u></p> <p>'Every story is different and you are never going to get a story that is the same'</p> | <p>P5: if we are aware that student if self-harming parents are contacted immediately and ...erm... then we would always suggest that are taken to the GP immediately or as soon as they can get an appointment</p> <p>R: do you have a conversation with the pupils first?</p> <p>P5: To tell them that we will be phoning home?</p> <p>R: yeah,</p> <p>P5: yes, we always do.</p> <p>R: How do children respond to that generally?</p> <p>P5: <i>Normally relief.</i></p> <p>R: ah that's interesting, why do you think that is?</p> <p>P5: why do I think that is? I think its probably because suddenly they are talking about that there is something wrong in their life.</p> <p>R: ah so a sense that actually they've maybe been waiting to speak to someone about this and then actually that support is there in some way.</p> <p>P5: yes, I would say, I think sometimes being a teenager it is difficult, and you don't know how to start the conversations.</p> <p>R: OK so generally <i>relief</i> from the students that you are contacting parents, generally. So then when you do contact parents, which I understand you've been involved in, what kind of responses do you get from parents is there a general? Are they all different? Is there kind of a range of responses you get?</p> <p>P5: I suppose every story is different and you are never</p> | <p>Parents contacted immediately</p> <p>GP immediately –medical model Sense of urgency</p> <p>pupils want parents to know? relieved to have parents involved</p> <p>pupils relieved SH enables conversations about what is 'wrong'</p> <p>Staff empathy with difficulties of being teenage</p> <p>SH has a story-journey?-all different</p> |

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| <p>Says about the story</p> <p>Disbelief</p> <p>Very upsetting for parents</p> <p>Some are already aware of it and have seen GP-have not communicated this to the school?</p> <p>'Unite' to meet the child's needs.</p> <p>It's about offering support and if parents ask telling them what to do</p> <p>use of 'tell' and this is changed <u>to guide them'</u> careful use of language and filtering.</p> <p>Practical strategies to prevent SH.</p> <p>'recommend' less powerful stance taken than 'telling'</p> <p>Conversation X3- shows the importance of communication</p> <p>This part of the answer feels less panicked than initial response.</p> <p>Sense they see need for parents to access other professionals</p> | <p>going to get a story that is the same and I think that it could be for so many different reasons that that child is self-harming, erm... I think there's sometimes an element of <u>disbelief form parents</u> that they weren't aware of it so that first phone call home is very upsetting for the parents, erm and then you will get parents that probably are aware of it and they will say to you I've been to the GP and erm obviously then we I suppose <u>unite</u> in terms of making sure that we are meeting the child's needs and if necessary a meeting will be had with the nurses and member of staff and parents or guardians whoever it is and the child erm, <u>so they feel supported</u>. And then I suppose there is an element of the parents saying ' <u>what shall I do</u>' and as I said earlier <u>you tell them, guide them</u> to obviously making sure that if you can you remove any items that they might be using to self-harm so for instance if it's a common one seems to be the pencil sharpener razor...</p> <p>R: right OK</p> <p>P5: so we <u>recommend</u> that they remove sharp objects if possible and obviously have the <u>conversation</u> with the child and find how they have been self-harming erm and that so that's a <u>conversation</u> that needs to be had and then just <u>following the right routes making sure that they are cleaned that they are bathed making sure that they are dressed if they need to</u> and then the <u>next step is probably to go down the doctor route</u> to open up the <u>conversation</u> with more</p> | <p>Parental disbelief</p> <p>Parents upset</p> <p>Range of parental awareness</p> <p>Parents and staff unite</p> <p>Supporting parents</p> <p>Ambiguity about role-and how authoritarian their stance is? Do they guide or tell?</p> <p>Practical strategies-in their role</p> <p>Less authoritarian stance</p> <p>Stress the importance of child-parent communication</p> <p>More practical strategies</p> <p>School support not enough?</p> |
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| <p><u>How do you feel personally about having these conversations with parents?</u></p> <p>'no' doesn't feel at all apprehensive? Goes to the role they are in</p> <p>Talks about it being hard to begin with when first in the role.</p> <p>Tails off, hesitation to the speech. Uses 'you' instead of 'I'</p> <p>'the most important thing in your job is that you inform the parents' More important than what? Own feelings?</p> <p>Have to be careful how they do it.</p> <p>Listening.</p> <p>Coming to a decision together supporting the child.</p> <p>All what they do rather than what they feel.</p> <p><u>Is there anything that makes the conversations easier?</u></p> <p>Nothing makes the conversation with parents easier 'it is never a nice phone call to make'</p> <p>Sadness that the child is struggling</p> <p>the self-harm is about control.</p> <p>Links it to other forms of Self-harm – anorexia and bulimia. Controlx3</p> | <p>professionals.</p> <p>R: right. OK so some quite practical tips there and useful strategies for parents thinking about managing it. How do you feel personally about having those conversations is it something you feel apprehensive about or something you feel quite comfortable with?</p> <p>P5: No, ...probably in the beginning of sort of when I was in the pastoral role I would probably find it quite hard to phone a parents and say your child is self-harming, but I think you you... I suppose having done it for quite some years now you you find that the most important thing in your job is that you inform the parents... you're careful with how you inform the parents and then I suppose mostly a case of listening to the feedback from the parents and coming to a decision together about what is the best way to support your child?</p> <p>R:so I suppose there is a real sense of working together isn't there</p> <p>P5:absolutely</p> <p>R:erm... so you feel more confident as your career has progressed in speaking to parents and more comfortable with that. Is there anything that makes those conversations easier?</p> <p>P5:erm... not really... in the sense that it is never a nice phone call to make, erm because at the end of the day its actually very sad when you are dealing with a young person that is unable to deal with life and feels that the only way to cope with it or control it at that time is self-harm. Erm... I suppose going</p> | <p>Developing confidence to talk to parents about SH through experience</p> <p>Focus is on informing the parents rather than personal feelings</p> <p>Careful, precarious relationship?</p> <p>Listening</p> <p>Decision-implies a solution or definitive option?</p> <p>Unpleasant conversation with parents.</p> <p>Sadness</p> <p>SH as control</p> <p>SH takes different forms</p> |
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| <p>'so no I don't think the conversations ever get easier' -this contradicts what was said earlier- they said about how in the beginning it was quite hard- here they say it doesn't get easier 'the important thing is that strategies are put in place to support the child'</p> <p>Sense of just having to get on with it. They don't feel that it gets easier but the needs of the child take precedent.</p> | <p>back to what you said earlier things are popping into my head like anorexia and bulimia and other things that are you know I see students trying to control when they feel out of control erm so no I don't think the conversations ever get easier I just think the most important thing is that the strategies are put in place to support that child.</p> | <p>Ambivalence about how hard the conversations with parents are.</p> |
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Appendix Q - Table of supporting quotes

| Superordinate theme | Sub theme | P | Quotes |
|---------------------|--------------------------------|---------------------------|---|
| Involving parents | No-one wants to talk about it. | P1, P2, P3, P4, P5, P6 | <p><i>'I felt like maybe they would go 'well who do you think you are to tell me what to do?' So ... that was quite nerve wrecking' P4 (249)</i></p> <p><i>'for me it's always take a deep breath how yeah how are you going to break this to that parent cos again it's not knowing their reaction so some people can be quite reluctant, you might be met with the aggression, again we've got to remember that they are possibly in shock and its oh my goodness, you know' P2 (185)</i></p> <p><i>'I would say the most common one for me is definitely the erm (*long pause*) marking themselves' P2 (12)</i></p> <p><i>'if it was one of my kids I think I'd like to tell the teacher first but none of them did' P4 (273)</i></p> <p><i>'his parents were really high achievers and they wouldn't accept a referral to CAMHS because they were worried about the impact that would have on his career' P3 (391)</i></p> <p><i>'I think people think if we ignore it it might go away [...] I think sometimes it's the stigma that goes to it' P2 (156)</i></p> |
| | Being a mediator. | P1, P2, P3, P5, P6 | <p><i>'...I don't know sort of gave him the heads-up really so that he (Dad) could behave in a certain way, cos obviously we know that some parents react really really badly, some parents are guna be upset and angry that their child's done that, but I think that the way we go about it is making sure that the conversation is had in a safe place' P3 (231).</i></p> <p><i>'mum wanted to know everything and we kept saying 'it's confidential' P3 (299),</i></p> <p><i>'We we always have to again safeguarding, so we always always have to contact erm the family member, carer or anything to make them aware of why...Erm usually in in most cases for me the child initially is freaks out and is not happy with that' P2 (107)</i></p> <p><i>'[the pupil said] 'if you tell my parents you're guna make me do this more' [that was] really difficult because...I knew ultimately we had to pass that on and we did, and we had to pass it on and the relationship broke down' P3</i></p> |

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| The emotional impact. | P1, P2, P3, P4, P5, P6 | <p><i>'we have a job to do' P3(214), 'I see that as part of my role' P1 (64)</i></p> <p><i>'I think sometimes I feel quite helpless, erm and er helpless and then sometimes frustrated so er I suppose for me after that conversation on Friday [with a parent] I felt both helpless and really really worried and anxious [...] and I feel a huge sense of responsibility' P1 (314)</i></p> <p><i>'worry, genuine worry [...] you'll read on the local news websites of whatever that someone has killed themselves, a young person and then I'm just, my anxiety just goes up and I think 'oh god what if it's one of the children I work with?' and so yeah worry for holidays and times I'm not there' P3 (447)</i></p> <p><i>'But I think what I've got to do is hold it together for that parent or carer at that time and then it after it's that, *symbolises dropping something with hand/ letting go gesture* and you know might have a little cry to yourself or whatever, erm, but then you've got to get on and not show them and be positive moving forward' P2 (204)</i></p> |
| Making sense of SH | 'They fall into two groups really'. P1, P2, P3, P5, P6 | <p><i>'they fall into two groups really, the ones who er, this sounds awful but [some pupils] making a really big fuss, often quite superficial cuts' P6 (75)</i></p> <p><i>'students that are doing it that are suffering internally and are not really telling anyone...and they are the ones that are more difficult as you are not aware of it until it becomes a bit more serious' P5 (75)</i></p> <p><i>'erm...er...er...to be honest there's a few that stand out and er...they are frightening and you know they frighten you and concern you about what could have been' P5 (275)</i></p> |
| Every story is different. | P1, P2, P3, P5, P6 | <p><i>'erm (*sigh*) immediately you know the first question you ask is why? er cos sometimes I think you're quite...you know it's like what ...what person SHs? How do we define that self-harmer and it could be anyone so it's why erm definitely why' P2 (69)</i></p> <p><i>'it might be the students erm self-esteem, it may be being bullied, it may be parents being separated. Erm for me one of those most extreme cases for me was erm a student that was in a very violent and controlling relationship with her boyfriend' P2 (41)</i></p> |

*'there's benefit pressures, I think there's job pressures, I think there's lots of parents in (area) 'For the majority the reason for it is that they feel unable to cope with the pressures of whatever it is that they are dealing with whether it's to do with their home life, their school life, erm...academia, not having friends, there doesn't seem to be a rule for why a student would SH' P5 (80)
who er struggle find work[...]yeah poverty' P1 (114)*

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| Challenged perceptions. | P1,P2, P3, P4, P5, P6 | <i>'you'd have quite a lot of 'oh you're into this music, you dress in black so you probably hurt yourself' so there were a lot of labels and stereotypes for self-harm from what I've heard of from college, erm and I think that changed a lot' P4 (31).</i> |
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'...I think for one most definitely the family was a very very well educated family a very well respected family. The girl was an A student who always skipped about school and as as jolly as anything and you just get the impression that the world is just so rosy, it's just so lovely, and I suppose from how they speak' P2 (314)*

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| Coping and solutions. | The importance of support. | P1, P2, P3, P4, P5, P6 | <i>'It's really good to have other people to talk to about it so other professionals and people higher up' P4 (358) 'Nothing [support for staff] and that's where teaching is very very wrong really. There's nothing. I come home and have to talk to my husband or someone [...] there's no recognition that staff need the equivalent of supervision really. Staff dealing with this should have some sort of supervision' P6 (288)</i> |
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|---|-----------------------|--|
| The role of teaching staff. | P1, P2, P3, P4, P6 | <p><i>'if you've struck a bond with a teacher its them that could be doing and helping' P4 (415)</i></p> <p><i>'I'll be honest in that I think that a lot of form tutors and teachers automatically think 'this is safeguarding' and bat it over...they don't want to be held responsible if something does happen [...] they haven't necessarily got the time, but I don't think that it's about the time, I think it's about this sort of responsibility that this is quite serious' P6 (238)</i></p> <p><i>'we still need to break those stereotypes with teachers as well' P2 (497)</i></p> <p><i>'I would think a lot of them [staff] would think like I did when I first started 'oh look at me I need attention' P4 (593)</i></p> <p><i>'it would be nice to develop their roles [teachers] if they are seeing them in form tutor...if they are comfortable with it' P6 (244)</i></p> |
| Feeling overwhelmed but maintaining hope. | P1, P2, P3, P5, P6 | <p><i>'you are picking up the pieces from previous days and it's that cumulative thing really cos what you dealt with today won't go away, you haven't dealt with it today and that's the end of it so you get your new cases tomorrow but you've still got the fallout from the previous days' P6 (318)</i></p> <p><i>'it's not about me it's about them' P3 (460)</i></p> |

Appendix R – Epistemological statement

Epistemology is the study of knowledge and how it is studied and obtained (Snape & Spencer, 2003). The views, beliefs and assumptions of the researcher will influence how they carry out research which will in turn determine the methodology which is chosen and the approach taken (Snape & Spencer, 2003). It is therefore important to consider the epistemological stance of the researcher and so it will be outlined in this statement.

Epistemological stances can be thought of as existing on a continuum (Willig, 2013). At one end positivist approaches assume there is a measurable ‘truth’ which exists, and at the other end is social constructionism, which proposes that there is not a single truth or reality but that reality is constructed through language and there can therefore be multiple realities.

Before clinical training the researcher adopted a positivist/realist stance and was familiar with objective measuring in research. Initially they aimed to approach the research project from this stance; however, it quickly became clear that little was known about the area of interest. The researcher was reluctant to adopt a more explorative stance due to reservations about such research would be reliable and inform practice.

The researcher identified that their interest lay in understanding how people make sense of their individual subjective experiences of a particular phenomena, and that qualitative research provides a way of exploring this. The researcher therefore holds a post-positivist position.

Interpretative Phenomenological Analysis (IPA) was therefore chosen as it allows exploration of subjective experience and personal perspectives. One of the key features of IPA is that it focuses on a particular context and on people who share a common experience and explores their personal meaning and sense-making (Smith et al., 2009).

IPA allowed exploration of participant’s subjective experiences of this previous

unexplored area, it also allowed for the capture of unique insights into how the participants made sense of these experiences. In particular the interest of the researcher in the dynamics of relationship and our lived experience and sense making of these lent itself to IPA.

Although the researcher's undergraduate research employed quantitative analysis it did explore the phenomenological quality of participant's thoughts about the past and future by comparing two groups to assess whether they were qualitatively different. This indicates the researcher's interest in understanding of subjective experience but with the previous methodology being nomothetic and the current idiographic.

The researcher acknowledged the double hermeneutic in IPA as the research attempts to makes sense of the participants attempts to make sense of an experience. Reflective practice and supervision were used throughout to reflect on the assumptions and views which informed the analytic process.

References

Smith, J. A., Flowers, P. & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. Sage: London.

Snape, D. & Spencer, L. (2003). *The Foundations of Qualitative Research in Qualitative research practice: A Guide for Social Science Students and Researchers*. London: SAGE Publications Ltd.

Willig, C. (2013). *Introducing Qualitative Research in Psychology: Third Edition*. Berkshire, UK: Open University Press.

Appendix S – Reflective statement

During the research process I kept a reflective journal in which I noted my thoughts and feelings before and after interviews and at various points during data collection, analysis and write up. I also attended qualitative research reflective practice groups and had a number of discussions with my research supervisor all of which informs this reflective statement.

To begin with I was unsure which area of interest would I like to explore, and wondered about what it would be like to be immersed in a particular subject area for nearly three years. Having had an initial placement in adult services I became interested in the concept of a ‘personality disorder’ and how this label evoked certain reactions from staff. It was during these placements that I first heard mention of ‘emergent personality disorder’ being used to describe young adults who had come to the service at 18 from Child and Adolescent Mental Health Services (CAMHS) who had a history of displaying impulsive or risky behaviours such as self-harm. I have a lot of difficulty with this term for a number of reasons, firstly because of the arguments against the concept of a ‘personality disorder’ itself and the detrimental effects of the use of this label, but also an awareness that people have told me they have very different feelings about this diagnosis, some disliking it and feeling ashamed, others feeling relieved to have an ‘explanation’. I also know that as practitioners diagnosis can help to direct and plan services and truthfully I still haven’t fully decided how I feel about the whole diagnosis debate. The diagnosis debate is too big to cover here but primarily something about labelling a young person in particular sits quite uncomfortably with me and the associated stigma that comes with some labels. I think part of this unease comes from reflecting on the fact that historically young people engage in behaviours which the preceding generation, certainly anecdotally, can struggle to make sense of and often perceive as reckless, irresponsible and unsafe. Where then do we draw the line from

teenage behaviour to an ‘emerging personality disorder’? As the research progress the focus became broader than initially planned and moved beyond the teacher’s experiences of directly communicating with parents as staff talked more broadly about their experiences of working in this area and the needs that they have in relations to this work.

I also have a natural interest in relationships and the dynamics of interpersonal relationships and how and why we respond to others (and labels) as we do. Alongside this general wondering about how we understand and respond to young people’s mental health I also have two children who were embarking on secondary school as thesis planning commenced. This inevitably influenced my area of interest. I heard from other parents alarming stories about the prevalence of self-harm in schools (as well as many other behaviours I would perceive as risky and worrying; smoking, drugs, bullying, promiscuity, etc).

I wanted to conduct research which took a positive slant on this stage of development, however tellingly this did not end up being the case, perhaps highlighting a maternal preoccupation with potential risks for young people which can be more salient. The positive focus was brought in in my systematic literature review which looked at positive psychology interventions for adolescents. This offered a welcome change of focus against the quite heavy themes of the empirical paper.

I felt naturally drawn to quantitative research, perhaps due to familiarity from undergraduate research, perhaps due to wanting to find an answer in a very positivist sense. However as the research question developed it became clear that my interest was in understanding interpersonal experiences and so a qualitative methodology would be preferable.

The design stage took much longer than it should have and I think this is in part because what I am interested in (ie dynamics of relationships and peoples experiences of these) required a shift in my research thinking from focusing on what is measurable to what is experienced. Initially, I struggled to see what value lay in understanding a handful of people's experiences in terms of what it would add to the literature when this information may not be generalizable and could not be 'proved' using statistical methods. I viewed it as interesting but perhaps not theoretically valuable. This is something that I continued to struggle with until data analysis when it became clear that the value lay in bringing to life peoples experiences and telling that story which may have not been told without the research being of a qualitative nature. I think at this point I stopped seeing research value being 'either/or' and starting to think of it as 'and' with a place for both qualitative and quantitative methods.

I had initially planned to recruit parents however after presenting my research plan to peers and discussing with numerous people the general consensus was felt to be that parents would be apprehensive about taking part and recruitment would be difficult. I therefore decided to focus on staff-parent communication from the perspective of school staff. I had envisioned a large pool of staff eager to tell me their stories, in reality recruitment was very challenging. I contacted endless local schools, as did friends, colleagues and contacts and people seemed interested and convinced people would take part. However, during the whole course of the research no schools responded to my request to go in to talk to them about my research. This perhaps reflects how busy schools are and that actually research which does not directly benefit the pupils is understandably perhaps not a high priority. It also perhaps reflected some of the stigma which surrounds self-harm and demonstrates reluctance even among schools to discuss this topic which perhaps mirrors the experience of parents and adolescents themselves. This was really disappointing. I started to focus on who I knew worked in schools and

in using these contacts and managed to complete my first interview in October 2017. I was really relieved as ethical approval had been granted just before the summer holidays so it took 3 months to get 1 interview.

One of the problems that soon became apparent was that in school most staff do not have any contact with parents about self-harm and it tended to be one or two people in each school who do this. There were a number of staff members who agreed to take part but weren't eligible and this was very frustrating. A lot of time was spent chasing up potential participants but with no response.

One participant had agreed to take part but the school vetoed this and said that they would not allow her to do this. I think there were a number of reasons for this. Concerns about confidentiality were mentioned by some potential participants and reassurance about the steps taken seemed to alleviate this anxiety. But I think that actually this highlights the 'hidden' nature of SH and the difficulty talking about it which was evident at times in interview.

Other trainees past and present were crucial in recruitment. Several participants were recruited through trainees and some were identified who could not take part. Although not all led to interviews I greatly appreciated that support and interest and this kept me motivated at times when I thought I would never get enough interviews. I think that the fact that the trainees empathised and saw the importance of the research really helped.

I generally felt slightly nervous before interviews and worried about whether there would be enough to talk about however this quite quickly abated once the interview started. I think this was related to being in a different role whereby I would not be using clinical skills or be able to 'offer something'. Following interviews I frequently felt overwhelmed by the amount that had been said and how I would make sense of this which in hind sight appears to parallel the experiences of participants.

I found the process of transcription boring but familiar so on some level felt ok with this as it felt like I knew what I was doing. Developing themes was the most difficult process for me as I felt overwhelmed by both the amount of data and by the complexity and inter-linkedness of the information. I think this mirrored a process experienced by the participants. This even extended to seeking support about my themes from several university staff members as I felt unable to manage this task on my own. I felt aware of this process at the time which did help my analysis but it was also challenging.

Writing up work has never been one of my strengths as I tend to jump from one idea to the next and lack structure and this was compounded by the processes which occurred. The interpretative nature of IPA meant that this was also a very new way of writing up findings and I craved some sort of familiarity and sense that understood the method throughout.

I have reflected on what I might have done differently which might have made this work easier. I think at times I avoided thesis as I felt so overwhelmed by it and didn't know where to begin. I would like to think that I would be less avoidant in the future but realistically I think perhaps this is how I work. I think ultimately doing a thesis (or doing most things that are worthwhile or new) is hard work. I probably would approach a future qualitative project differently but more as a result of having a better understanding of the process and appreciation of the value of the method and through maturation as a researcher.

I chose to submit to the Oxford Journal of Education for both my systematic literature review and empirical paper as it was felt that this would enable the research to reach an audience with an interest in education and where it may impact educational practices.

An international journal was chosen due to the fact that the SLR studies included covered four countries and would be of interest in other countries and because self-harm

is currently a problems across numerous countries and so the studies finding might be of interest internationally.

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- ⁱ schools chosen based on proximity to the research institute and non-governmental (excluded if governmental)
 - ⁱⁱ one school which approached the researchers. Control school-not clear how selected
 - ⁱⁱⁱ worker at school interested.
 - ^{iv} letters sent to 42 schools (excluded ultra-orthodox religious schools and special educational schools).
 - ^v states the religion of the schools but did not formally assess the level, location and that they are non-governmental
 - ^{vi} gives the number of pupils in school, age, academic rating of school, and SES of intervention school but not clear for control school.
 - ^{vii} SES and ethnicity collected
 - ^{viii} age, gender, religion, SES, family status. Intervention school randomly selected from those possible and control picked as had similar social-demographic features
 - ^{ix} SES and religion data. Includes exclusion criteria. Details of teacher age, gender, SES and marital status and teaching experience given. Details of trainers given.
 - ^x age and gender
 - ^{xi} age and gender
 - ^{xii} age and gender
 - ^{xiii} age, gender, ethnicity, SES
 - ^{xiv} age, gender, SES, Religion, family status
 - ^{xv} age, gender, SES, family status, religion data
 - ^{xvi} age, gender, SES, ethnicity, parental marital status, and guardianship
 - ^{xvii} age and gender
 - ^{xviii} no standard deviation
 - ^{xix} offered counselling of debriefing. No-one felt they were negatively affected
 - ^{xx} follow-up not currently completed
 - ^{xxi} 1 school grade took part- not possible to know if these were representative
 - ^{xxii} Whole school screened
 - ^{xxiii} Whole school used and matched to control
 - ^{xxiv} Whole schools used
 - ^{xxv} Whole school screened
 - ^{xxvi} 2 of 4 schools dropped out. Gave reasons which are reported. Pupil engagement checked
 - ^{xxvii} recorded adherence as high
 - ^{xxviii} 70% completed but adherence unclear
 - ^{xxix} fidelity high but completion by parent low
 - ^{xxx} fidelity was checked
 - ^{xxxi} fidelity checked and reported
 - ^{xxxii} reports 100% fidelity
 - ^{xxxiii} different schools
 - ^{xxxiv} mix of schools and years
 - ^{xxxv} different schools but matched
 - ^{xxxvi} Excel randomisation
 - ^{xxxvii} cluster randomisation
 - ^{xxxviii} school assigned classes to intervention or control
 - ^{xxxix} stratified random assignment
 - ^{xl} school was randomly selected for intervention and matched control picked
 - ^{xli} matched classes randomised

^{xliii} states and a priori power analysis was not conducted as the sample was opportunistic and that program delivery was organised before the evaluation was designed

^{xliv} Estimated power .80 assuming an alpha of .05.