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The emotional well-being of young people: a review of the literature.

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**THE
ROBERT GORDON
UNIVERSITY**
ABERDEEN

The Emotional Well-Being of Young People: A Review of the Literature

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February 2005

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1. Background to the Literature Survey

1.1 The Global Problem of Suicide

Suicide is increasingly described by governments and policy-makers as a global public health problem. Between 1950 and 1995 global suicide rates have increased by 60%. In 2000, 815,000 completed suicides were recorded worldwide with rates of 14.5 per 100,000 globally and 19.1 per 100,000 in the European Region (WHO: EHEN 2003: 6). The highest rates in Europe are also the highest rates worldwide. Suicide rates are also affected by under-reporting, with some estimates suggesting the scale of under-reporting to be between 30 and 200 per cent (Crowley et al 2004).

In recent years concerns have been expressed in Scotland and the UK about rising suicide rates amongst children and young people and the accumulation of increasing evidence that the adoption of negative coping strategies is contributing to rising levels of deliberate self harm (DSH). Ten per cent of 15 and 16 year olds in a large survey carried out in England (Hawton et al 2002) reported that they had engaged in DSH, seven per cent in the previous 12 months. Girls were four times more likely to self-harm than boys. Despite a recognition that the highest suicide rates worldwide are amongst the 20-24 age range, it has been suggested that suicidal behaviour preceding completed suicide begins to develop much earlier in life. Westefeld et al (2000) also note that, 'suicide risk increases with age' and that 'the elderly have the highest suicide rates of all age groups', though this may be hidden as other causes of death from chronic illness also rise in the older age groups. Conversely, in 2003, 'suicide and undetermined death' was the main cause of death for both males and females between the ages of 15 and 34 in Scotland, ahead of 'accidents' and 'mental disorders' for males (the latter almost exclusively associated with drug and alcohol abuse) and 'cancer' for females (GROS 2003). It needs to be remembered that young people are not as susceptible to the diseases which are common in later life, so that the relative risk of suicide would be expected to be higher as a major cause of death in this age group.

In the UK and Ireland, Scotland registered the highest suicide rate amongst 15-24 year olds between 1991-96, but Ireland reported the highest rates 1997-2000. Between 1991-2001, suicide rates fell in England and Wales but rose in Scotland, Northern Ireland and Ireland. In the decade 1991-2001, the highest suicide rates in the UK for both males and females aged 15-24 were recorded in Scotland (Crowley et al 2004: 11) and it is estimated that 1 in 17 young people aged 11-15 has attempted self-harm or suicide (National Statistics 2001). The Scottish Executive reported more than 600 completed suicides per year in Scotland and around 7,000 hospital admission following an episode of deliberate self-harm (Scottish Executive 2002). The General Register Office for Scotland (2003) reports that when 'undetermined deaths' are included – as recommended by the WHO for international comparisons - the annual number of completed suicides rose to 887 in 2002.

A Samaritans report on suicide trends (2004) notes that the rate amongst 15 - 24 year old males in Scotland, which stood at 36 per 100,000 in 2000, fell to 30 per 100,000 in 2002, whilst for the 25 - 34 year old male group, rates have increased from 40 per 100,000 to 54 per 100,000 over just one year, 2001 - 2002 (see also the General Register Office for Scotland 2003). In 2003 the suicide rate amongst those aged 15 and over in Scotland was higher than in England and Wales, Germany, Spain and Italy, but lower than in France, Switzerland, Austria and Belgium. International trends need to be treated with some caution however, as differing recording practices throw some doubt on the validity of cross-national comparisons.

A range of policies to address rising suicide rates have been implemented across European countries, but by far the most widely used location for suicide prevention programmes is the school environment (Table 1.1).

Table 1.1: Location of European suicide prevention programmes

Country	Schools	Workplaces	Housing	Military
Austria	+	-	-	-
Bulgaria	+	-	-	+
Czech Republic	-	-	-	-
Denmark	+	+	-	+
Estonia	+
Finland	+	+	+	+
France	+	-	+	-
Germany	+	-	+	-
Hungary	+	-	-	+
Ireland	+	-	-	-
Lithuania	+	-	+	+
Norway	+	+	-	+
Slovenia	+	-	-	-
Sweden	+	-	-	-
United Kingdom	+	+

... = no answer.

[source: Wasserman et al 2004: 16]

1.2 Scotland's National 'Choose Life' Strategy and Action Plan

Into this context, the Minister for Health and Community Care, MSP Malcolm Chisholm, for the Scottish Cabinet, published '*Choose Life: A National Strategy and Action Plan to Prevent Suicide in Scotland*' in December 2002, outlining the first 3-year phase of a 10-year plan aimed at achieving a 20% reduction in the general suicide rate in Scotland by 2013. This ambitious target will require a second phase, from 2006 to 2012, which will, 'be informed by evaluation, review and assessment of results from the initial phase of activity'. The strategy and action plan can be understood as part of a much wider policy framework seeking to tackle need in relation to health, social justice, children and young people, education, crime, substance misuse and social exclusion in rural areas.

Underpinning the strategy and action plan is an appreciation that suicide must be understood within a multi-dimensional framework that recognises the importance of cultural, community, individual and service factors.

1.3 Priority Area: Children and Young People

The implementation of the national strategy and action plan is to be effected through a partnership created between the statutory sector, the voluntary sector, community groups and individuals and will make use of existing mechanisms of the Community Planning process, including the local joint health improvement action plans. With a remit that embraces the health and related needs of the whole community, the strategy and action plan will nevertheless target particular ‘priority groups’, including children, young people (especially young men), those with mental health problems, those who have attempted suicide and people living in rural areas. In the priority area of children and young people, the Executive noted that the period of entering secondary school, ‘is marked by increased exposure to risks that may predispose young people to poor mental health ... [including the] onset of anxiety, depression, eating disorders, substance misuse, psychosis and DSH’. To address this, the Executive argued for the following:

- developing and building the emotional literacy of our children and young people and supporting them through the many transitions they face.
- Continue to develop and expand school-based programmes on positive emotional mental health and well-being.
- The National Programme will encourage and support work which aims to promote greater understanding and awareness of mental, emotional and social health and well being and mental illness ... The next 3 years will see a focus on the development of mental, emotional and social health and well-being in schools in collaboration with others.

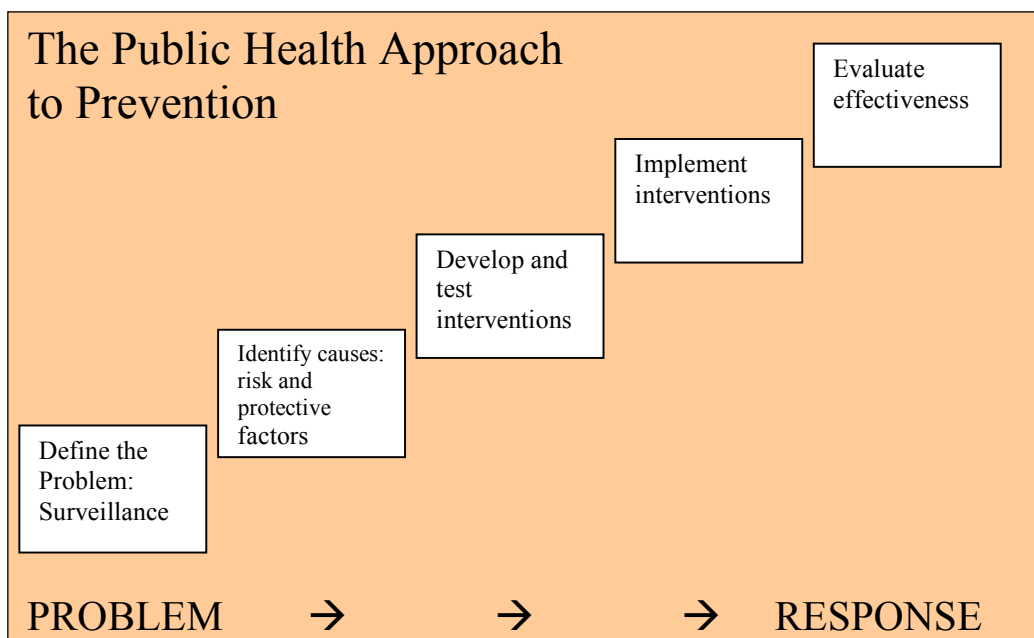
The *Choose Life* initiative in Scotland required local authorities to produce their own Local Implementation Action Plans which would set out how the national Choose Life agenda would be addressed in relation to:

1. early prevention and intervention
2. responding to immediate crisis
3. long term work to provide hope and support recovery
4. coping with suicidal behaviour and completed suicide
5. promoting greater public awareness and encouraging people to seek help early
6. supporting the media in its depiction and reporting of suicide and suicidal behaviour
7. knowing what works in terms of information and interventions

This agenda remains broadly in line with the public health approach to suicide prevention, in so far as it moves through a process from problem identification to solution. That is:

1. problem definition; 2. identification of risk and protective factors; 3. development and testing of interventions; 4. implementation of appropriate intervention; 5. evaluation of the intervention's effectiveness (Figure 1).

Figure 1: The prevention process in public health interventions



1.4 The Community Response in Aberdeenshire

In Aberdeenshire, a mainly rural area, the '*Aberdeenshire Implementation Action Plan 2003*' was drawn up by a multi-agency group - the Aberdeenshire Community Planning Partnership (ACPP) - including the local authority, NHS Grampian and the Voluntary sector, co-ordinated by Linda Reid (Joint Commissioning Manager, MH). The Plan follows the objectives of the National Strategy and addresses each of its priority areas. Under *Objective 1*, 'Early Prevention and Intervention' and *Objective 7*, 'Knowing what works', the Plan proposed the following as part of a range of actions in relation to the prevention of young people's suicide and DSH:

➤ *Action 1*

To pilot some action research in relation to young people with measurably low self-esteem and emotional literacy to see if a particular programme or activity has produced improvement in the short and longer term.

A multidisciplinary social science research team including sociologists, psychologists and a statistician, headed by Dr John Love at the Robert Gordon University made a successful bid for the action research pilot project, centred on one school community in rural Aberdeenshire (henceforth, the Robert Gordon University Emotional Well-Being Project (RGU EWB)). This research looks to satisfy the three main aims of the Choose Life initiative:

1. To inform the development of an 'intervention' for ALL children in the chosen location as a means of enabling them to increase their self-esteem, emotional literacy and resilience with consequent impact on their involvement in self-harming behaviour.
2. To enable key stakeholders including teachers, health workers, social workers, youth workers and police, to develop effective ways of joint working to promote self-esteem, emotional literacy and resilience among young people in the area

with consequent impact on young people's involvement in self-harming behaviour.

3. To provide knowledge and understanding of measurable immediate and longer term 'outcomes' of any intervention to apply the lessons elsewhere (Choose Life 2002).

The Scottish Executive has also set 2007 as the target for all Scottish schools to become 'health promoting schools' which should aim to 'promote the physical, social, spiritual, mental and emotional health and well-being of pupils and staff' and to 'work with others in identifying and meeting the health needs of the whole school community' (Scottish Health Promoting Schools Unit 2004). This policy is consistent with the Choose Life action plan.

2. Literature Search Criteria

This Review marks the end of the initial systematic and extensive literature review carried out between April and December 2004, covering the key terms: children, young people, suicide, suicidal ideation, school-based suicide prevention, deliberate self-harm (DSH), self-harm, emotional literacy, emotional intelligence and resilience (applied in educational contexts). The Report attempts to clarify definitions of key terms and concepts for the Research Team; describe the range of school-based prevention programmes targeting emotional well-being, self-esteem, suicide and deliberate self-harm and to describe the development of school-based emotional literacy initiatives and programmes. The Review summarises the main findings of this wide-ranging survey and makes some suggestions flowing from it which, alongside findings from the first two waves of quantitative surveys, will inform the proposed school-based intervention.

Databases searched were: SSCI, ASSIA, Zetoc, Web of Knowledge, PsychInfo, ERA, Medline, ERIC and the Cochrane Database of Systematic Reviews. A book search used a

snowball method beginning with the most often-cited texts and references and extending outwards to the most often cited within these. A search of relevant official websites included (amongst many others) the World Health Organisation (WHO), Scottish Executive and the UK Government. As the concept of ‘emotional literacy’ (EL) has emerged and developed largely outside of the academic and policy mainstream, a search of so-called ‘grey resources’ was also carried out. This included a range of materials from EL advocacy groups and consultancies, together with several voluntary agencies working in the mental health field more generally. Hence, this part of the search generated a range of materials from numerous sources including: Antidote – the Campaign for Emotional Literacy, National Emotional Literacy Interest Group (NELIG), Southampton Local Education Authority, Collaborative for Academic, Social and Emotional Literacy (CASEL, USA), the Self-Harm Alliance, Penumbra and Young Minds.

The search criteria for existing systematic and meta-analytic reviews focused on those which used a clear question and well-defined search strategy, which also included some evaluations of school-based programmes, information on the ages of research subjects, the content of school-based interventions and assessments, if available, of the quality of the reviews. The search criteria specifically excluded all studies of postvention work, non-school-based interventions and all of those reviews and studies which made no mention of suicide, DSH or self-harm more generally (excluding work on emotional literacy).

A large body of literature in several key areas was collected from a variety of sources including official or governmental, academic mainstream and grey sources. What follows is the distillation of relevant findings from this extensive search focused on effective, potentially effective or ‘promising’ school-based programmes aimed at increasing self-esteem, emotional literacy or resilience as a way of enabling young people to develop the skills and capacities which will help them to cope more effectively with the emotional demands of major life transitions. It must be noted at the outset that age specification in the literature is often very broad or unclear, with 12-19 and 15-24 the most common age ranges identified. No studies or interventions aimed specifically at the RGU EWB

project's target age range - 11-13 years - and experiencing secondary school transition, were identified. School-based suicide prevention programmes are predominantly aimed at older school students and it is highly unlikely that any existing suicide prevention programme could be recommended for the RGU EWB intervention.

3. Definitions and Conceptual Issues

3.1 Defining Key Concepts

Defining key concepts is an essential and normal part of academic research which is necessary if comparative studies are to be valid and reliable. This is not to say that it is always possible to arrive at agreed definitions or that there are no examples of good research studies using 'working definitions' rather than well developed ones. However, unless working definitions are relatively similar it is not possible to draw firm conclusions from the international literature, particularly when working cross-culturally and drawing from research findings across different national societies. Within the literature on suicide and self-harm research, definitions are not generally agreed upon and researchers working in these fields as well as those conducting systematic reviews, have identified the clarification of definitions and concepts to be a priority for further development. Similar definitional and conceptual pluralism exists within research on emotional literacy and emotional intelligence, though perhaps this is to be expected in what is a relatively new field of academic research in which concepts, measurement and comparative work are still rapidly developing alongside a more general social scientific interest in the role of emotions in social life (Lewis and Haviland-Jones 2004).

A listing of definitions of key terms follows with a brief comment on the relevance of the concept under definition for the RGU EWB action research project.

3.1.1 Suicide

‘An act of deliberate self-harm which results in death’ (Choose Life 2002).

Definitions of suicide are notoriously inconsistent in the international literature though many focus on the question of ‘intent’. If self-harming behaviour is intentionally aimed at taking the person’s life, then it can be defined as ‘suicide’ rather than deliberate self-harm. However, the Scottish Executive’s *Choose Life* definition above does not concentrate on intent. Rather, it sees suicide as any act of self-harm resulting in death. The *Choose Life* definition views suicide as one possible outcome of self-harming behaviour and presumably if the same act did not result in death it would be classified as an act of DSH rather than a ‘suicide attempt’, ‘parasuicide’ or any other alternative definition. Such inconsistencies are commonplace in this literature and difficulties in resolving them have led to a lack of conceptual clarity which many now perceive to be unhelpful, particularly for applied research and attempts to evaluate suicide prevention programmes.

A social class gradient in suicide has also been identified in men aged 20-64 in England (though not so far amongst children and young people in the 12-19 range), where suicide rates in social class V have been recorded as twice that in social class IV and four times higher than in social class I (Crowley et al 2004: 1). Clearly this finding has implications for existing suicide prevention programmes aimed at individuals, perhaps pointing up their limitations in reducing suicide rates.

3.1.2 Deliberate Self-Harm

‘An act which is intended to cause self-harm, but which does not result in death. The person committing an act of deliberate self-harm may, or may not, have an intent to take their own life’ (*Choose Life* 2002).

Such acts may include: ‘cutting, burning, biting ... destructive use of alcohol and drugs, controlling eating patterns, overdosing, indulging in risky behaviours, and mental and

emotional self-harm' (Haydock, 2001). DSH has been identified as the strongest risk factor for future suicide (Hawton et al 2002).

Unfortunately, definitions of self-harm are also inconsistent across the literature. Some research describes 'self-harm' as all those behaviours resulting in harm to the self, including suicide attempts (including the *Choose Life* definition above), whilst other studies clearly differentiate DSH from suicide attempts, noting that risk factors for the two behaviours are significantly different and the question of intent should be integrated in any definition. Clearly it is very difficult to make comparisons across the international research findings when the behaviour under study may well be dissimilar.

3.1.3 Mental Health (sometimes 'Mental Well-Being')

Although it may not be possible concisely to define mental health (Public Health Institute of Scotland 2003), it is necessary to understand some of the factors which make up a person's 'mental health' or 'mental well-being.' To this end, mental health is quite commonly defined as, 'The ability to develop psychologically, socially, emotionally, intellectually and spiritually' as well as the ability to, 'initiate, develop and sustain mutually satisfying relationships, use and enjoy solitude, become aware of others and empathise with them, play and learn, develop a sense of right and wrong and to face and resolve problems and setbacks satisfactorily and learn from them' (Edwards 2003: v).

Although it may be difficult in practice to separate out the psychological, social, emotional, intellectual and spiritual elements of mental well-being, the remit of the small-scale RGU EWB action research pilot study is primarily aimed at understanding and working to improve the 'emotional well-being' of young people. Therefore the project works with one, albeit significant, element of a complex whole in relation to mental health and well-being rather than attempting to develop a holistic or 'whole-school' intervention which might also cover clinical mental health treatment interventions.

3.1.4 Self-Esteem

‘An evaluation of personal worth based on the difference between one’s ideal-self and one’s self-concept’ (Humphrey 2004: 348).

This definition describes a person’s ‘self-concept’ as their ‘perceived competencies’ and the ‘ideal-self’ as the ‘individual’s pretensions’ (how they would like to be). Self-esteem is thought to be differentiated, such that a person may have, say, high self-esteem in relation to their academic capability but low self-esteem in relation to their physical appearance. A person’s ‘global self-esteem’ or evaluation of personal worth, will depend on the relative significance of different self-esteem ‘domains’ and this will be strongly influenced by social factors such as family expectations and social position or status. Self-esteem is also developmental, moving from overly positive evaluations in early childhood to more realistic and sometimes pessimistic evaluations in later childhood and adolescence. Some systematic reviews argue that differences in parental acceptance best explain individual differences in self-esteem (Emler 2001), though this is disputed by others who focus on the influence of peers and teachers, particularly with regard to academic self-esteem (Burnett and Demnar 1996).

A review of the literature on the causes and costs of low self-esteem by Emler (2001) found much disagreement about the nature of self-esteem, the main difference centring on whether self-esteem is a generalised feeling about the self, as in G.H. Mead’s (1934) theory of self-formation, or the sum of a set of judgements about personal value, worthiness and competence. Nevertheless, Emler reports that there are reliable tools available for the measurement of self-esteem and concludes that the literature shows that relatively low self-esteem is *not* a risk factor for delinquency, violence towards others, drug use, alcohol abuse, educational under-attainment or racism. However, relatively low self-esteem *is* a risk factor for suicide, suicide attempts, depression, teenage pregnancy and victimisation by others. Relatively low self-esteem is also associated with adolescent eating disorders and lack of employment continuity in young adulthood, though the reason for the latter is not well understood.

In educational contexts it has been believed (especially in the 1970s USA) that raising students' self-esteem was worthwhile as a resilience-promoting factor, though more recent research has suggested that excessive or unrealistic self-esteem may actually cause mental health problems. In addition, a comprehensive review of the self-esteem literature by Baumeister et al (2003) concludes that there is no evidence that school-based self-esteem programmes have any effect on academic achievement and that there is little understanding of how such programmes may actually affect self-esteem. Furedi (2003) also argues that there is little or no evidence that self-esteem programmes are actually effective, but suggests that they continue to be introduced in educational environments as part of a wider 'psychological turn' in public policy, which tends to individualise social problems.

Nevertheless, criticisms notwithstanding, several research studies have found that aspects of self-esteem, such as negative evaluations of physical appearance, are self-reported as significant factors leading to self-harming behaviour by young people themselves (Hawton et al 2002; Haydock 2001). It would therefore seem incautious for problem-focused action research to disregard such self-reported evidence. Similarly, positive self-esteem has regularly been cited as one factor which may - along with better coping skills and access to social support - promote emotional well-being (Harden 2001; Harrill 1996). Humphrey's (2004) conclusion, that school-based programmes aimed at increasing self-esteem or self-development are useful regardless of their impact on academic achievement may be seen as a reasonable one.

3.1.5 Emotional Intelligence

'A form of social intelligence that involves the ability to monitor one's own and others' feelings and emotions, to discriminate among them, and to use this information to guide one's thinking and action' (Salovey and Mayer 1990).

It is now widely accepted that the EI construct has a much longer history than is evident from the current post-1990 period of expansion based on the study of emotions in organisational and workplace cultures. Some psychologists trace the basic idea back to interest in a range of ‘social intelligences’ between 1920-1940 (Petrides et al 2004). There are also different types and levels of EI in the contemporary literature. One basic distinction in ‘types’ of EI is that between ‘trait EI’ and ‘ability EI’ (Petrides et al 2004). Trait EI refers to a variation on personality theory focusing on ‘a constellation of emotion-related dispositions and self-perceived abilities’ (Petrides et al 2004: 575). Measurement using this definition makes use of self-report studies. Ability EI refers instead to certain cognitive abilities related to emotion management which are measured using performance tests rather than relying on potentially unreliable self-report surveys. Trait and ability EI stem from different theoretical bases.

Mayer, Salovey and Caruso (2000) also identify three *levels* at which EI functions in the literature. The first level is a view of EI as part of the *Zeitgeist* or ‘spirit of the age’. Mayer et al argue that EI fits into and promotes a wider cultural trend towards open emotional expressiveness as a reaction against the previous trend of anti-emotionalism or excessive rationalism. The second level refers to EI as certain personality traits which may or may not overlap with those which have previously been identified by psychologists. Finally, EI can be seen as a particular mental ability or newly identified intelligence concerned with the processing of emotions. The third level of EI is seen as amenable to scientific work and is favoured by Mayer et al as well as some popular writers such as Goleman (1996), who suggests that not only can emotional intelligence be measured (EQ) but it may be more significant than cognitive intelligence (IQ) for life success and happiness. The concept of EI is popular in the USA but less so in the UK, including Scotland. EI has developed most rapidly in organisational psychology though there is now evidence that some EI advocates are turning their attention to young people and schooling (Salovey and Sluyter 1997; Brearley 2001) and parenting (Gottman 1998). EI research continues to expand and a number of reviews in the form of ‘Readers’ are now available which cover the theoretical basis of and empirical evidence for the existence of EI (Bar-On and Parker 2000; Sternberg 2000).

3.1.6 Emotional Literacy

‘The ability to recognise, understand, handle and appropriately express emotions’ (Southampton Emotional Literacy Interest Group 1998).

Emotional literacy (EL) is a concept derived largely from academic psychological work on emotional intelligence, together with educational programmes devised in the USA covering ‘social and emotional learning’ (SEL). The definition above is broadly similar to many definitions of EI. EL in the UK context is primarily targeted at schools and young people, perhaps because educators are already familiar with the concept of ‘literacy’ so that emotional literacy is a more familiar concept for teachers (Weare 2004: 2). Advocates for EL programmes in education argue that schooling has become overly concerned with cognitive intelligence and IQ at the expense of a recognition that in order to develop intellectually, children and young people need to be emotionally competent as described in the definition. The RGU EWB research project’s remit is to work with this concept of EL as a key part of any suggested school-based programme, though it needs to be recognised that there have been no systematic evaluations of the effectiveness of EL programmes in the UK educational contexts. A detailed discussion of EL is presented in Section 7 below.

3.1.7 Resilience

‘The maintenance of competent functioning despite an interfering emotionality’ (the clinical definition) OR ‘a universal capacity which ... allows a person, group or community to prevent, minimize or overcome damaging effects of adversity’ (Newman and Blackburn 2002).

Resilience research has attempted to identify risk factors, the accumulation of which makes inappropriate coping behaviours more likely, together with those factors at the individual, family and environmental levels which help to insulate people from turning to

inappropriate behaviours during stressful periods of personal adversity. Resilience Factors are listed in Table 3.1.

Table 3.1: Resilience-promoting factors: individual, familial, social
Resilience factors

The Child	The Family	The Environment
Temperament (active, good-natured)	Warm supportive parents	Supportive extended family
Female prior to and male during adolescence	Good parent-child relationships	Successful school experiences
Age (being younger)	Parental harmony	Friendship networks
Higher IQ	Valued social role (eg care of siblings)	Valued social role (eg a job, volunteering, helping neighbours)
Social skills	Close relationship with one parent	Close relationship with unrelated mentor
Personal awareness		Member of religious or faith community
Feelings of empathy		
Internal locus of control		
Humour		
Attractiveness		

[source: Newman and Blackburn 2002]

Edwards (2003) summarises the Public Health Institute of Scotland's (2003) conclusions from their review of resilience research thus:

A young person living in a supportive environment in the family and at school, and in possession of good coping skills will be better able to weather the trials and tribulations of life. A young person in a poor environment with little outside support and lacking coping skills is at greater risk of developing mental health problems when faced with life's problems. The research shows that risk accumulates and that a young person experiencing three risk factors is at greater risk of developing mental health problems than a young person experiencing one factor.

The literature also suggests that resilience is more likely to develop and be sustained where young people have a trusting relationship with at least one constantly available person. In addition, the research points to having an adaptable nature and positive self-esteem as important factors in the production of resilient young people.

This summary may seem like little more than a repetition of widely-held commonsense views. Nevertheless, the research evidence does point to the fact that many young people with emotional problems *do* live within very difficult environments, *do* perceive that they have little social support (or are not aware of this) and many *do* adopt negative coping strategies such as self-harming behaviour to help them deal with a ‘terrible state of mind’.

It has been argued that ‘trends in resilience research are shifting from identifying characteristics of children who are resilient in the face of adversity, to identifying processes that promote resilience under normative conditions’. This is because resilience ‘is seen as a common phenomenon that results in most cases from the operation of basic human adaptational systems’ (Davey et al 2003: 347-8). Davey et al’s analysis of the association of three personality profiles with ‘self-worth’ and ‘coping’ found that self-worth *was* associated with extroversion, agreeableness and being open to new experiences, as expected. However, in addition to this and against their expectation, positive coping was highest for individuals who also scored high on disagreeableness and emotional *instability*. The authors suggest that a possible explanation for this finding may be that, ‘because adolescence is a period of actively reconstructing the self, it is possible that resilience can also be found in nonoptimal personality profiles’ (Davey 2003: 358). Such findings, if replicated, would challenge the idea that only emotionally stable young people spontaneously develop their own positive coping methods. Helping young people to develop as resilient individuals is therefore not a simple task and it is widely accepted that it is unlikely to be achieved through school-based programmes alone.

4. Emotional Problems of Young People

The survey reveals that a large literature exists on mental health or mental well-being, self-esteem and emotional intelligence, with very little academic research on emotional literacy. Given the survey's focus on exploring potentially effective emotional literacy interventions within schools, it has therefore been necessary to look for emotion-centred strategies and programmes within the broader mental health literature. This approach corresponds with the action research project's overall framework of 'emotional well-being' within which, emotional literacy or emotional intelligence constitutes one element.

4.1 Evidence from Scotland

Edwards (2003) reports that one in five children and young people in Scotland will suffer from clinically defined mental health problems during their school career. Ten per cent of children aged between five and fifteen years of age experience clinically defined mental health problems. This breaks down into: 5 % - conduct disorders, 4% - emotional disorders (including self-harm) with 1% likely to be hyperactive. Around 125,000 young people under the age of 19 have mental problems which cause them daily difficulties in living (Public Health Institute of Scotland 2003). Between 1971-3 and 1996-8, the suicide rate for 15-24 year-olds more than doubled, whilst for females it trebled (Haydock et al 2001), albeit from initially small numbers. In 1997 there were around 1500 female admissions and 900 male admissions in the 15-19 age range, to the Royal Edinburgh Hospital and St John's Hospital in West Lothian. In addition it is assumed that there is an unknown 'dark figure' of unreported self-harming behaviour. In Aberdeenshire in 2002, 15 men and 8 women completed suicide and many more engaged in self-harming behaviour. There were also 7 drug related and 13 directly related alcohol deaths along with a significant number of accidental or undetermined deaths. The ACPP notes that whilst the suicide rate self-harm rates in Aberdeenshire are not as high as the national average they are currently rising (Aberdeenshire Community Planning Partnership 2003).

The Scottish literature consistently records that the mental health of boys is better than that of girls across the age range for young people. Girls are more concerned with physical appearance than boys at all ages. Self-harming behaviour is used as a coping strategy to deal with overwhelming negative feelings by both boys and girls, with self-harming behaviour often beginning early in adolescence. Suicidal and depressed school-age young boys report feeling overwhelmed by schoolwork, experience violence and bullying and feel they have no-one to confide in. In addition, many self-report studies report an unwillingness by both boys and girls to speak to teachers about their emotional problems, casting some doubt on whether schools are the best location for tackling the latter (Harden et al 2001). A similar finding from outside Scotland can be found in Sellen's (2002) widely reported study of one London Borough. Amongst black and ethnic minority young people over 12 years of age, it was found that only 6% of boys and 5% of girls were in favour of school-based counselling for emotional problems. This is consistent with many other studies internationally.

A study of one New Community School in East Lothian (Edwards 2001) found that twice as many girls as boys reported that having good friendships and close family relations helped to maintain well-being, whilst four times as many boys as girls reported that being physically active helped in maintaining their well-being. The young people said they would talk to family and friends on some intimate issues but were reluctant to speak to guidance teachers due to peer pressure, embarrassment and a belief that their guidance teachers did not really understand them. This finding is consistent with the literature which consistently reports that teachers are not seen as the appropriate adults for students wanting to report emotional problems.

An anonymous survey of 4404 Scottish school students aged 11-15 by the Child and Adolescent Health Research Unit, University of Edinburgh in 2002, found that the mental health of boys was consistently better than girls and that primary school children had better mental health than those in secondary school (Currie and Todd 2003). Self-reported 'happiness' declined with age with 55% of 11 year olds reporting that they were 'happy' compared to 44% of 13 year olds and 38% of 15 year olds. No gender difference

in mean life satisfaction scores was evident until the age of 13, when the 'life satisfaction' score for girls was noticeably lower than amongst boys. 37% of boys reported that they were 'good looking' against just 26% of girls whilst 24% of girls said they were not good looking, compared to just 13% of boys. Although 28% of boys reported that they were 'always' confident compared to 15% of girls, this was set against the wider finding that general self confidence levels of young people in Scotland have improved since 1994. Since 1987, girls increasingly report feeling more under pressure to do well in school and it may be that this finding follows from rising levels of academic achievement for girls (see West and Sweeting 2003 for evidence from the West of Scotland).

Gordon and Grant's (1997) anonymous 'snapshot' survey of 1634 young people aged 13-14 years old in Glasgow, reported that students identified boredom, monotony, the stress of too much schoolwork, teachers' attitudes towards them and doing badly as the main factors preventing them from 'feeling good' at school. Other general factors included: 'being put down', difficulties with peers, being blamed unfairly, doing badly at school, doing badly at sport, not being 'good', poor physical appearance, being shy, not able to share emotions and not being in control of their life. External factors included bereavement, boredom, staying in and the weather, and less commonly having no money, violence, fears about going out and racism. Gordon and Grant report that 'feeling good' included getting respect from friends, boyfriends or girlfriends, families, congratulations, compliments, being good looking, doing well at school and being good at sport. It seems that central to 'feeling good' was acceptance from others (as described by Humphreys' assessment of the self-esteem literature above), perceiving that they were doing well and feeling they were 'virtuous,' confident and in control. These results are similar to other recent research with young people in Scotland (Edwards 2001; Public Health Institute of Scotland 2003).

In one small-scale action research project in Edinburgh, 45 young people (31 females and 15 males) in the 16 - 21 age range self-reported as engaging in self-harming behaviour (Haydock 2001). However, this sample was not identified as being at school. This group

reported that self-harm was a response to feelings produced as a result of: bullying (6), sexual abuse (4), physical abuse (2), poor body image and low self-esteem (4), family break-up (4), bereavement (2), homelessness (2), drug and alcohol addiction (3), sexuality (2), and mental health problems (2). The majority began self-harming before 15 years of age: 32% began under 12, 32% between 13 and 15. The young people gave a number of reasons for this: self-punishment, a way of linking the emotions with the body, to gain a sense of relief and as a reprieve from emotional turmoil. The authors conclude that self-harming behaviour seems to stem primarily from attempts to cope with emotional problems. Again, these findings are consistent with other research reported here, that much self-harming behaviour emerges in the early teenage years.

The Scottish Executive expresses concern regarding the higher suicide rate amongst young people in Scotland compared to England and Wales and it may be that the causes of poor mental and emotional health in Scotland may be different from the rest of the UK and elsewhere (Gallagher & Millar 1996; Bagley & Mallick 1995). One finding which may be significant is that Scottish students consistently report difficulties in coping with schoolwork as a cause of emotional and mental problems. Clearly, this raises concern about the effective importation of preventive interventions devised in and for different national educational contexts, as it is evident that the overwhelming majority of preventive interventions have been created and delivered in the USA.

4.2 Evidence from the UK and Beyond

A large-scale study of self-harming behaviour was carried out for The Samaritans by Hawton and colleagues at the Oxford University Centre for Suicide Research in 2001-02. The study involved 41 schools in Birmingham, Northamptonshire and Oxfordshire during 2000-2001: 35 state schools, 4 independent and 2 grammar schools. In all, 6,020 pupils took part. At least 90 per cent of these were aged 15 and 16 years old, rather older than the RGU EWB target group. 82.3 per cent were white, 11.1 per cent Asian, 2.8 per cent black, while 2.6 per cent described themselves as 'other' (ie; mixed race). The surveys

were conducted anonymously, in school and under exam conditions. The significant findings were:

- 10 per cent of teenagers aged 15 and 16 years old have deliberately self-harmed - seven per cent in the previous year.
- The majority, more than 64 per cent, of those who self-harm cut themselves.
- Girls are nearly four times more likely to self-harm than boys.
- 41 per cent of those who self-harm seek help from friends before acting.
- The most common reasons given by pupils for deliberate self harm were 'to find relief from a terrible state of mind' or because they had 'wanted to die'. Contrary to popular belief few were 'trying to frighten someone' or simply 'get attention'.
- Those who self-harm have more problems and life events than other teenagers.
- People who self-harm are also more likely to suffer anxiety, depression and have low self-esteem than others.
- Those that self-harm often have friends who self-harm.
- Girls who self-harm may have concerns about sexuality, boys may have suffered physical abuse.
- Those who self-harm find it difficult to cope and are more likely to blame themselves, get angry, drink alcohol or shut themselves in their room than talk things through.
- Those who self-harm believe they have fewer people in whom they can confide compared to other adolescents.

(Hawton et al 2002)

Hawton et al's survey also usefully distinguished risk factors for suicidal thoughts and DSH (Table 4.1). It should be noted that 'having friends who have engaged in suicidal behaviour' and 'low self-esteem' were risk factors *both* for suicidal thoughts and DSH and for *both* males and females. Otherwise, risk factors appear to be dissimilar for suicidal thoughts and DSH.

Table 4.1: Risk factors for suicidal thoughts and self-harming behaviour

	Suicidal thoughts		Deliberate self-harm	
	Males	Females	Males	Females
Having friends who have engaged in suicidal behaviour	●	●	●	●
Family member had engaged in suicidal behaviour	-	-	●	●
Smoking	-	●	-	-
Drug use	-	-	●	●
Drunkenness in the previous year	●	●	-	-
Sexual orientation	-	●	-	-
Physical abuse	●	-	-	-
Depression	-	-	-	●
Anxiety	●	●	-	●
Low self-esteem	●	●	●	●
Impulsivity	-	-	-	●

[source: Hawton et al 2002]

An Audit Commission report in 1999 argued that young people were at risk of developing emotional and mental health problems if they were living with only one natural parent, either in a step-family or with a lone parent, living in families where the main breadwinner was unemployed, experiencing some form of learning disability or were looked after by the local authority.

In a study of adolescents from across the UK (including Scotland), Meltzer *et al* (2001) found that the prevalence of self-harming behaviour among 11–15 year olds was higher in lone parent compared with two parent families (3.1% and 1.8%); in families with step-children compared to those without (3.7% and 1.9%); in families with five or more children compared to those with less (6.2% and 2%); in families who were social sector tenants (3.7%) or private renters (3.2%) compared with owner-occupiers (1.5%) and amongst those living in Wales (2.8%) and England (2.2%) rather than Scotland (1%). In addition, young people who have learning difficulties of any kind, have chronic physical illness, have experienced physical or sexual abuse or witnessed domestic violence or who

have a parent with mental health problems are more at risk of developing self-harming behaviour (Public Health Institute of Scotland 2003).

Bergman and Scott's (2001) study of young people in England aged 11–15 reports that those from the poorest households reported having the least worries (a finding that is consistent with Durkheim's thesis of the solidarity-creating effects of relative poverty). However, poverty and living in 'poor environments' are widely reported as underlying structural causes of many other serious health problems and as noted earlier, a social class gradient in recorded suicide statistics in the UK and Ireland has been identified by Crowley et al (2004). Bergman and Scott (2001) also found, as have several other studies, that adolescent boys had higher self-esteem, lower negative self-image and tend to self-report less unhappiness than girls. It is unfortunate that some of these quantitative findings have not been followed-up with qualitative research to rule in or out some possible explanations. For instance, the widely-reported finding that boys self-report more 'happiness' than girls lends itself to explanations rooted in the longstanding gendered difference in public emotional expressiveness, rather than pointing to real gender differences in emotional and mental well-being. More sensitive research projects in this area might produce a different pattern of responses which would allow some of the apparent contradictions and inconsistencies across survey findings to be better explained.

5. A Typology of School-Based Interventions

5.1 Intervention Types

Public health interventions, including those delivered in school environments have been distinguished according to their target group. Hence, such interventions can be designed to target all of those within a particular population, only those within that population who have several known cumulative risk factors, or may include a screening process in order to identify and target only those showing minor but identifiable signs of emotional

problems. It is also possible to design an intervention which combines some or all of these approaches.

5.1.1 Universal Interventions

Universal intervention programmes are targeted to a whole population group, none of whom have been identified on the basis of individual risk. This could involve designing and introducing a whole-school programme or perhaps whole-cohort programmes in the transitional year.

Some of the benefits of universal programmes reported in the literature are relatively high participation rates and the possibility for positively impacting on ‘at-risk’ groups in an inclusive way. Universal programmes have also been identified as being capable of having a *continuing* positive impact as the risk status of individuals is likely to change over time. Such programmes can also have a secondary impact on existing depression and forms of anti-social behaviour. Universal programmes aim to remove barriers to care, enhance people’s general knowledge of DSH and suicide, improve access to sources of help and to services, improve social support and teach coping skills which can help people to develop positive strategies for dealing with emotional problems. Universal approaches also fit with the ‘social inclusion’ agenda within education and therefore may have political advantages over some other approaches.

In Guo and Harstall’s (2002) review of suicide prevention programmes for children and youth, two out of ten universal suicide prevention programmes were found to have produced reduced levels of suicidal thoughts (or ‘ideation’) and impacted positively on coping skills and ego-identity. Many universal programmes were also found to produce higher levels of knowledge and a better understanding of suicide and DSH and to dispel many of the myths around self-harm more generally. However, a cautious note has been expressed by some reviews, which have found that despite increased levels of knowledge and understanding, there remains little if any evidence that universal suicide prevention

programmes have any impact in actually changing behaviour (Shaffer et al 1991). In addition, Shaffer et al also note that many of those who had previously attempted suicide reported that they found the universal programmes ‘unhelpful’. Some systematic reviews report negative effects of school-based suicide prevention programmes (Ploeg et al 1999) which may have some harmful effects. However, it is worth noting that Guo et al (2003) argue that all of the systematic reviews which have reported possible harmful effects have low scores for methodological quality, whilst the relatively few reviews that do score highly for methodological quality and rigour find no such effects.

A review of suicide prevention strategies carried out by the European Health Evidence Network (EHEN) of the WHO (2004) reported around 30 types of school-based programmes aimed at young people between 12 and 19 years of age, though no differentiation amongst this age range was made. Around half of these programmes were ‘treatment’ rather than prevention programmes. No single intervention was found to be effective in reducing suicide rates, though those targeting ‘at-risk’ individuals held the most promise according to the review’s authors. Universal school-based programmes based on behavioural change and coping strategies showed some success in lowering ‘suicidal tendencies’, improved ego-identification and better coping skills whilst those selective programmes focusing on skills training and social support for at-risk individuals reduced risk factors and enhanced certain protective factors.

Guo and Harstall’s systematic review of school-based suicide prevention programmes (2002) reported that at one end of the spectrum were short ‘induction’ programmes of just one session of one and a half hours duration at the start of a school term. In contrast were interventions consisting of 180 sessions each lasting 55 minutes which continued for the first half of the school year. This survey also noted that ‘the most widely used’ universal programmes have never been evaluated and no comparative evidence on their effectiveness exists.

The Oxford Health Services Research Unit (1998) surveyed 8,000 publications in the field of suicide prevention programmes and found that of these, only 9 had measured the

effects of the programme and of these 9, just 3 had been carried out in the previous 5 years and all of them in the USA. The conclusion they were able to draw from the 9 evaluated programmes was that, 'long-term programmes promised the best outcomes'. Again though, it needs to be remembered that programmes devised and delivered for the American educational system may not be appropriate or effective in Scotland.

5.1.2 Selective Interventions

Selective intervention programmes can be, 'targeted to individuals or a subgroup of the population whose risk of developing mental disorders is significantly higher than average' (Guo, Scott and Bowker 2003).

Selective suicide prevention programmes specifically target a population subset, notably those considered to be in 'at-risk' groups based on existing knowledge regarding family background, environment and other known risk factors. The aim of such risk selection is to work towards preventing the onset of suicidal ideation and self-harming behaviour. In order to achieve this, selective programmes use or devise a risk identification tool which can be used in assessment. Such programmes also involve a measure of training for so-called 'gatekeepers'. These could be teachers, social workers, school nurses, community workers or other school staff. Once identified, the programmes use skills-training for 'at-risk' groups in order to improve coping skills and help-seeking strategies whilst at the same time professionals work towards improving the existing sources of support and strengthening the student referral process.

Guo, Scott & Bowker (2003) found that three systematic reviews of selective intervention programmes discovered that these had led to a reduction in risk factors such as depression, a sense of hopelessness, growing anxiety, anger and self-reported stress. In addition the three programmes had led to an increase in protective factors including better personal control, higher reported levels of self-esteem in the at-risk groups, improvements in problem-solving skills and evidenced improvements in available social

support. However, none of the three programmes was able to record an evidenced reduction in actual suicides or suicide attempts and their effectiveness in tackling suicide rates remains in doubt.

5.1.3 Indicated Interventions

Indicated intervention programmes are, ‘targeted to high-risk individuals identified as having minimal but detectable signs or symptoms foreshadowing mental disorder’ (Guo, Scott and Bowker 2003).

Indicated interventions target specific ‘high-risk’ individuals who have already been identified as showing minimal but detectable signs of mental disorders. Such interventions have the two-fold aim of reducing cumulative risk factors as well as increasing protective factors and involve the collection of evidence through screening and monitoring. Indicated interventions tend to be more controversial than the previous two types. Introducing screening and monitoring methods for all children could be considered too intrusive in itself, but secondly, screening and monitoring should lead to positive actions and these require adequate levels of funding, support and services within and associated with schools if the intervention is to be successful. This might require skills training, setting up support groups, parent-support training for staff, individual case management, improvements in crisis services and ultimately treatment.

5.1.4 Combinations of Interventions

Universal, selective and indicated interventions are not necessarily opposed but can be used in complementary ways. Combinations of all three may therefore be categorised as ‘USI’ programmes, encompassing universal, selective and indicated preventive measures. The World Health Organisation, the United Nations and much of the American research supports USI programmes for suicide prevention. Similarly, Hawton et al’s (2002) survey

of DSH (including suicidal thoughts) concluded that there is a need for school-based prevention programmes which focus on identifying emotional and psychological health problems. The authors suggest that teachers could be trained to recognise pupils who are getting into difficulties and may be at risk of self-harm or, more controversially, screening methods could be introduced to detect at-risk students.

A recent evaluation of one American school-based suicide prevention initiative, the 'Signs of Suicide' (SOS) programme, claims that this is the first to demonstrate 'significant reductions in self-reported suicide attempts' (Aseltine and DeMartino 2004: 446). In itself, the authors' claim, coming as it does in 2004, shows how far evaluation has lagged behind intervention in this field of problem-solving research. The SOS programme combines curricula to raise awareness of suicide and related issues (universal intervention) with a brief screening for depression and other suicide risk factors (indicated intervention). Three months after the end of the intervention period, students self-reported no suicide attempts. It should be borne in mind however that the programme was used with USA 'ninth grade' students aged 13-14 and would probably not be acceptable for students in the RGU EWB project's target age range of 10-12. Also, the claims for effectiveness are based on relatively short - three months after the intervention - follow-up surveys.

All of the good quality systematic reviews of school-based suicide prevention programmes report that this literature provides insufficient evidence either to support or not to support school-based interventions (Guo and Harstall 2002; Guo et al 2003; Crowley et al 2004). It is important to note that this statement does *not* mean that suicide prevention interventions are not effective. It may be that the evaluations in the literature were not rigorous enough to identify any real programme effects. However, on the basis of current knowledge, it is not possible to identify one school-based intervention that is demonstrably effective on the basis of evidence in reducing suicide amongst young people.

6. Promoting Emotional and Mental Well-Being

6.1 Examples from Scotland and the UK

In spite of the existence of many school-based suicide prevention, self-harm prevention and mental health improvement interventions, evidence for the success of these is weak and exists mainly in small-scale ‘snapshot’ studies. In the case of emotional literacy, the evidence exists entirely within the ‘grey’ literature. There have also been no rigorous evaluations of successful interventions in other settings. Therefore the effectiveness of school-based programmes currently remains unclear.

A consultation exercise covering health professionals, teachers, young people and parents (Public Health Institute of Scotland 2003 (PHIS)) argued that interventions can potentially be effective when the intervention is introduced early in the problem cycle and when the child is young. Interventions should involve people familiar to young people or those who are able to empower parents and work in partnership with professionals such as health visitors and trained volunteers. Interventions should be, ‘intensive and sustainable, multifaceted and involve parents as well as young people’. Interventions should focus on health, education and parent training and preferably be of proven effectiveness. As has already been noted, the latter remains an ideal rather than reality. Interventions should involve joint working with a range of health professionals such as GPs, health visitors, social workers, trained volunteers and Child and Adolescent Mental Health Services (CAMHS) professionals.

The PHIS (2003) Report found that school nurses spent an average of two hours per week dealing with mental health issues, but also found that only nine per cent of class teachers reported receiving any training in child and adolescent mental health. The Scottish Development Centre for Mental Health (2003) reviewed possible examples of good practice in the field of suicide and self-harm prevention with the wider goal of improving emotional and mental well-being. Burnfoot Community School in Hawick was identified as amongst the best practice. The school nurse runs a drop in centre, offers information,

and provides links to other organisations which support young people. Discussion is encouraged in after-school activities so that mental health is not discussed in isolation but alongside more general health and social issues. This practice is one example which is in line with the Scottish Executive's aim of 'mainstreaming' mental health in order to reduce stigma and encourage early help-seeking behaviour.

Across the UK, 'circle time' has become a feature of many primary school curricula as they attempt to promote emotional well-being. Circle time is a form of group-work which encourages students to discuss possible problems (emotional or otherwise) openly, which are affecting them in school. However, circle time is hardly used at all in a secondary school context and appears to be seen as unsuitable for older children and adolescents. Some advocates for emotional literacy have argued that circle time may be profitably continued beyond the primary school environment. Successive Ofsted reports have recognised the value of circle time in promoting good behaviour and relationships as well as early identification of disaffected children, though there is no evidence that it directly affects self-harming or suicidal behaviour.

Edwards (2003) surveyed some recent 'peer support' schemes and provides a useful summary of several initiatives which aim to include students themselves in the promotion of emotional and mental health in schools. One research project funded by the Calouste Gulbenkian Foundation (which financially supported the EL experiment in Southampton and the setting-up of the NELIG website) suggests that circle time has potential for secondary school (Alexander 2002). The research reported that 83% of students enjoyed circle time, shyness was reduced, and there was an increased willingness among students to ask questions in mainstream classes, thereby facilitating learning. More confidence in 'sharing feelings with peers' and a stronger group cohesion are reported as resulting from circle time. One particular group of boys from years 8 and 9, with a history of getting into trouble was targeted in order to prevent future offending. The boys group were involved in their own survey of the problems of local residents with students recruited to do gardening and litter collection in the community. The aim was to change behaviour by having positive expectations and involving others. The outcomes of this project were

rather mixed. The school's head teacher expressed a commitment to continuing with the initiative, though there were 'lapses' in the boys' behaviour afterwards.

A survey of peer support schemes (Alexander 2002) reports on case studies in five English schools which developed various types of intervention to promote the emotional and mental health of young people. The schools were: one small semi-rural school of 750 students, two large mixed comprehensive schools in London with 1300 and 2000 students respectively, one school in a deprived area in the North East (numbers not known), and one large mixed comprehensive school of 1500 students in a city suburb. The survey asked school staff and peer workers to identify their own practice in relation to the emotional and mental health of their students.

The small semi-rural school had a team of 24 'peer counsellors', selected through application and interview, who were trained by *Childline's* London staff. Teachers reported that peer counsellors were encouraged to develop a mature attitude to their work with younger students, thus developing knowledge, increased self-confidence and better interpersonal skills. Teachers reported that the peer counsellors' support for students going through the transition from primary school was most appreciated.

In the London comprehensive school with 1300 students, up to 70 languages had been identified as regularly spoken in the students' homes. In addition to their existing anti-bullying programme, the school introduced a 'peer listening scheme' in order to develop their anti-discrimination agenda in the attitudes and behaviour of new students. The peer listening scheme was created and delivered by two external voluntary agencies. Alexander notes that peer education schemes are typically one part of much broader school-based approaches to promoting emotional and mental well-being.

In the second large London mixed comprehensive (2000 students) a peer listening scheme was introduced to help tackle the problem of bullying. Peer listeners and teachers who volunteered to be 'peer support workers' were trained by the relationship counsellors at *Relate*. Peer listeners reported that they were available in the playground at breaks for any student to approach. They also befriended younger pupils to enhance their

perceptions of safety in the school environment. The research reported that peer listening had helped to reduce conflict and help to create a better atmosphere in the school.

In the North Eastern school, a more general peer support training was provided, including listening and communication skills, buddying and anti-bullying strategies. The school reports that students were concerned about levels of bullying in the school and the push for change came from students themselves. The peer support scheme widened its remit to take in anti-bullying, peer pressure, smoking, health education, team building, self-confidence and promoting listening skills. 'Peer supporters' met with staff once every half-term for guidance and support and links had been forged with the local medical centre and youth project. In the last, city suburb school (1500 students), 'peer mediators' were trained by the existing school counsellor.

Five school-based projects funded by the Mental Health Foundation (MHF 2002) also looked at the potential of peer support in secondary school environments. Their own evaluation found that the senior management team's support for these schemes was crucial, as was a representative group of 'peer supporters'. External evaluation of the schemes was partial as 66% of peer supporter responses came from three schools only and 57% of staff responding came from just two schools. A clear gender divide emerged from these schemes. Girls dominated the peer support schemes. Of 50 'peer support' respondents, just six were boys, but the reasons for this were not investigated. The Mental Health Foundation concluded that peer support benefits both the school and scheme participants. They may promote mental health by:

- Giving access to sources of help
- Building confidence and self-esteem in participants and students
- Teaching strategies to deal with bullying and peer pressure
- Promoting confidence and skills in peer supporters
- Teaching students how to relate to others.

Lessons learned from the projects are:

:

- Peer support should be part of a whole school approach to guidance.
- Support of senior staff, guidance staff, and a group of staff ready to commit to the project is essential.
- A needs analysis should inform the aims and objectives of schemes
- Adequate time should be allocated to maintaining the programme
- There must be clear rules on confidentiality
- Regular, consistent supervision and monitoring for peer supporters
- The programmes should be continually monitored and evaluated (Edwards 2003).

6.2 Examples from outside Scotland and the UK

Most research studies and programme evaluation research has been carried out in the USA rather than UK or Europe. Nicholas and Broadstock (1999) found few examples of good quality research on programme effectiveness, noting that most studies focused on children in middle childhood rather than adolescence. Durlak and Wells's (1997) meta-analysis of 177 child and adolescent mental health promotion interventions in the USA focused on interventions targeted at normal populations rather than those considered 'at-risk' (ie; universal interventions). The majority of these achieved positive effects with average effect sizes ranging from 0.24 to 0.93, depending on the particular intervention reported. These effects were reported to be superior to those achieved for preventative medical interventions that have effect sizes typically estimated as 0.07. This analysis focused on 'mental health' effects and was not directly focused on suicide or DSH prevention. In contrast, Clarke et al (1993) report that an educational and skills-training intervention with 14 and 15 year old students in two American schools showed no identifiable effects on 'depression, knowledge, attitudes towards treatment or actual treatment seeking'.

The School Transitions Environment Project (STEP) in the USA targeted a reduction in stress levels and better support for high-risk students during the schools transition period

(ie; a selective intervention). 20-30 new students were allocated to so-called 'homerooms' in which, they stayed together for a minimum of four subjects a day. Homeroom teachers committed themselves to the extra responsibility of offering advice and counselling. Evaluation of the scheme found that it, 'prevented deterioration in grades, attendance and levels of self-concept' (Durlak 1997). Teachers also reported improvements in classroom behaviour. Again, although this project seems to have had some impact in improving self-concept and contributing to better behaviour, it was not targeted at suicide prevention or reducing the incidence of DSH.

Nicholas and Broadstock's (1999) assessment of one 12 week school-based intervention in the USA, based on providing education and training and concentrating on self-harm and emotional distress, is that it was 'quite effective' in reducing 'potential suicide'. Like many other programmes it also led to increased knowledge about suicide as well as available sources of help. Nevertheless, it is worth repeating that better knowledge and the dispelling of myths does not automatically lead to changes in behaviour. It is not clear what Nicholas and Broadstock mean by reducing 'suicide potential', a term which is vague and not common in this literature.

An American review of 102 interventions (Haney & Durlak 1998) targeted at the promotion of higher self-esteem and improved self-concept found that the majority of interventions produced a 'modest' effect, though 'general' interventions (ie; those with less clearly defined aims) were less effective than those focusing specifically on promoting self-esteem and self-concept. Also in 1998, suicide prevention interventions in New Zealand were reviewed by Hider (1998), who found few controlled evaluations and could not recommend any on the basis of proven effectiveness. This is also a very common conclusion amongst reviews in the USA and Europe.

A meta-review by Guo, Scott and Bowker (2003) concluded that there was uncertainty and insufficient evidence as to the effectiveness and safety of school-based suicide preventive programs for adolescents. The programs directed to 'at-risk' students appeared 'promising' in terms of a reduction in suicidal risk behaviours and enhancement of

protective factors compared with universal interventions. In three systematic reviews reported by the authors the consensus was that there is insufficient evidence from evaluations to either support or not support school-based curriculum programs. Suicide prevention programs may also have some negative effects on certain groups of students, particularly those already defined as ‘at-risk’. As noted, according to Guo and Harstall (2002), evidence from reviews with a relatively good methodological quality suggested that suicide prevention programs targeted to the at-risk population appeared promising and encouraging in reducing suicidal behaviour among adolescents.

In Crowley et al’s (2004) review of school-based suicide prevention programmes, none were definitely supported by the evidence. Those aimed at changing behaviour and teaching coping strategies showed limited evidence of effectiveness. Curriculum-based suicide prevention programmes had conflicting or inconclusive evidence of effectiveness. A lack of evidence characterised school-based programmes to reduce suicide amongst young adults and adolescents, whilst education-based and knowledge-based interventions were identified as non-effective and even potentially harmful for some groups of students (Table 6.1).

Table 6.1: Summary of the effectiveness of interventions to prevent youth suicide

	Evidence of effectiveness	Limited evidence of effectiveness	Conflicting or inconclusive evidence	Current lack of evidence of effectiveness	Evidence of non-effectiveness or of harm
School-based interventions		Programmes stressing behaviour change and coping strategies lowered suicidal tendencies and in some cases improved coping skills	Curriculum-based suicide prevention programmes and their impact on attitudes about suicide Training in coping skills in schools	School-based programmes to reduce suicide among young adults or adolescents	Some evidence that school-based education initiatives may increase suicidal behaviour among adolescents Knowledge-based sessions were ineffective in preventing depression

[Source: Crowley et al 2004: 46]

7. School-Based Emotional Literacy Initiatives in the UK

7.1 Developing Emotional Literacy in the Educational Context

The Scottish Executive has identified ‘emotional literacy’ as a key element in its *Choose Life* suicide and self-harm prevention strategy. However, suicide and DSH prevention are not the primary focus of the overwhelming majority of EL programmes, initiatives and interventions which concentrate instead on lowering school exclusions, increasing motivation and thus academic performance, preventing bullying, reducing conflicts and producing better interpersonal relationships. The concept of EL is now widespread within the grey literature rather than within the UK academic community, though this may be changing. In the USA, EL is embedded within the wider framework of social and emotional learning (SEL) in curriculum design and almost all of the evaluations of emotional literacy in the school setting have been carried out in the USA with almost none elsewhere (Weare 2004: 83). School-based SEL programmes have been seen as successful provided that they are well supported, have good curriculum design, co-ordinate with larger systems and teachers and professionals are properly prepared (Weissberg et al 2003). Such programmes address emotional and mental health, substance abuse, violence prevention, sexuality, character and social skills. Key SEL competencies are awareness of self and others, positive attitudes and values, responsible decision making, and social interaction skills (Elias and Weissberg 2000).

EL and EI are closely related concepts (or ‘constructs’) for which a great deal has been claimed. Emotional literacy/intelligence is said to facilitate workplace promotion, help people to forge and maintain relationships, enhance cognitive achievement in schools, reduce conflict, promote tolerance, improve students’ motivation and generate psychological and mental well-being. Emotionally literate people are said to be better equipped to ‘deal with difference’ and therefore make better citizens for multicultural societies. EL has also been seen as potentially redressing the cultural imbalance between masculine and feminine characteristics so that the latter are allowed to rise from their previously subordinate status (Orbach 2001).

One advocate describes EL as ‘intelligence with a heart’ (Steiner 1999), which means that EL programmes are ‘value-driven’, aimed not simply at creating emotionally intelligent young people who are able to, ‘recognise, understand and manage their own emotions and those of others’, but also to do this, ‘in ways that are helpful to ourselves and others’ (Weare 2004: 2). There are many reports in the grey literature which claim successes for such programmes and initiatives but these claims are overwhelmingly based on weak evidence, usually gleaned from those actually taking part in or promoting the initiative itself. There are no systematic reviews of school-based EL programmes, nor have the myriad small-scale, usually single school experiments been systematically assessed for effectiveness. Given the advocacy of EL by the Scottish Executive it would seem that evaluation of EL interventions by independent researchers, based on objective criteria is an urgent priority.

7.2 School-Based Emotional Literacy Programmes

Despite very weak evidence for the success of EL interventions in the school context, many small projects aimed at improving students’ EL have been introduced into secondary schools across the UK, many of them dealing with anger management as part of anti-bullying and conflict-reduction strategies (Faupel et al. 1998). These projects can therefore be seen as educational experiments in emotional literacy (Sharp 2001) aimed at creating ‘emotionally literate schools’ (Weare 2004).

This section describes the claims for effectiveness of EL initiatives using small-scale school-based projects together with Southampton Education Authority’s five-year ‘emotional literacy experiment’, the first to put EL into mainstream education policy. Given the RGU EWB project’s focus on the secondary school transition, only those projects which are delivered in secondary schools are included here. A recent promotional book produced by *Antidote* (‘the Campaign for Emotional Literacy’)(2003)

gives some examples of EL interventions and a sample of these with a brief description and assessment follows.

7.2.1 Westborough High School (Kirklees, West Yorkshire)

This intervention uses an Induction Day on arrival as an introduction to ‘The Westborough Way’ – ie; discrimination will not be tolerated, prejudices will be challenged, learn about the effects of bullying and racism, students will be encouraged to find ways of working co-operatively and learn about the importance of respect for each other’s cultures but the school will be tough on intolerance and indifference. These issues are revisited in PSHE lessons and tutor groups throughout the school career. Teachers are encouraged to be available and recognise that students need many opportunities to explore their feelings and thoughts.

Antidote claim that Westborough’s academic record has improved significantly since 1992 and that the school’s ‘relaxed and positive’ environment makes a major contribution to this. A former head teacher of the school says Westborough ‘is a telling school. If there is a problem, it is talked about and dealt with. Things are never allowed to become issues.’ (Antidote 2003: 6). Rather than concentrating on raising the EL of individuals, this programme tries to change the school culture by creating a distinctive identity for Westborough students which they are encouraged to adopt. EL plays a part in this as students are presented with many opportunities to openly discuss their feelings and develop their emotional competence in a ‘relaxed and positive’ school environment.

7.2.2 Cotham School (Bristol)

Cotham is an inner city, multi-racial and multi-faith 11-18 school. The school’s Development Plan explicitly commits it to EL. The school works with the community to, ‘shape narratives that might help it work towards becoming in some sense, an emotionally literate school community’.

The focus is on '6 narratives':

1. working with students about what it means to be learners
2. explaining the implications of being a multiracial, multi-faith community and a positive environment for children
3. distressed or disaffected students to be tackled through psychodynamic, therapeutic interventions. Acceptance that behaviour is communication
4. the school will be successful if staff, parents and students' voices are heard, listened to and acted on
5. working with feelings outside and beyond the curriculum seeking to be affective and effective rather than rational and instrumental
6. working with new ideas about leadership

Antidote claims that the school 'will have' raised its five A to C grades from 60-80 per cent over a three year period (2003: 7). This appears to be an aim of the approach rather than clear evidence of success. The focus on 'narratives' is also rather vague. It is not clear what 'narratives' actually are and no definition is offered. This approach appears to be unfocused or 'general' rather than concentrated and although claims for success have been made it needs to be remembered that the literature on school-based interventions of many kinds strongly suggests that unfocused approaches tend to be less effective than those with clear aims and objectives.

7.2.3 Walton High School (Staffordshire)

Walton High is a large 11-18 comprehensive school with a mainly middle-class intake which claims to have introduced one of the first UK 'peer-support' systems organised and run by students themselves. The school also introduced anti-bullying contracts which all students are expected to sign. The peer support system is based on 'buddies' who take 7 days of 're-evaluation counselling training on how to manage and release emotions, and provide a confidential listening and helping service'. Essentially, this is similar to several other peer support schemes described above. The buddies organise weekly lunchtime

drop-in sessions over lunchtime and offer a limited guarantee of confidentiality to students. The scheme is organised around the following:

- All Year 7 tutor groups have between 2 and 4 buddies who visit once a week, play ‘self-esteem games’ and teach basic listening and counselling skills.
- Students from any year can ask for a one-to-one counselling session and buddies’ photographs are located in tutor rooms for identification.
- If preferred, students can write down their request / problem and leave it in a ‘problem box’ at the main entrance from where it can be collected by buddies.

Antidote claims that two surveys carried out by Keele University have shown a reduction in previous levels of bullying and students self-report feeling safer in school than previously. This intervention seems to have been aimed directly at tackling the problem of bullying and no claims have been made regarding academic achievement, suicide or self-harm prevention.

One further school deserves mentioning. At Buckingham Middle School (Sussex) between 1998 and 2003, circle time was extended throughout the school, PSHE lessons concentrated on teaching students to understand the emotional shaping of behaviour, a peer mediation scheme was introduced and the School Council was used to provide a forum for students to voice their ideas about the school. Antidote reports that the local secondary school has adopted a similar approach and is working with Buckingham to develop new strategies. As with many EL initiatives, this one has not been evaluated as effective and claims for success are vague and largely subjective at present.

7.2.4 The Southampton EL ‘Experiment’

In the UK, Southampton City Council was the first to integrate EL into its policy for schools, making EL ‘the third key priority’ in its 1998 Strategic Education Plan. The EL

experiment was led by Southampton's then Principal Educational Psychologist, Peter Sharp and the then Chief Inspector, Ian Sandbrook. This development ran alongside the creation of a National Emotional Literacy Interest Group (NELIG) with its own website (from 2000) and a Southampton ELIG (SELIG). Since the creation of SELIG, EL interest groups have been formed in the West Midlands, Devon, Gloucestershire and Wiltshire in England together with East Ayrshire in Scotland.

The scale of the Southampton experiment marks it out as easily the most significant attempt to introduce the EL concept into UK education and for this reason deserves special attention, though it has not yet received a full evaluation (Sonuga-Barke and Stratford 2000). Weare (2004) reports that four other LEAs were 'looking at' EL as part of other organising frameworks: Cumbria, Leicestershire, Birmingham and North Tyneside. However, only Southampton's approach was framed by the concept of EL and it is not clear to what extent the other four LEAs re-focused their existing work around EL. SELIG says that 18 other LEAs have commissioned work from them and more than 60 LEAs have received some element of SELIG's EL training, mostly anger management courses.

SELIG argue for a developmental approach to EL in schools as follows:

There should be an incremental approach to the taught curriculum, which is age, stage and ability-specific. So this will generally begin with the teaching and exploration of a feelings vocabulary, then move on to developing understanding of feelings, and then later to the management and appropriate expression of feelings. This may be mediated through work and play, but should lead to a stronger sense of identity for children, for their feeling of belonging, and ultimately to the development of meaningful and enduring relationships (Faupel and Sharp 2003: 5)

Drawing freely from work on emotional intelligence, it is suggested that an 'emotional competence framework' consists of self-awareness, self-regulation, motivation, social

competence and social skills. This can be produced through developing conscious awareness, understanding thoughts, feelings and actions, managing feelings, promoting self-esteem, managing conflict, understanding groups and communication skills.

However, SELIG is clear that the plan for an ‘emotionally literate school’ does not simply target students and teachers, but involves whole communities. They point out that teachers and school staff, particularly the senior management team (SMT), parents and parents’ groups, governors and governing bodies, LEAs, social services and health workers all have a role to play. In this way SELIG aims to change the educational culture of the whole school and even LEA in the direction of promoting emotional literacy. The central aim of the Southampton approach is,

to see, in all schools, emotionally literate learners, working with emotionally literate teachers, who have themselves emotionally literate managers, so that emotionally literate schools are working within and emotionally literate local authority (Faupel and Sharp 2003: 3).

The links between EL and EI is explicit in SELIGs work which takes Goleman’s (1996) ‘emotional competence framework’ (ECF) as the model for an EL curriculum. Faupel and Sharp (2003: 5-6) argue that this means developing the a framework which encompasses:

Self-awareness – *knowing one’s internal states, preferences, resources and intuitions:*

- Emotional awareness
- Accurate self-assessment
- Self-confidence

Self-regulation – *managing one’s own internal states, impulses and resources:*

- Self-control
- Trustworthiness
- Conscientiousness

- Adaptability
- Innovation

Motivation – *emotional tendencies that guide or facilitate reaching goals:*

- Achievement drive
- Commitment
- Initiative
- Optimism, persistence and resilience

Social competence – *empathy and the awareness of others' feelings, needs and concerns:*

- Understanding others
- Developing others
- Service orientation
- Leveraging diversity
- Political awareness

Social skills – *adeptness at inducing desirable responses in others:*

- Influence
- Communication
- Conflict management
- Leadership
- Change catalyst
- Building bonds
- Collaboration and cooperation
- Team capabilities

(Faupel and Sharp 2003: 5-6)

Leaving aside the initial, but serious, problem of clarifying these definitions, what seems striking is the sheer ambition of the Southampton approach in relation to the transformation of individual selves in numerous directions, defined as positive in advance

of further discussion and negotiation. Further, according to the ECF above, the self appears almost infinitely malleable. Not only *can* the self be (re)modelled but clearly, it *should* be (re)modelled in order to produce emotionally literate, socially responsible young people capable of better understanding themselves and others.

Obviously the Southampton experiment is, so far, the only one to have taken EL as a guide for the re-shaping of a whole education authority, though there is much interest in the evaluation following the first five years. More widespread are the small-scale EL initiatives designed to address specific school problems such as bullying, conflict and exclusions.

8. Informing the RGU EWB School-Based Intervention

No existing suicide or DSH prevention programme can be recommended on the basis of measurably effective outcomes evidenced in the international literature. Suicide prevention programmes are also aimed at somewhat higher age groups than the RGU EWB project is dealing with. Self-esteem can be reliably measured but there is doubt as to whether existing programmes designed to raise low self-esteem actually work over the longer-term. Emotional literacy initiatives are now quite widespread in the UK but none have been systematically evaluated as effective.

These general findings mean that this Review is only able to identify some of those interventions and elements within interventions which have been said to ‘show promise’ and which may therefore be suitable for the RGU EWB school-based intervention. As the project moves towards informing an intervention, there is a need to consider how to bring together measurement, intervention and evaluation.

- **Raising low self-esteem** - factors which may promote emotional well-being have been said to be: better coping skills, positive self-esteem and better access to social support (Harden 2001). Measuring self-esteem is said to be reliable from

existing and available tools and low self-esteem is a risk factor for suicide, suicide attempts and depression. The RGU EWB intervention could focus on raising self-esteem, perhaps alongside ‘coping skills’ training and raising awareness of existing social support services. Though current evidence for the success of self-esteem programmes is weak, the project would add to existing knowledge of ‘what works’ in this area.

- **Peer Support schemes** - are seen by teachers and students who use them to be helpful in attempts to prevent emotional and mental health problems. Peer educators are usually trained by outside (often voluntary) agencies in a range of skills including: listening, communication, assertiveness, buddying, anti-bullying, team building, self-confidence, assertiveness and passing on what they learn to younger students. The same agencies that train students to become peer educators also train teachers to become peer support workers. Introducing or strengthening existing peer support arrangements could be the focus of an intervention, particularly as Portlethen Academy has its own peer support initiative(s) on which to build. Measurement and evaluation could then focus on levels of self-confidence, happiness, feelings of safety and so on as well as evaluating the system from the standpoint of peer mentors themselves.

- **Emotional literacy** – EL has a growing presence in schools and within the grey literature but EL programmes have not yet been systematically evaluated. Measurement tools are available for emotional intelligence and an intervention could combine these two closely-related concepts. Measures of EI could be taken and possibly derived from earlier survey findings, whilst the intervention itself could take the form of an EL initiative or programme (perhaps circle time and/or peer support?). This could then be evaluated on EI measures across several survey waves and in comparison with the initial cohort survey as part of the wider questions regarding ‘emotional well-being’. However, EI remains as one element within the wider concept of ‘emotional wellbeing’.

- **A combination** of these elements may also be possible, given the research focus on ‘emotional well-being’ rather than simply EL, EI or self-esteem, but the delivery vehicle (intervention) would still need to be identified.

Given the stated aims of Choose Life, the funding body and the RGU research project, on balance, some form of **Peer Support Scheme** would seem to provide the best vehicle for achieving the goals set out above. It would have the distinct advantage of potentially providing a long-term intervention which, if demonstrated to be effective, would remain with the School even after the research project itself comes to an end. Peer Support Schemes are also the most appropriate type of intervention for the specific transitional age range with which the project is concerned.

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