Self-harm training in secondary schools: An educational psychology intervention using interpretative phenomenological analysis.

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Abstract

Self-harm in adolescents is a major public health concern in the UK and affects at least 1 in 12 young people aged 11-25 years. In light of the recent published Government Guidelines on *Mental Health and Behaviour in Schools*, it is timely for Educational Psychologists, equipped with applied psychology, research skills, training in therapeutic approaches, understanding of pedagogy and educational systems to proactively claim their role in supporting schools in understanding and working with low risk self-harm at both a preventative and early intervention level.

This paper outlines a mixed methods research project which explored and evaluated the experiences of a group of 10 key pastoral support staff in a secondary school who attended a training workshop on adolescent self-harm. The aim of the project was to explore each participant's experiences of the workshop in order to capture the meaning and psychological processes at work. The research design comprised of qualitative (Interpretative Phenomenological Analysis- IPA) and quantitative approaches (pre and post training rating scale questionnaires).

This was a small scale research project therefore the key findings from this project are limited to the specific school context and pastoral staff. However, the well-developed and overarching theme of 'connectedness' showed that the training provided a safe and shared reflective space for each participant to connect emotionally and psychologically with their anxieties and understanding around self-harm, which supported their change in attitude and beliefs around self-harm. The shared training experience created a peer support group resource for school based consultations.

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Introduction

Self-harm is a widespread and major public health concern (Department of Health, 2015). A National Inquiry, commissioned by the UK government (Mental Health Foundation, 2006) reported that 1 in 12 young people aged 11-25 years self-harm and there is evidence that suggests the rate of self-harm in the UK are higher than anywhere else in Europe. Future in Mind (DOH, 2015) highlights that a failure to promote resilience, prevention and early intervention of children and young people's emotional well-being is costly in terms of money, physical health, educational and work prospects. There are significant gaps in appropriate support and early interventions for self-harm and mental health (DOH, 2015). The recent, Mental Health and Behaviour in schools (DFE, 2015) guidance highlights that schools play a key role in developing whole school approaches to promoting and improving well-being and preventing mental health problems. Research undertaken in relation to self-harm indicated that secondary schools in the UK are not universally equipped or trained to provide support or manage low risk self-harm (Best, 2005). The National Institute of Clinical Excellence (NICE, 2004) recommends that all staff clinical and non clinical who have contact with people who self-harm should be provided with appropriate training in understanding and managing self-harm. This study explores how Educational Psychologists can play a key role in training schools and mental health leads to develop whole school approaches, procedures and protocols on assessing and responding to low level self-harm in secondary schools. This area of research is significantly under-researched.

Defining Self-Harm?

The only consensus about the definition of self-harm is that there is no consensus. There are no medical diagnostic criteria for self-harm as a specific mental health

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disorder. Although, more recently in the revised Diagnostic Statistical Manual V (American Psychiatric Association, 2013), non-suicidal self-injury (NSSI) was included for the first time in the DSM V as a condition for further study as it was found to be concurrent with major depression, social phobia and post traumatic stress disorder (PTSD).

The Mental Health Foundation (2001) defined self-harm as 'causing deliberate hurt to your own body, most commonly cutting, but also by burning, abusing drugs, alcohol or other substances.' (pg.2). The Foundation lists the following self-harm behaviours: cutting, burning, bruising, hitting oneself, hitting hard objects, overdose, picking skin, pulling out hair, skin scratches and swallowing objects. These self-harming behaviours are considered to be of low lethality, however, the frequency, types of substances and objects taken have implications for the degree of risk. The Young Minds Organisation (2003) explores a definition of self-harm that captures the experiences and feelings linked with self-harm: 'a way of dealing with very difficult feelings that build up inside.' (pg. 3). Self-harm is a maladaptive coping mechanism in response to expressing profound emotional pain.

For the purposes of this study the following self-harm definition- non suicidal self-injury (NSSI) was adopted. The purpose of the study was to explore the role and impact of Educational Psychologists' training in secondary schools to raise school's confidence and competence in assessing and responding to low risk self-harm where there is intention to damage one's own body tissue without the conscious intent to die. Self-harm is engaged in repetitively to relieve stress, significant emotional distress and numbness which acts as a form of communication where words fail (Jacobson, Mufson, 2012).

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Self-harm as a coping and control mechanism

In the UK, cutting and self-poisoning are the most common forms of self-harm acts (Fox & Hawton, 2004). Cutting to the wrists and forearms is generally considered as low risk lethality. Self-poisoning (overdosing) by its nature, results in more hospital admittances.

The cycle of self-harm (Jacobson & Mufson, 2013) highlights the cyclical nature of self-harm and how it functions as a control and coping mechanism to relieve unbearable emotional distress. A trigger event, often an inconsequential incident triggers stress/distress. In order to relieve the profound emotional pain, a self-harm act that one controls takes place to relieve tension, providing some respite from the torment, enabling them to cope as they have broken through the unbearable feelings. However, following the act, feelings of guilt and shame about the self-harm act replace the feelings of relief and coping and the intense feelings can build up over time which are then triggered by an event that increases stress.

The cycle of self-harm shows the range of functions served by self-harm such as control, coping, relief of tension, expression of profound emotional pain and comfort. The cycle also explains the difficulties arising through compromised communication and problem-solving skills due to high levels of distress and stress (Jacobson & Mufson, 2013).

Self-harming behaviours are differentiated from the culturally acceptable self-harming behaviours- CASHAS (e.g. nail biting, alcohol intake, under/over eating) by the level of desperation and emotional distress involved and the degree of the behaviours. Turp, 2003 coined the concept of CASHAS and explored self-harm in terms of compromised self-care which removes the idea of identifying self-harm as a qualitatively distinct condition unrelated to normal behaviour. Underpinning Turp's

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interpretation of self-harming behaviours is the idea that the act of self-harm is a 'self-soothing' form of self care which is very normal in the context of ordinary behaviour (Turp, 2003).

Secondary Schools and Self-harm Research

Self-harm amongst young people is widespread and the consequences are far reaching. Schools have daily contact with young people. They are 'front line' in terms of managing young people's social, emotional and behavioural problems that impact on their learning and relationships at school. They are aware of changes in normal patterns of behaviour, social and academic functioning. By creating a supportive, nurturing and caring learning environment for young people, emotional well-being can be promoted. In terms of self-harm, the reaction a young person receives when they disclose their self-harm has a major impact on whether they seek help and recover (Mental Health Foundation, 2006).

Teachers' perceptions of and responses to self-harm were explored by Best (2005) in a qualitative pilot study, triggered by a request from an independent church girl's school in a predominantly middle-class area seeking guidance on developing a self-harm policy. Semi-structured interviews were conducted with 34 predominantly 'front line' professionals working in the educational sector, including, teachers, counsellors and school nurses. Best's study was a small study, therefore the findings cannot be interpreted as representative for all schools in the UK. Best's study did not define the parameters of self-harm, therefore the range of self-harming behaviours that the participants described as self-harm was unclear. The participants included teachers, care worker in a secure unit, school chaplain, counsellors, clinical psychologists, social worker and NHS child & adolescent mental health workers. This had implications in terms of the study's focus of schools' responses to self-harm. Some of the participants did not work in a school context. They would also have had some

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experience with working with self-harm due to the nature of their professional role, such as the clinical psychologists, care worker in a secure unit and social worker based in Child Guidance. Therefore these participants could not be considered to represent schools' responses to self-harm. The manner in which the semi-structured interviews were conducted was inconsistent. The majority of the interviews were conducted with individual participants, but there was also one group interview with three members of staff from a secure unit for youth offenders. The variations in the interview times also varied significantly from fifteen minutes to an hour and a half. The lack of consistency with how the interviews were conducted may have implications on the quality, range and type of data collected.

However, the study highlighted the lack of schools' provision for young people who self-harm and the need for more research in the area of schools' experiences and responses to self-harm. Best found that the levels of awareness of self-harm and prevalence rates were low with estimates ranging from 0.16% to 2.1% in schools, whereas 10-15% was a more realistic estimate of self-harm prevalence rates (Truth Hurts. 2006). Best's study also showed that training provision on self-harm in schools was inadequate, 'for most interviewees (excluding the school nurses), explicit courses on self-harm were virtually non existent even for staff in Pupil Referral Units and the secure unit.' (Best, 2005, pg. 282)

Schools' attitudes and responses to self-harm

How one responds to self-harm can greatly influence and impact on whether the young person seeks help. Therefore, it is important to understand schools' and teachers' knowledge and attitudes towards self-harm.

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Research investigating the knowledge and attitudes of health professionals in response to self-harm is more common than investigating schools' or teachers' knowledge and attitudes towards self-harm (Heath, Toste & Beettam, 2006). The National Inquiry reported that the young people interviewed about their experiences and interactions with health professionals said that they often encountered a negative interaction and a lack of understanding with health professionals. However, there are some studies that have also shown that young people have reported positive experiences and encounters with health professionals (Burgess, Hawton & Loveday, 1998). It appears that the variations in the young people's experiences between the different studies may represent the different services, professionals and contexts involved. Crawford, Geraghty, Street & Simonff (2003) suggested that it was likely that Child and Adolescent Psychiatric Services have a more positive attitude towards these patients. In a study conducted by Patterson, Whittington and Bogg (2007), they tested the effectiveness of an educational intervention aimed at changing nurses' attitudes towards self-harm. They found that following the training, there was preliminary evidence that showed a 20% reduction in antipathy towards self-harm amongst course attenders that was maintained over a period of 18 months, compared with a 9% reduction in the comparison group who attended a different course unrelated to self-harm. Crawford et al.'s study showed that for those health staff who felt more effective in their approach to self-harm also felt less negative towards their patients who self-harmed. The health studies discussed show that more understanding of self-harm and an increased belief in effectiveness regarding one's ability to manage self-harm can contribute to more positive attitudes, engagement and a capacity to help (Patterson et. al, 2007). Best's study focused on knowledge and attitudes towards self-harm in educational settings. He found that pastoral staff were the key members of staff who generally managed and were more likely to be aware of self-harm issues/cases in schools. The wide range of feelings and emotions reported by school staff in relation to self-harm were:

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' alarm, panic, anxiety, shock, scared, repulsed, bewildered, fazed, mystified, incomprehension and frustrated etc.' (Best, 2005, pg. 168)

Best reported that the panic responses were in relation to the common myth that self-harm is a suicidal behaviour which triggers an immediate 'fight or flight' reaction to self-harm especially where levels of awareness amongst school staff was low. Best explored how different types of self-harm can lead to different responses, for example, where self-harm is seen as an unnecessary and risky behaviour or where young people do it for acceptance into a group or that it's 'cool' or 'attention seeking,' more negative attitudes tend to be associated with these views of self-harm and unsympathetic responses. Best's study concluded that:

'Education for teachers in the aetiology and recognition of self-harm and the many forms it takes combined with training in basic counselling skills and a clear induction into the established policy and procedures (where they exist) to be followed within the school are obvious starting points.' (Best, 2005, pg. 173).

Local Context of the Study

The ACCESS Service comprised of Education, Social Care and Health professionals working as one team to support vulnerable young people and their families in schools and the community to promote resilience and emotional well-being. There were no other services within the Local Authority or Child and Adolescent Mental Health Services (CAMHS) that provided training to schools in self-harm. A cluster of secondary school Head teachers' from within one Local Authority had requested ACCESS to provide self-harm training as they were concerned about the increase of students who were self-harming and their staff's lack of knowledge and understanding of self-harm.

A one day self-harm training was developed and provided by a Specialist Educational Psychologist (Researcher) and an Integrative Arts and Interpersonal Psychotherapist. The training comprised of facts, figures, myths and definitions of self-harm, two key experiential activities which included, exploring the meaning and communication behind self-harm and exploring own experiences of stress and coping mechanisms as well as case studies and a focussed group task to develop a self-harm protocol. The aims were:

to increase knowledge and understanding of self-harm, identify significant risk factors, develop effective strategies in supporting young people and to develop a school self-harm protocol.

Research Questions:

1. How is the adolescent self-harm training experienced by the participants?
2. What aspects of the self-harm training worked and why?

Mixed Methods Design

Both qualitative and quantitative data were used for this study in order to provide a more in depth understanding of the research data. This is consistent with a critical realist perspective as the mechanisms at work are revealed through the participants' experiences (qualitative) and the numerical value they assign to the effects (quantitative). The mixed methods design enabled the researcher to explore whether the training led to an increase in knowledge and understanding of self-harm and explore the experiences and perspectives of the participants who attended the training to understand what and why it worked.

Questionnaires

Pre and post training questionnaires consisting of an ordinal rating scale (1 low to 5 high) of: a) knowledge of self- harm, b) appropriate strategies and c) significant risk

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factors were used in the study to gain an overview of the participants' base line rating of their knowledge of self-harm before the training and how this rating compared after the training. Ordinal rating scales order the category from low to high or less to more, however the value between each rate is not exact.

Descriptive statistics were applied to the pre and post questionnaire data (Statistical Programme, Windows Version 14) to summarise statistics and create pre and post training boxplot measures of the three variables: knowledge of self-harm, strategies and significant risk factors. Boxplots are a graphical display of the numerical data around the central tendency (median: central value of all scores when arranged in order of size). The box plots presented the distribution of scores of each variable.

Interpretative Phenomenological Analysis

At the heart of phenomenology is the study of human experience and accessing the world of the research participant. Interpretative phenomenological analysis (IPA) was developed by Smith to explore the experiences of the participants within the field of health psychology. The approach attributes the participant as the 'expert' on their own experiences and also acknowledges that the analyst engages in a 'subjective and reflective' process to interpret the experiences of the participants. IPA accepts that the researcher brings as part of their interpretation of the 'lived experiences' of the participants, their own personal beliefs and positions to the interpretation process and accepts that the phenomenological analysis is the researcher's interpretation of the participant's experiences (Willig, 2008).

IPA takes an inductive approach (bottom up) where there are no prior hypotheses or assumptions made. IPA seeks to explore the 'lived experiences' and 'insider's perspective' of participants and surpasses any objective truth or reality (Smith, Flowers & Larkin, 2009). Smith argued that through the process of exploring the

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experiences of the participants, their underlying cognitions such as beliefs and attitudes can be accessed. All qualitative data from the individual interviews were analysed following Smith's recommended 5 IPA analysis steps (read/re-read, recurring key descriptions, recurring themes, categorise subthemes, superordinate themes).

Interviews

Design of the semi- structured interview post training

A pilot semi-structured interview was devised comprising of seventeen questions. The questions were structured around each area and activity that the training covered. Following piloting the questionnaire with two participants who had attended a previous training (feedback-questions were too prescriptive and long and did not allow the participants to 'tell the story of their experiences), the semi-structured interview schedule was revised and the structure was informed by a developmental approach to access and engage the participant's stories about their experiences of the training. The developmental structure took the shape of 10 questions in total comprised of a) engaging them in telling their story about their role in school, b) what interested them in coming to the training, c) their expectations and experiences of the training, d) attitudes and feelings towards self-harm. Each question was simplified to one key focus area and centred round process.

Participants

A purposive sample was selected. A purposive sample has the advantage of reducing the levels of extraneous variability as it is a target sample defined in terms of role, shared 'client' and working context. However by using a purposive sample, the findings from the study cannot be sweepingly generalised to a larger and more diverse population. The sample comprised of 10 secondary school pastoral staff (nine female and one male), none of whom had previous training in self-harm

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School

The school is a popular mainstream co-educational secondary school for pupils aged 11-18 years. The school had recently restructured their pastoral support system to implement a range of 'interventions' to support vulnerable students The aim is to improve academic grades and support students personalised learning and emotional well-being to enable each student to fulfil their potential.

Interview Procedures

Participants were interviewed over a six week period following the training. The interview slots were dependent on the mutual availability of the participant and researcher. The interviews were conducted in a private room in the school during the participant's free period however as they were pastoral support staff, they were on call all the time to parents, school staff and students regarding pastoral concerns and some interruptions occurred during the interview. All the interviews were completed in the same session. The interview times varied from twenty five minutes to forty minutes depending on the responses of each participant.

Results

Part One: Qualitative Data- IPA

Each transcript was analysed systematically and coded adhering to the 5 IPA stages (Smith et al., 2009). Two peer auditors also examined one complete transcript each for consensus replication. One predominant superordinate theme emerged from the IPA: 'connectedness.' Eight sub themes emerged from the superordinate theme.The themes were interrelated and at times overlap, but provide a framework to organise the complex data set. Theme 9 was around the dissatisfaction with the training time schedule. Paradoxically, the dissatisfaction with the timing of the sessions was raised as an issue as the participants wanted to stay connected and immersed with the topic and group process.

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1. Connectedness to the school culture (interventions).

2. Connectedness to supporting students who self-harm.

3. Connectedness to the pastoral role .

4. Connectedness with group facilitators (group process).

5. Connectedness to peers (group process).

6. Connectedness to the internal state of mind of self-harming.

7. Connectedness to the psychological models of self-harm.

8. Connectedness to thinking about positive strategies and responses to self-harm.

9. Dissatisfied with the limited time allocation for training.

PART TWO: QUANTITATIVE DATA- PRE & POST TRAINING QUESTIONNAIRE RATINGS

These findings are based on the quantitative data collected from the pre and post training through ordinal rating scales:

Table 1: Participants' Pre and Post Training Knowledge ratings of:
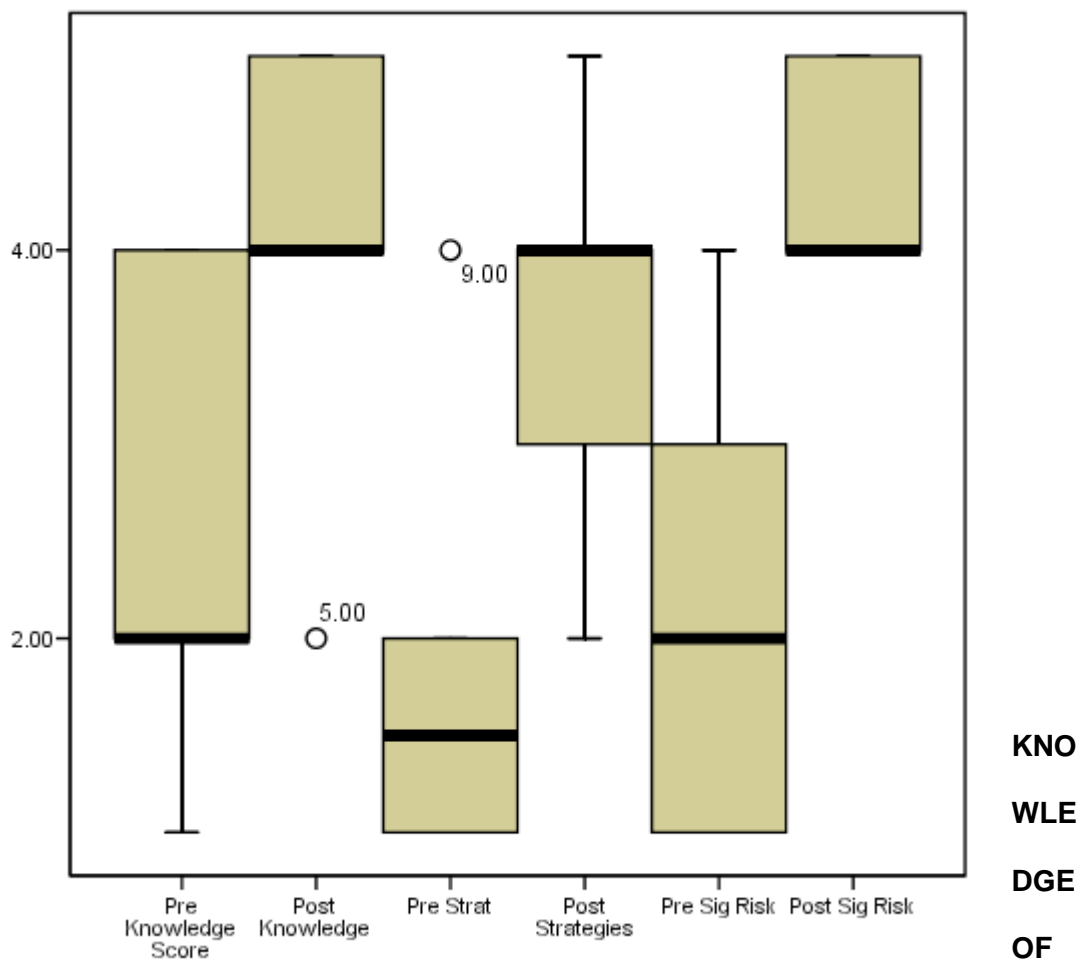
Self harm (K)

Strategies in supporting self-harm (S)

Significant risk factors of self-harm (SR)

SCALE: 1=low 5=high	PRE- TRAINING			POST –TRAINING		
PARTICIPANTS	K	S	SR	K	S	SR
ANN	4	2	4	4	4	5
RITA	2	2	2	4	4	5
VERONICA	2	2	2	4	3	4
LUCY	1	1	1	4	4	4

NIGEL	3	1	2	2	2	4
RACHEL	2	1	2	4	2	4
SANDRA	4	2	3	4	4	4
EVA	1	1	1	5	5	5
KEEVA	4	4	4	5	5	5
CATHY	2	1	1	5	4	4

Table 2: Boxplots and Pre & Post Training Distribution of Ratings on Knowledge of Self-harm (K), Appropriate strategies (S) and Significant Risk Factors of self-harm (*SR*).

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SELF-HARM

Table 1 and 2 show that pre-training, the ratings on knowledge of self-harm, strategies and significant risk factors were low between 1 and 2 on average (with the exception of Ann & Keeva (4) which will be explained in Part 3) but post-training, the average ratings on knowledge of self-harm, strategies and significant risk factors increased to 4 and 5. The boxplots provide a graphical display of the median of the scores and the shape of the distribution of each of the three variables pre and post training across a range of 1 to 5 (1=low 5 =high).

PART THREE: TRIANGULATION AND COMPLEMENTARITY

The quantitative data informs us that the overall group distribution scores for knowledge on self-harm, strategies and significant risk factors increased from ratings of 1-2 to 4-5. There were however, scores that went against the trend. The qualitative data from the IPA provides further insight into the meaning of the scores that were inconsitent with the trend and pattern of the overall scores.

On the pre-training rating on knowledge of self-harm, three participants' scores fell in the upper range of the distribution of scores (4). One of the participant's taught 'A' level psychology and felt that she had a good grasp of the psychology of self-harm:

Sandra: Interview 7

(um) There were parts when I felt a little bit frustrated probably because of my background in psychology and having perhaps a greater understanding than others in the room who do not have a psychology degree …

The other two participants had experience of successfully supporting a student over a period of time who was self-harming. The students had stopped self-harming.

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Keeva: Interview 9

(um) about three years ago I was a form tutor here and one of my tutees was self-harming and she came to me…But I think it's just knowing exactly what to do if that situation comes up again and I think once you've had a personal experience that close to you because you know I took her all the way through school…and it was just sitting down and saying to her 'well look we can sort this out. We can deal with this'…and she didn't stop straight away but it got less and less and less and eventually she did and it was just a real relief she was fine and she is now you know…

However, a higher level of perceived knowledge pre training did not translate to greater understanding and 'connectedness' with the experience of self-harm as these quotes show:

Ann- Interview 1

Hmm apart from seeing images on TV, you know, the odd documentaries on prisons, women prisons and that sort of thing, the thing that stands out in my mind is when I took my children to north open air pool and there was a young woman there…who had been cut or the scars actually, not cut but the scars, inch long scars all over her body absolutely all over…I just couldn't understand how she could have done that to herself…visually it was quite shocking.

However, this quote shows how following the experiential activity, Ann had connected with the experience of self-harm through understanding her own coping strategies. She had a greater capacity to understand the function and emotional turmoil of a person who self-harms:

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Ann- Interview 1

…I'm a hideous picker, when I get really stressed I'm a scratcher, I am. I thought 'oh God that's me, I do that' or 'I go for a glass of wine or two or three (um) but hopefully I can sort of detach myself from the habit forming but there is a bit of a habit… Yes because I have a better understanding of being able to cope with something and the build up of stress and because I now understand that that and cope in my own way and know that my brain desists when I'm coping…I can associate and compare that with how a self-harmer might feel so from that point of view, definitely, I have changed

On the post-training rating on knowledge of self-harm, one participant's rating showed up as an outlier on the box plots, as it was the only rating that decreased which went against the group trend. The decrease was not due to less knowledge and understanding of self-harm following the training as the quantitative data suggests. Paradoxically, by understanding that self-harm behaviours were not qualitatively different to normal behaviours, heightened his vigilance to self-harm. The realisation that it was not possible to know and identify all cases of self-harm was difficult for Nigel.

Nigel- Interview 5

(um) I think that in week 1, after week 1 my mind was just bubbling over with information and I suddenly started labelling not everybody, but students in my year group and students in the school as self-harmers…I think for the whole week I was getting bogged down in the whole context of it. The second workshop helped clarify a lot more than that by saying 'No not everyone's a self-harmer. People take risks in life. That's normal…but we don't have to have to panic that everyone is suddenly self-harming…Ok we're dealing with what we can but there's all this other stuff going

on but I came out of session 2 thinking as long as we deal with what we see in front of us and what is presented to us then we're doing our job.

Discussion

This study explores the experiences of a group of secondary school staff who attended training on adolescent self-harm. The overarching theme of connectedness can be interpreted through the psychodynamic model of containment (Bion, 1962). 1) The shared connectedness in terms of the school and the pastoral support staff's beliefs that good 'interventions' for students can make a difference. The school and participants were committed to supporting students who self-harm. They were motivated to improve their understanding of 'interventions' for self-harm and to develop a self-harm protocol (Themes 1-3).

2) The training provided a secure base for sharing, exploring and containing anxieties around self-harm, which created a safe, reflective, containing thinking space to engage with understanding and interacting with self-harm on a emotional, psychological, cognitive and group level – 'containment' (Themes 4-8).

Bion's (1962) container/contained theory explores the process of an active experience of an emotional connection between the mother/carer and infant. Bion described the mother/carer as the 'container' and the infant as the 'contained.' The mother/carer is open to and responsive to the infant's anxiety and distress. The mother/carer processes these feelings, makes sense of them (eg fear, discomfort, hunger & pain) and returns them in a more meaningful form to the infant. The infant experiences and internalises an active holding in the mother/carer's mind and a container of feelings that can hold onto thoughts, which soothes them. This experience supports the infant's development of self/emotional regulation and emotional thinking.

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The facilitators created a safe and reflective space for school staff who were connected and motivated by their beliefs and wish to understand and support students who self-harmed. The experiential activities (exploring the meaning/communication behind self-harm and how they experience and cope with stress) enabled the participants to connect with the emotional and psychological 'state of mind' linked to self-harm (difficulties with communicating needs and harnessing problem-solving skills). Through their active experience of peer support: sharing, trust, being listened to, feeling understood and supported, the participants felt safe to draw on their own 'lived experiences' to assimilate and reflect on the emotional and psychological processes involved in self-harm.

The training had enabled the school to develop a self-harm policy and create a peer support group for self-harm.

In order to develop, cumulative knowledge on what works and why in terms of self-harm training, future studies in similar contexts might explore in more depth the 'containment' component found in this study. Further research could explore how 'containment' can support training in different contexts and across a range of professionals (multi-agency). The training content, style and delivery will be different according to the context (residential settings, schools, hospitals, youth teams, social care), the relationships and roles (teachers, parents, social workers, foster carers, nurses and doctors) and the size of the group.

Implications for the professional practice of Educational Psychologists

This study has several implications for the professional practice of Educational Psychologists in relation to mental health and emotional well-being in schools. The Health Committee Report (2014) raised concerns about the fragile funding

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arrangements and disinvestment which have cut early intervention and targeted services for children and adolescent emotional well-being. CAMHS are experiencing an ever growing number of referrals, which they are unable to fully service. In light of the mental health and behaviour in schools guidance and the significant gaps in emotional well-being early intervention services, this study provides evidence based, practice based evidence and a model for Educational Psychologists to undertake a key role in the training on low level adolescent self-harm in secondary schools.

The key components that contributed to a climate conducive to facilitating 'containment' were:

1) Training was provided at a time when the school were developing their 'interventions' to enable all students to achieve their potential. The school and staff were committed to understanding and supporting students who self-harmed and the training.

2) A pre-training planning meeting was set up to agree key aims of the training with the managers and that all participants attended on a voluntary basis.

3) Group rules ensured the confidentiality, commitment, health and safety of the group members and the group.

4) Participants were invited at the start to take active responsibility for their own learning and to dynamically interact with the training experience.

5) A clear and direct route of support was offered on a confidential basis to each participant should the training trigger any emotional issues.

6) The group numbers were capped to 12-13 group members.

7) The self-harm protocol was directly linked to the school and Local Authority's safeguarding policies and procedures and clear signposting and information was given regarding local services for further consultation and referral as appropriate.

Self-harm is a complex and multi-faceted phenomena which evokes strong feelings and responses. This study showed that for the participants in this particular secondary school who were all connected and committed to the training that the key psychological process at work that impacted on the participants' meaningful understanding and engagement with the psychological processes of self-harm was 'containment.' This study also raises the issue of preparedness of Educational Psychologists' in undertaking self-harm training. This might also include a review of Doctorate in Educational Psychology training courses, in terms of whether self-harm and mental health training is embedded in the curriculum?

Educational Psychologists are well placed to support school staff and staff working in the community to provide individual and or group reflective supervision/ consultation sessions in order to support schools and staff working with young people who self-harm. It is important to provide a protected 'mental space' to step back from the self-harm act and respond to the person and the relationship that the teacher/staff member has with the young person. Thinking about what is behind the act and having a staff group support resource on self-harm were two predominant processes that this study found that supported the participants in being freed up to think and reflect about their responses to self-harm, despite knowing that there were no easy answers or solutions.

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The key dynamic process and component from this study was that the training created a resourceful and reflective self-harm peer support group in the school, where self-harm issues can continue to be explored, supported, discussed and kept alive!

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