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Abstracts

Systematic Review of the Literature (SRL): Effectiveness of Universal Secondary School-Based Interventions addressing the Psychological Risk Factors of Eating Disorders in Adolescents

Objective: To evaluate the effectiveness of universal secondary school-based interventions that address core eating disorder (ED) psychopathology, in addition to at least one other psychological risk factor.

Method: A systematic search of databases was conducted, including Scopus, CINAHL, Embase, PsycINFO, MEDLINE and Google Scholar in March 2025. Randomised controlled trials (RCTs) were included if they reported quantitative outcomes following a universal, secondary school-based intervention targeting weight/shape/eating concerns and at least one other psychological risk factor in non-clinical boys and girls aged 11–18 years. A narrative synthesis was employed to synthesise the results, and the Cochrane Risk of Bias (RoB-2) was used to assess the quality of studies.

Results: Seventeen cluster RCTs were included. Eleven studies were conducted in Europe, most participants were female and in middle adolescence. Overall, there is mixed evidence for the effectiveness of universal school-based ED interventions on reducing ED psychopathology and broader wellbeing outcomes, and no changes on BMI. However, the high RoB limits the confidence of findings.

Discussion: Of the improvements, these were in the short term and effects were mostly small or non-existent. Future research would benefit from adopting active comparison groups and longer follow-ups. Whilst core ED psychopathology in addition to the risk factors of body image dissatisfaction, dieting, exercise and social

media appear consistent factors to include in universal interventions, further understanding of the most effective risk factors to target in this population is needed.

Service Improvement Project (SIP): “It’s sometimes so overwhelming you just cry”: Understanding Staff Experiences of Compassion on an Older Adult Inpatient Ward

Background: Working with older adults on mental health inpatient wards can be highly rewarding. Yet the complexity of this patient group, alongside wider NHS challenges, can create threat-based environments whereby staff experience work-related stress and reduced wellbeing. Understanding and experiencing the role of compassion in healthcare staff has been shown to improve wellbeing and job retention.

Methodology and Aims: This service improvement project was conducted in an older adult inpatient ward within Oxford Health NHS Foundation Trust. It sought to understand staff experiences of compassion and to recommend how compassion to self and others can be improved. Ten multidisciplinary staff participated in semi-structured interviews, with their accounts analysed using Thematic Analysis.

Results: Four themes were inferred from analysis. (1) what compassion means to me, (2) “people are running around like headless chickens basically”, (3) (relentless) dedication to the role, and (4) “it’s just as important looking after yourself as it is looking after others”.

Conclusions: The results of this project provide detailed understanding and experiences of compassion on an older adult inpatient ward. Based on this, recommendations to the leadership team were given. This project is a foundation for future research to deepen our understanding of experiences of compassion for healthcare staff.

Theory Driven Research Project (TDRP): Attachment and Self-Compassion in Adolescents and their Prediction on Help-Seeking Intentions for Emotional Difficulties in Schools

Background: Mental health difficulties are rising substantially in young people. Schools are a likely provision for seeking support, yet teachers often feel deskilled, and many young people face barriers to accessing support. Attachment styles and self-compassion have been explored as predictors of help-seeking for mental health difficulties in adults but have yet to be investigated in adolescents. The current study explored possible predictors of young people intending to seek support for emotional difficulties in schools.

Method: One hundred and twenty-nine 14-16 years olds currently attending mainstream secondary school completed a questionnaire measuring factors thought to influence help-seeking intentions including anxious and avoidant attachment, self-compassion, mental health literacy, gender, emotional wellbeing, help-seeking intentions, ethnicity, stigma, and help sought previously for difficulties.

Results: Altogether, multinominal logistic regression analysis found variables to significantly explain 41.3% of the variance in the model. Individually, emotional wellbeing and mental health literacy were significant predictors of informal help-seeking intentions, with the latter a barrier in formal help-seeking too. However, all other variables did not individually predict help-seeking intentions in this population.

Conclusion: These findings have implications for schools helping adolescents accessing support for emotional wellbeing. Limitations of the current study were discussed.

Systematic Review of the Literature

Effectiveness of Universal Secondary School-Based Interventions addressing the Psychological Risk Factors of Eating Disorders in Adolescents.

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Internal Supervisor: Dr Joanna Adams

Proposed Journal: This paper is intended for submission to *International Journal of Eating Disorders* (See Appendix 1.1 for Author Guidelines). This journal has been chosen due to being a leading peer-review journal and mission to advance the understanding, treating, and prevention of eating disorders. Appendix 1.2 contains keywords for manuscript title page, Public Significance statement, and key points.

Abstract

Objective: To evaluate the effectiveness of universal secondary school-based interventions that address core eating disorder (ED) psychopathology, in addition to at least one other psychological risk factor.

Method: A systematic search of databases was conducted, including Scopus, CINAHL, Embase, PsycINFO, MEDLINE and Google Scholar in March 2025. Randomised controlled trials (RCTs) were included if they reported quantitative outcomes following a universal, secondary school-based intervention targeting weight/shape/eating concerns and at least one other psychological risk factor in non-clinical boys and girls aged 11–18 years. A narrative synthesis was employed to synthesise the results, and the Cochrane Risk of Bias (RoB-2) was used to assess study quality.

Results: Seventeen cluster RCTs were included. Eleven studies were conducted in Europe, most participants were female and in middle adolescence. Overall, there is mixed evidence for the effectiveness of universal school-based ED interventions on reducing ED psychopathology and broader wellbeing outcomes, and no changes on BMI. However, the high RoB limits the confidence of findings.

Discussion: Of the improvements, these were in the short term and effects were mostly small or non-existent. Future research would benefit from adopting active comparison groups and longer follow-ups. Whilst core ED psychopathology in addition to the risk factors of body image dissatisfaction, dieting, exercise and social media appear consistent factors to include in universal interventions, further understanding of the most effective risk factors to target in this population is needed.

Introduction

Disordered eating behaviours, including dieting, use of compensatory behaviours (e.g., self-induced vomiting or excessive exercise) are increasing rapidly in adolescents (Lopez-Gil et al., 2023). Around 12.3% of 11–16-year-olds screened positive for eating difficulties in 2023, up from 6.7% in 2017 (Newlove-Delgado et al., 2023). Across 16 countries, 1 in 5 children and young people (CYP) displayed disordered eating, with behaviours significantly higher in cisgender girls than boys (Lopez-Gil et al., 2023). Furthermore, disordered eating is rising in several minoritised groups including those from lower-income backgrounds, transgender and gender diverse, and ethnic groups (Guss et al., 2017; Larson et al., 2021; Rodgers et al., 2017; Simone et al., 2022). While disordered eating can vary in severity, behaviours do not meet the criteria required for an eating disorder (ED) diagnosis (Pereira & Alvarenga, 2007). However, such behaviours can be significant predictors for the onset of EDs (Breton et al., 2022; McClelland et al., 2020).

Disordered eating and EDs can cause significant psychological and physical impairments (Barakat et al., 2024; World Health Organization [WHO], 2022), with mortality rates in EDs higher than any other mental health (MH) condition (Ayton et al., 2024). Whilst there are treatment pathways, significant barriers to accessing services remain (Hamilton et al., 2022) and remission rates are low (Miskovic-Wheatley et al., 2023). In addition, low help-seeking behaviour and high rates of drop out from treatment result in prolonged illness and increased healthcare costs (Austin et al., 2021; Fatt et al., 2020). It is therefore imperative research focuses on effective and practical strategies for prevention and early intervention (Koreshe et al., 2021).

Adolescence is a developmentally sensitive time (Kessler et al., 2005; Micali et al., 2013); emerging research suggests preventative interventions for CYP,

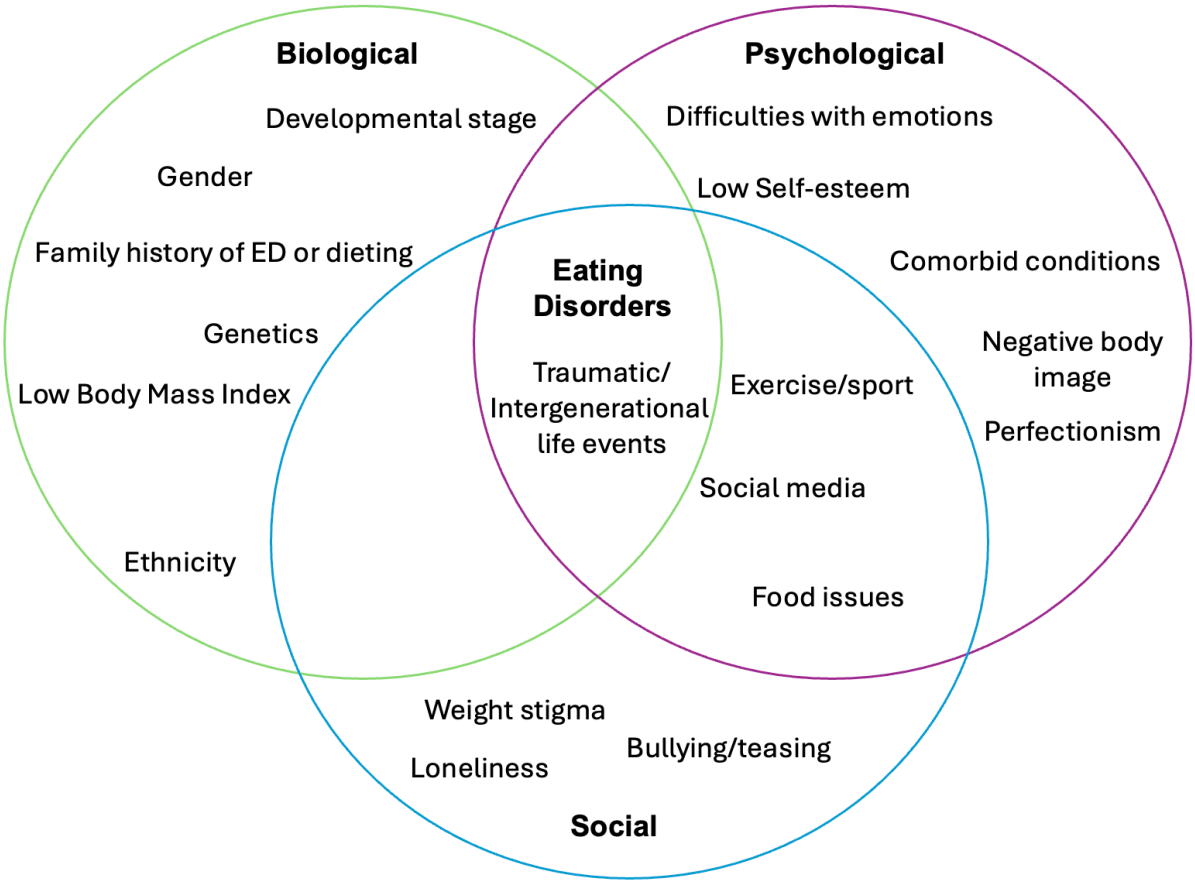
targeting the transdiagnostic core psychopathology of EDs and its risk factors, improves dietary restraint, thin-ideal internalisation, body dissatisfaction, and disordered eating (Chua et al., 2020; Pursey et al., 2021; Schwartz et al., 2019; Stice et al., 2010). Prevention programmes aim to minimise psychopathology and associated risk factors of health conditions and are classified as targeting either a 'universal', 'selective', or 'indicated' population (WHO, 2004). Universal programmes target a whole population group that have not been identified as being at risk; selective programmes target individuals at risk of developing a condition (WHO, 2004). Schools provide appropriate settings for prevention programmes (Adametz et al., 2017; Levine & Smolak, 2005), thus clinicians and policymakers worldwide advocate for schools to incorporate universal interventions to promote good physical and MH (Breton et al., 2022; Department for Education, 2019; National Eating Disorders Collaboration, 2023; Parliamentary Health and Social Care Committee, 2022).

Grounded in extensive empirical research and theoretical models including the biopsychosocial model (Engel, 1977) (Figure 1.1) multiple risk factors across ED diagnoses are recognised. Individuals who develop EDs likely have a biological predisposition, with contributing factors including gender, developmental stage, ethnicity, low Body Mass Index (BMI), genetics and family history of EDs (Barakat et al., 2024; Stice et al., 2017; Watson et al., 2021). Additionally, social factors include weight stigma, loneliness, and bullying; whilst psychological factors may include body image concerns, perfectionism, negative affect, low self-esteem, comorbid conditions (e.g., anxiety/low mood), food issues (e.g., dieting), exercise and sports (Hilbert et al., 2014; Keel & Forney, 2013; Solmi et al., 2021; Stice et al., 2017; Striegel-Moore & Bulik, 2007). Mapping onto the models, the transdiagnostic core

ED psychopathology processes of eating, weight, and shape concerns (Fairburn et al., 2003) are considered the strongest contributing factors to the development, and maintenance, of disordered eating behaviours (Breton et al., 2022; Munkholm et al., 2016) and thus are key to educational provisions too.

Previous reviews highlight the need for theory-driven interventions (Adametz et al., 2017; Koreshe et al., 2021; Nehmy & Wade, 2014). Two systematic reviews have evaluated the effectiveness of school-based body image interventions, suggesting improvements in body image and esteem (Chua et al., 2020; Yager et al., 2013). Interventions were more effective when delivered separately for boys and girls (Yager et al., 2013), with girls benefitting more than boys (Chua et al., 2020). However, drawing conclusions is difficult as effect sizes (ES) were small, and quality of evidence low. Additionally, a multi-risk factor primary-school ED prevention review revealed improvements in body image-related, with some progress in weight control and eating behaviours (Pursey et al., 2021). However, when focusing solely on ED symptomology, secondary school-based interventions do not reliably demonstrate effectiveness compared to control groups over time (Berry et al., 2025). This review suggests broadening the scope of school-based interventions to address both core ED psychopathology and risk factors.

Figure 1.1 Biopsychosocial Model of Risk Factors for Eating Disorders



Researchers recommend monitoring treatment response across four key areas: ED behaviours and cognitions, physical health, co-occurring MH conditions, and quality of life (Austin et al., 2023). Additionally, it is argued modifiable risk factors should be mapped appropriately to target prevention and early interventions (Barakat et al., 2024). Accordingly, the psychological risk factors outlined in Figure 1.1 have been included in this review. Therefore, this review aims to evaluate the effectiveness of universal secondary school-based interventions that address the transdiagnostic core ED psychopathology of eating, weight, or shape concern, in addition to at least one other psychological risk factor as listed previously. Specifically, the primary outcome measure of interest was self-reported ED psychological outcomes (e.g., EDE-Q; Fairburn & Beglin, 1994) and at least one

psychological risk factor. We were also interested in the effect interventions have on physical health outcomes (e.g., BMI) and broader psychological wellbeing outcomes (e.g., depression and anxiety).

Method

Protocol and Registration

This review was pre-registered with PROSPERO (CRD42024517930) and performed according to Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Moher et al., 2009). Inclusion criteria and quality assessment were amended during the review process and recorded appropriately.

Eligibility Criteria

Inclusion criteria is displayed in Table 1.1. Non-English studies and grey literature were excluded due to resource constraints and to prioritise peer-reviewed studies with rigorous methodological standards and verified reliability, respectively.

Search Strategy

Search terms (Appendix 1.3) were co-developed with a librarian and by reviewing Pursey et al.'s (2021) search terms. Key terms included: eating disorder*, body image*, psychosocial factor*, intervention*, adolesc*. Searches were conducted across databases (Scopus, CINAHL, Embase, PsycINFO, MEDLINE) and Google Scholar by the first author (MS) in September 2024 and March 2025. Alerts were created (closed 22/05/2025) to identify newly published articles. Reference lists were searched and researchers were contacted for any missed studies.

Selection Process

A total of 12,456 titles and abstracts were retrieved from the initial search (Figure 1.1). Duplicates (*n* = 3,313) were removed manually and using Covidence

(2025). A second reviewer (RM) screened 20%, with inter-rater reliability κ = 0.826 (McHugh, 2012). Before full text screening, study design criteria was refined to include only RCTs to improve methodological rigour of the review and maintain feasibility given the unexpected high number of eligible studies. MS screened selected full texts (*n* = 453) with RM screening 20%. Inter-rater reliability was κ = 0.849 (McHugh, 2012). Twelve papers were irretrievable despite author's efforts in contacting researchers and university/NHS libraries. Discrepancies were discussed between authors. Eighty-eight additional papers were identified from database alerts and updated searches, with titles and abstracts screened separately. No additional papers met criteria.

Data Extraction

A data extraction form (Appendix 1.4) was developed and tested to ensure all relevant information was charted. The remaining articles (*n* = 17) were included for data extraction and information comprised (a) study location and language; (b) design and analysis; (c) intervention and setting; (d) sample characteristics; (e) core psychopathology and risk factor measures; (f) outcomes. Researchers were contacted to gather absent information. MS completed data extraction, with 50% also extracted by RM to ensure reliability. Disagreements were discussed and resolved between authors.

Quality Assessment

The Cochrane Risk of Bias 2 (RoB-2) (Sterne et al., 2019) tool is recommended for accessing the quality of RCTs and was used to critically evaluate the findings in relation to study quality. The measure assesses six areas of potential bias including: (1) randomisation; (2) timing of identification/recruitment of

participants; (3) deviations from the intended interventions; (4) missing outcome data; (5) measurement of the outcome; and (6) selection of the reported result. Studies are assessed and shown to have either a low-risk of bias, some concerns relating to bias, or a high-risk of bias, as determined by a validated a priori algorithm. Papers were rated by MS, with 50% randomly selected papers also evaluated by RM. Disagreements were discussed between authors.

Effect Measures

Where possible, the results section was presented with ESs. Given the heterogeneity of papers, a variety of ES measures was reported. This included Cohen's *d* and Hedge's *g* (small = 0.2, medium = 0.5, large = 0.8), and partial eta squared (small = 0.01, medium = 0.06, large = 0.14).

Synthesis Methods

A meta-analysis was not performed due to heterogeneity across outcomes. Thus, this review is a narrative synthesis. This review follows the Synthesis Without Meta-Analysis guidelines (Campbell et al., 2020) following the shortcomings of previous narrative syntheses. Findings were grouped according to aims of the review: (1) ED outcomes; (2) physical health outcomes; and (3) broader psychological wellbeing outcomes. Within this, authors synthesised according to use of individual outcome measure and where possible gender.

Figure 1.2

PRISMA Flow Chart created using Haddaway et al. (2022) online tool

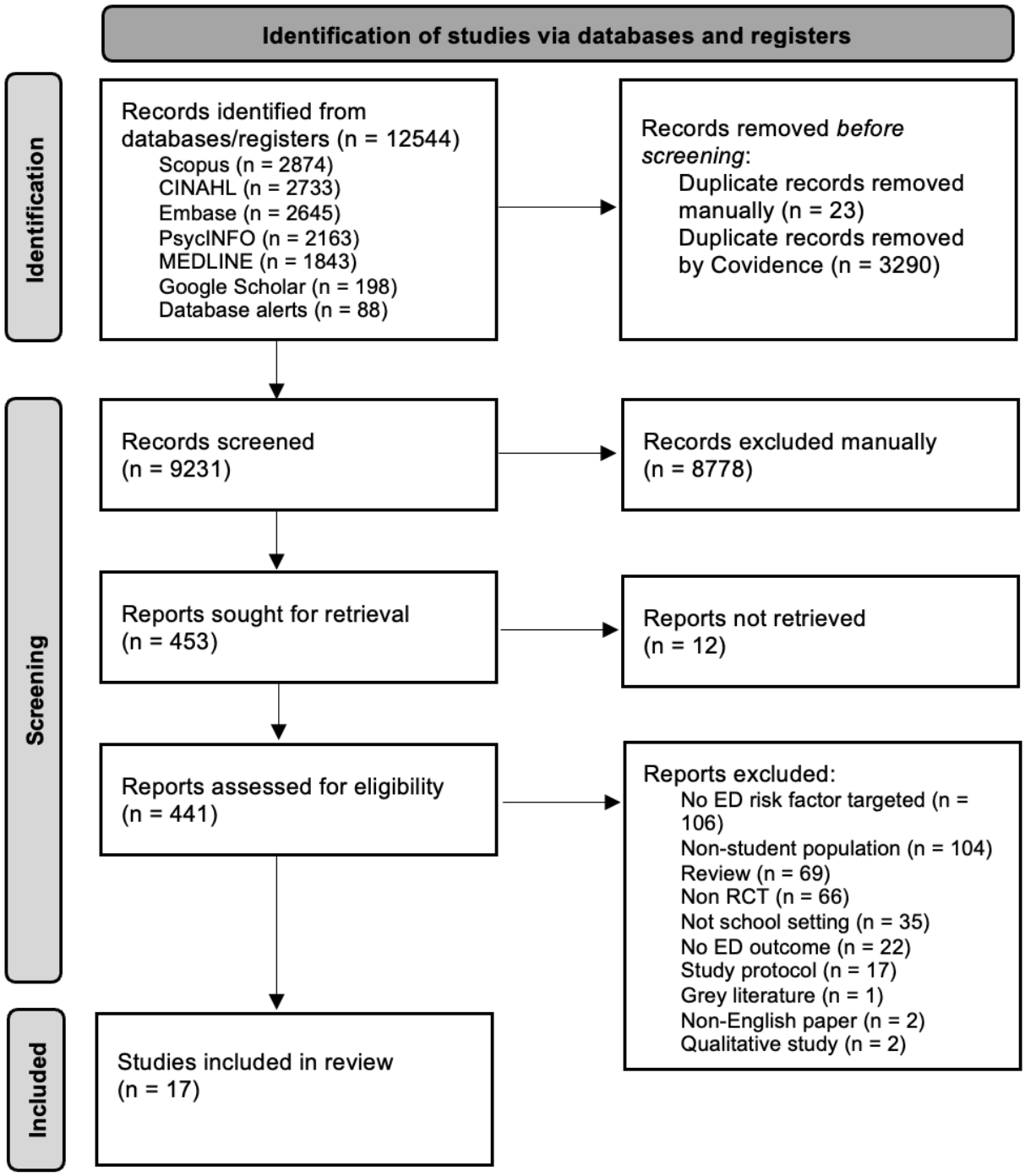


Table 1.1

Inclusion and Exclusion Criteria

	Inclusion	Exclusion
Participants	• Boys or girls aged 11-18 or presented data stratified by age enabling extraction of data from of children 11–18 years. Studies were included if the age range included a small proportion of boys or girls aged 10 or 19 years, but the sample mean, and majority of participants were within 11–18 years. • Boys or girls not identified as having an eating disorder, or at high-risk of developing one.	• Boys and girls under 11 years old, adults and older adults. • Have an eating disorder or at high-risk of developing one.
Intervention	• Universal (programmes target a whole population group that have not been identified as being at risk) secondary school-based interventions. • Interventions must address transdiagnostic core eating disorder psychopathology of weight/shape/eating concern. • Interventions must include at least one other identified, modifiable psychological risk factor *(e.g., comorbid conditions, social media, exercise, nutrition, body image, perfectionism, self-esteem, or mood/wellbeing)*	• Interventions not based in a secondary school (e.g., primary school or university settings). • Selective or indicated interventions. • Interventions not delivered solely in school lessons (e.g., after school interventions, web-based interventions but recruited from schools). • Specialist institutions (e.g., ballet or sport schools). • Integrated parent and/or teacher interventions. • Interventions that do not address transdiagnostic core eating disorder psychopathology of weight/shape/eating concern (e.g., obesity interventions). • Interventions that do not address at least one other identified, modifiable psychological risk factor.
Outcomes	• Post intervention changes measuring transdiagnostic core eating disorder psychopathology outcomes (e.g., EDE-Q) and at least one psychological risk factor (e.g., mood/wellbeing, self-esteem, social media, exercise, nutrition, perfectionism, comorbid conditions)	• Report solely acceptability or feasibility outcomes.
Study design	• Randomised control trials	• Studies employing other designs, such as observational studies, quasi-experimental studies, or case reports • Qualitative studies • Non-English studies • Book chapter or review articles • Grey literature and unpublished
Comparator	• Any comparison group	

Results

Study characteristics

Seventeen cluster RCTs were included in the final analysis (see Table 1.2). Studies were conducted across eight countries including Spain (*n* = 4), Germany (*n* = 3), Australia (*n* = 3), Italy (*n* = 2), USA (*n* = 1), Argentina (*n* = 1), UK (*n* = 1), and Norway (*n* = 1). One study was conducted in Italy and USA. Studies were published between 2001 and 2023.

A total of 11,587 participants were included across studies, ranging from 78 to 2,442 per study. Most studies recruited from state schools, with three from both state and private, and two from private schools only. Two studies did not report school type. Age of individuals ranged from 11-18 years old, with the majority being in middle adolescence (*M* = 14.18, *SD* = .58). Nine studies were comprised exclusively of girls, eight were comprised of boys and girls. No papers exclusively studied boys. Only half of the studies reported on race and ethnicity, with most participants coming from a Caucasian background (47%-55%). Of these studies, some reported birthplace, with a mixture of European, American, and Australian participants. Only one study reported socioeconomic status (SES), with five studies reporting parental income or education. Ten studies reported mean BMI of participants (range 18.3 – 22.70 kg/m^2). Outcomes adopted across studies were variable, self-report measures. Duration of follow-up ranged from immediately post-intervention to 2 ½ years post-intervention with the most common at six and twelve-months. Despite universal interventions, three studies (Abascal et al., 2004; Weiss & Wertheim, 2015; Wilksch et al., 2015) utilised ED measures to create low and high-risk groups for facilitation and analysis of data. Additionally, Wilksch et al. (2015; 2017) used the same dataset from a single RCT.

Intervention characteristics

All interventions aimed at reducing weight, shape, or eating concerns (see Table 1.3). Interventions covered a range of risk factors including body image (*n* = 12), social media (*n* = 12), dieting (*n* = 9), exercise (*n* = 8), nutrition (*n* = 8), self-esteem (*n* = 6), emotions (*n* = 5), and perfectionism (*n* = 1). Strategies commonly incorporated in interventions included group discussions (*n* = 12), practical in-class activities (*n* = 7), critical analysis (*n* = 5), videos (*n* = 4), letter/journal writing (*n* = 3), roleplays (*n* =2), and homework (*n* = 2).

Interventions were commonly delivered in face-to-face group format (*n* = 16), with one study of individual and online format. Psychologists (*n* = 6) and teachers (*n* = 4) facilitated most interventions, with other professionals including research authors and assistants (*n* = 4), postgraduate students (*n* = 2), and coaches (*n* = 1). Intervention length ranged between 2 and 9 sessions (*M* = 5.24, *SD* = 2.14). Most studies offered weekly sessions ranging from 45–120 minutes (*M* = 82.33, *SD* = 30.35). Two studies did not report session lengths. Comparators included active controls, no intervention, class as usual (CAU) and waitlist control (WLC); however, the comparators were not well described across studies.

Methodological Quality Assessment

Domain scores for RoB-2 in each study are summarised in Figure 1.2. Inter-rater reliability was almost perfect κ = 0.824 (McHugh, 2012). Significantly, no included study scored low on RoB-2 overall. Most studies (64.71%) were rated as high-risk overall, with the remaining studies (35.29%) scoring with some concerns. Of the domains, the randomisation process was the most problematic with 6 studies scoring as high-risk. The timing of recruitment domain, however, received the

highest proportion of low-risk ratings (*n* = 15), suggesting recruitment occurred before randomisation in most studies.

Table 1.2

Description of Randomised Controlled Trials included in Review

Study & Country	School setting	*N*	Gender & age	Ethnicity/SES	Physical Health (at baseline)	Interventions	Outcomes	Analysis	Time of Data Collection
Abascal et al., (2004) *USA*	Private high schools for girls	78	Gender: 100% girls Age: *M* ± *SD* = 15.3 ± 0.60, range 13-16 years	Ethnicity: 55% Caucasian, 14% Asian, 14% Multiethnic or other, 12% Hispanic/Latina, 1% African American Family income /education/SES NR	BMI NR	Student Bodies: HRHM group *(8 sessions)* Student Bodies: lower-risk or lower-motivated students *(8 sessions)* Student Bodies: HRHM & lower-risk or lower-motivated students combined *(8 sessions)*	EDE-Q EDI (drive for thinness and bulimic symptoms)	Completer (*N* = 75)	Baseline EOT
Dunstan et al., (2017) *Australia*	State secondary schools	200	Gender: 100% girls Age range: 11 - 14 years **Co-ed group** Age: *M* ± *SD* = 12.67 ± 0.44 **Single-sex group** Age: *M* ± *SD* = 12.66 ± 0.38 **Control group** Age: *M* ± *SD* = 12.77 ± 0.41	Ethnicity: 90% Australian Family income /education, SES NR	BMI NR	Happy Being Me (co-educational) *6 sessions* Happy Being Me (single sex) *6 sessions* Non treatment condition	EDI-BD SATAQ-I (Internalization-General Media Subscale) PACS RSES MRFS-III (weight teasing & peers subscale) ACS DEBQ-Restraint	ITT	Baseline EOT FU6M
Favaro et al., (2005)	Vocational Training School	141	Gender: 100% girls	Ethnicity, Family income/education, SES NR	BMI NR	6 weekly group sessions	BMI EAT-26	Completer (*N* = 129)	Baseline EOT

Study & Country	School setting	*N*	Gender & age	Ethnicity/SES	Physical Health (at baseline)	Interventions	Outcomes	Analysis	Time of Data Collection
Italy			Age: *M* ± *SD* = 17.0 ± 1.1, range 16 – 18 years			Non treatment condition			
Grave et al., (2001) *Italy*	State middle school	106	Gender: 57.55% girls, 61, 42.45% boys Age: *M* = 11.60, range 11- 12 years	Ethnicity NR SES: 54.7% lower class, 45.3% middle class Family income /education NR	BMI: *M* = 18.3	6 weekly group sessions Control condition[a]	EDE-Q EAT-26 RSES	Completer (*N* = 104)	Baseline EOT FU6M FU12M
Gonzalez et al., (2011) *Spain*	State and state-subsidised schools	443	Gender: 57.34% girls, 42.67% boys Age: *M* ± *SD* = 13.50 ± 0.4	Ethnicity: 92.8% European, 4.7% South American, 1.9% Moroccan, 1.2% missing data Family income /education, SES NR	BMI: girls, *M* = 20.9 (*SD* = 3.5); boys, *M* = 20.7 (*SD* = 3.4)	Media Literacy *(4 sessions)* Media Literacy + Nutrition Awareness *(5 sessions)* Non treatment condition	EAT-26 CIMEC-26	Completer (*N* = 276)	Baseline EOT FU7M FU30M
Gumz et al., (2017)[b] *Germany*	State secondary schools	2342	Gender: 55.60% girls, 44.40% boys Age: *M* ± *SD* = 14.60 ± .22, 14 and 17 years old	Family education (SES proxy): 17% low (both parents), 21.8% high (one parent), 61.2% high (both parents) Ethnicity, Family income, SES NR	BMI: *M* = 19.9 (*SD* = .17)	3 sessions delivered over 2 weeks Non treatment condition	Ch-EDE-Q SATAQ-G MSCS PHQ-9 GAD-7	Completer (*N* = 1452)	Baseline EOT FU6M
Lopez-Guimera et al., (2011)[c]	State and public schools	263	Gender: 100% girls Age: *M* ± *SD* = 13.41 ± .38	Ethnicity: 89.73% Spanish, 5.32% Latin-American, 2.28%	BMI: *M* = 21.19 (*SD* = 3.8)	Media Literacy *(4 sessions)*	BMI EAT-26 CIMEC-26	Completer (*N* = 252)	6 Baseline EOT FU6M

Study & Country	School setting	*N*	Gender & age	Ethnicity/SES	Physical Health (at baseline)	Interventions	Outcomes	Analysis	Time of Data Collection
Spain				North-African, 1.90% Mixed origins, 0.76% Unspecified Family income /education, SES NR		Media Literacy + Nutrition *(5 sessions)* Class as usual *(1 session)*			
Perez-Vazqueq et al., (2023) *Spain*	State secondary schools	161	Gender: 45.96% girls, 54.04% boys **Intervention Group** Age: *M* ± *SD* = 12.46 ± .48 **WLC Group** Age: *M* ± *SD* = 12.51 ± .48	Ethnicity, Family income /education, SES NR	**Intervention Group** BMI: *M* = 22.40 (*SD* = 4.40) **Control Group** BMI: *M* = 20.60 (*SD* = 3.86)	e-Health psychoeducational intervention *(3 sessions)* WLC	EAT-26 BMI RSES	ITT	Baseline EOT
Raich et al., (2008)[c] *Spain*	Public and public subsidized private secondary schools	349	Gender: 100% girls Age: *M* ± *SD* = 13.11 ± .48	Ethnicity, Family income /education, SES NR	BMI: *M* = 21.57 (*SD* = 4.2)	AMC + ML *(2 sessions)* AMC + ML + NUT *(2 sessions)* Class as usual *(2 sessions)*	EAT-26 CIMEC-26 NUT-Q	Completer (*N* = 288)	Baseline EOT FU6M
Rutsztein et al., (2023) *Argentina*	Secondary schools	509	Gender: 100% girls Age: *M* ± *SD* = 15.39 ± 1.30, range 13 - 18 years	Ethnicity, Family income /education, SES NR	BMI: *M* = 22.70 (*SD* = 4.37)	PIA-2 *(3 sessions)* Class as usual *(3 sessions)*	EDI-3-RF SATAQ-4 (thin-ideal internalisation subscale)	ITT	Baseline EOT FU3M
Sharpe et al., (2013) *UK*	State secondary girl schools	448	Gender: 100% girls Age range: 12 – 14 years **Intervention Group**	**Intervention group** Ethnicity: 53% White, 17% Asian, 15% Black, 14% Other	BMI NR	Me, You, & Us *(6 sessions)* Class as usual *(6 sessions)*	BES EDDS (frequencies of binge eating and	ITT	Baseline EOT FU3M

Study & Country	School setting	*N*	Gender & age	Ethnicity/SES	Physical Health (at baseline)	Interventions	Outcomes	Analysis	Time of Data Collection
			Age: *M* ± *SD* = 13.06 ± .59 **Control Group** Age: *M* ± *SD* = 12.99 ± .54	Family education (SES proxy): 1% primary education, 24% secondary education, 76% university education **Control group** Ethnicity: 47% White, 21% Black, 19% Asian, 12% Other Family education (SES proxy): 23% secondary education, 78% university education Family income & SES NR			compensatory behaviours) SATAQ-3 (thin-ideal internalisation subscale) ACFS MSPSS (Friends subscale) DASS (Depression subscale)		
Svantorp-Tveiten et al., (2021)[d] *Norway*	State and private schools	2442	Gender: 33.91% boys, 66.09% girls Age range: 16 – 18 years **Intervention Group** Age boys: *M* ± *SD* = 16.77 ± .46 Age girls: *M* ± *SD* = 16.76 ± .49 **Control Group** Age boys: *M* ± *SD* = 16.73 ± .49 Age girls: *M* ± *SD* = 16.78 ± .48	**Intervention Group** Parental income (boys): >$104,000 48.80% Parental income (girls): >$104,000 34.90% Family education (SES proxy): boys: 76.80% paternal university education, 79.80% maternal university education; girls: 72.90% paternal university	**Intervention Group** BMI: girls, *M* = 21.41 (*SD* = 2.79); boys, *M* = 21.58 (*SD* = 2.64) **Control Group** BMI: girls, *M* = 21.48 (*SD* = 3.11); boys, *M* = 21.84 (*SD* = 3.16)	Healthy Body Image *(3 sessions)* Class as usual *(3 sessions)*	EDE-Q RSES SCL-10 BIAAQ SATAQ-4 (media pressure, thin & muscular internalisation subscales) DLS Protein, creatine and diet aids use (weekly frequency)	ITT (*N* = 1228)	Baseline EOT FU3M FU12M

Study & Country	School setting	*N*	Gender & age	Ethnicity/SES	Physical Health (at baseline)	Interventions	Outcomes	Analysis	Time of Data Collection
				education, 74.80% maternal university education **Control Group** Parental income (boys): >$104,000 44% Parental income (girls): >$104,000 25.50% Family education (SES proxy): boys: 64% paternal university education, 64.60% maternal university education; girls: 63.40% paternal university education, 70.80% maternal university education				
Warschburger & Zitzmann (2018) *Germany*	Grammar and comprehensive schools	1112	**Intervention Group** Gender: 52% girls, 48% boys Age: *M* ± *SD* = 13.0 ± .80, range 11- 16 years **Control Group** Gender: 56% girls, 44% boys Age: *M* ± *SD* = 12.90 ± .80, range 10- 16 years	Ethnicity & SES NR Ethnicity, Family income /education, SES NR	**Intervention** BMI: *M* = 18.9 (*SD* = 2.8) **Control** BMI: *M* = 18.4 (*SD* = 2.4)	Potsdam Prevention at Schools *(9 sessions)* WLC	EAT-26 EDI-2 (drive for thinness and bulimic symptoms) SATAQ-3 (internalization and media pressure subscales) OEQ PACS	ITT	Baseline EOT FU12M

Study & Country	School setting	*N*	Gender & age	Ethnicity/SES	Physical Health (at baseline)	Interventions	Outcomes	Analysis	Time of Data Collection
Weiss & Wertheim (2005) *Australia*	Catholic private girl schools	173	Gender: 100% girls Age: 47% 14 -14.9 years, 50% 15 -15.9 years, 3% 16-16.9 years	Ethnicity: 83% Australian, 9% Asian, 9% European Family income /education, SES NR	BMI NR	*4 weekly group sessions* Non treatment condition	POTS RSES EDI (drive for thinness, bulimic symptoms, body dissatisfaction and interoceptive awareness) WLBS (Food abstinence & Purging)	NR	Baseline EOT FU3M
Wilksch et al., (2015)[e] *Australia*	Public, private, and Catholic schools	1316	Gender: 64% girls, 36% boys Age: *M* ± *SD* = 13.21 ± .68	Ethnicity: 26.97% South Australian, 35.49% Victoria, 37.54% Western Australia Family income /education, SES NR	BMI NR	Media Smart *(8 sessions)* Life Smart *(8 sessions)* HELPP *(8 sessions)* Class as usual	EDE-Q (weight, shape, & eating concerns subscales) DEBQ-Restraint EDI-BD SATAQ-3 (media internalisation subscale) PSPS CDI MRFS-III MPS Project EAT Physical activity (mean hours per day)	Completer (*N* = 941)	Baseline EOT FU6M FU12M
Wilksch et al., (2017)[e] *Australia*	See Wilksch et al., (2015)								

Study & Country	School setting	*N*	Gender & age	Ethnicity/SES	Physical Health (at baseline)	Interventions	Outcomes	Analysis	Time of Data Collection
Wiseman et al., (2004) *Italy and USA*	High schools	188	Gender: 100% girls Age: range 15 -16 years	Ethnicity, Family income /education, SES NR	BMI: USA only, *M* = 20.85 (*SD* = 2.77)	*5 group sessions* Health lectures *(5 sessions)*	RSES EDI TFEQ	NR	Baseline EOT

Abbreviations: ACFS; Appearance Conversations with Friends Scale, ACS; Appearance Conversations Scale, AMC; Aesthetic Model Criticism, BES; Body Esteem Scale for Adults and Adolescents, BIAQ; Body Image Avoidance Questionnaire, BIAAQ; Body Image – Acceptance and Action Questionnaire, BMI; Body Mass Index, BSQ-8c; Body Shape Questionnaire – Short Version, CDI; Child Depression Inventory, Ch-EDE-Q; Children's version of the Eating Disorder Examination Questionnaire, CIMEC-26; Questionnaire on Influences of Aesthetic Body Ideal-26, DASS; Depression, Anxiety, and Stress Scale, DEBQ; Dutch Eating Behavior Questionnaire, DLS; Drive for Leanness Scale, EAT-26; Eating Attitude Test, EDDS; Eating Disorder Diagnostic Scale, EDE-Q; Eating Disorders Examination Questionnaire, EDI; Eating Disorder Inventory, EDI-2; Eating Disorder Inventory-2, EDI-3-RF; Eating Disorder Inventory-3 – Eating Disorder Risk Index, EDI-BD; Eating Disorder Inventory – Body Dissatisfaction Scale, EOT; end of treatment, FU; follow-up, GAD-7; Generalized Anxiety Disorder Scale, HELPP; Helping, Encouraging, Listening and Protecting Peers Initiative, HRHM; higher-risk & higher-motivated, ITT; Intention to treat, M; Mean, ML; Media Literacy, MPS; Multidimensional Perfectionism Scale, MRFS-III; McKnight Risk Factor Survey, MSCS; Multidimensional Self-Concept Scale, MSPSS; Multidimensional Scale of Perceived Social Support, NR; not reported, NUT; Nutrition, NUT-Q; Nutrition Questionnaire, OEQ; Obligatory Exercise Questionnaire, PACS; Physical Appearance Comparison Scale, PHQ-9; Patient Health Questionnaire-9, PIA-2; prevenci onintegrada de trastornos alimentario y obesidad [Integrated prevention of eating disorders and obesity], POTS; Perception of Teasing Scale, Project EAT; Project Eating Among Teens, PSPS; Perceived Sociocultural Pressure Scale, RSES; Rosenberg Self-Esteem Scale, SATAQ-G; Sociocultural Attitudes Towards Appearance Questionnaire, SATAQ-I; Sociocultural Attitudes Toward Appearance Scale-3, SATAQ-4; Sociocultural Attitudes Towards Appearance Questionnaire-4, SCL-10; Hopkins Symptom Checklist-10, SD; Standard Deviation, TFEQ; Three Factor Eating Questionnaire, WLBS; Weight Loss Behaviors Scale, WLC; waitlist control

[a] Comparator condition is unclear. Authors were emailed but reviewers did not receive a reply.
[b] Demographics are recorded from completers.
[c] Only female results have been analysed.
[d] Demographics for participants included in the effect analyses.
[e] Demographic information and study description compiled for all three studies as they report findings from the same randomised control trial.

Table 1.3

Details of Interventions and Outcomes of Randomised Controlled Trials

Study	Descriptions of Interventions ***Core Psychopathology/Risk factors addressed***	End-of-treatment	Follow-up
Abascal et al., (2004)[a]	**Name of intervention:** Student Bodies **Duration:** 8 x 45 min individual sessions over 6 weeks **Content:** Readings addressing issues such as ***body image dissatisfaction***, ***excessive weight concerns***, ***dieting*** or restrained eating patterns, ***exercise*** and ***nutrition***. This was followed by a cognitive task (e.g., challenging negative thoughts and observing 'real' women in public and comparing them to women seen in fashion magazines). Students encouraged to post weekly entries in the confidential body image journal, with the goal for students to identify the situations that trigger their negative body image and to eventually challenge their dysfunctional beliefs. **Delivery:** Completed online in computer labs. Students logged onto the programme during class. **Control:** Student Bodies (HRHM & lower-risk or lower-motivated students combined)	<u>Primary Outcomes</u> HRHM-C participants saw a significant improvement in ED psychopathology of restraint (p <.050, ES[b] = .49), shape concern (p <.010, ES = .75), drive for thinness (p <.050, ES = .75), but not in bulimic symptoms. Other-C participants saw no significant improvements in drive for thinness or bulimic symptoms.	No follow-up.
Dunstan et al., (2017)[c]	**Name of intervention:** Happy Being Me **Duration:** 6 x group sessions over 6 weeks. Length of sessions unknown. **Content:** *Session 1:* introduction to intervention and identify and challenge sociocultural appearance ideals. *Session 2:* Identify the occurrence and consequences of appearance teasing and focus on qualities other than appearance. *Session 3:* Impact of appearance conversations (emphasis on ***weight and shape***) and develop alternatives to engaging in appearance conversations. *Session 4:* understand the concept of appearance comparisons and the	<u>Primary Outcomes</u> Intervention group saw a significant improvement in body dissatisfaction at post-treatment (p <.010, η^2 = .030) compared to the control group. <u>Secondary Outcomes</u> Dietary restraint improved over time regardless of having the intervention or not (p = .010, η^2 = .06). Dietary restraint did not change over time between the intervention or control group (p = .310). Significant interaction effect for self-esteem (p = .020, η^2 = .04), with compared to the control group,	<u>Primary Outcomes</u> Body dissatisfaction was not significantly different at follow-up in the intervention group. <u>Secondary Outcomes</u> Compared to the control group, self-esteem (p < .050) and appearance comparisons (p < .010) were significantly higher for participants in the intervention group at follow-up, with internalisation of the thin ideal significantly lower for participants in the intervention group at follow-up (p < .010) compared to the control group.

Study	Descriptions of Interventions ***Core Psychopathology/Risk factors addressed***	End-of-treatment	Follow-up
	negative influence this can have on ***body image***. *Session 5:* explore and challenge the relationship between the ***media*** and beliefs around appearance. *Session 6:* review and consolidate important messages of each session. **Delivery:** Facilitated by two psychology research assistants. Overview of the topic and group discussion **Control:** Non-treatment condition	self-esteem was significantly higher for participants in the intervention group post-intervention ($p < .010$). Significant interaction effect for internalisation of the thin ideal ($p = .010$, $\eta^2 = .06$) with scores significantly lower post-intervention in the intervention group compared to the control group ($p < .010$, $d = .26$). Significant interaction effect for appearance comparisons ($p = .010$, $\eta^2 = .04$) with scores significantly lower post-intervention in the intervention group compared to the control group ($p < .010$). Appearance conversation scores improved over time regardless of having the intervention or not ($p = .040$, $\eta^2 = .03$), but not between the intervention or control group ($p = .140$). Weight-related teasing scores did not change over time between the intervention or control group ($p = .390$).	
Favaro et al., (2005)	**Duration:** 6 x 2hr group sessions over 6 weeks **Content:** *Session 1:* relation between adolescents and their family, adolescents and their peers, and with themselves and their own body. *Session 2:* the body during adolescence, with descriptions of normal growth and development processes. Concepts like ideal body and body ideal, body acceptance, ***body dissatisfaction***, and body denigration were also discussed. *Session 3:* dealing with the media's overemphasis on thinness and to discourage the use of excessive caloric restriction. ***Pressure to be thin***, different methods to lose weight, advantages and	<u>Primary Outcomes</u> Intervention group showed a significant improvement in bulimia symptoms ($p <.005$) compared to no change observed in control group. No significant differences were observed between groups for total EAT, or the subscales of dieting and oral control. No significant differences were observed in either intervention or control group for BMI ($p >.050$).	No follow-up.

Study	Descriptions of Interventions ***Core Psychopathology/Risk factors addressed***	End-of-treatment	Follow-up
	disadvantages of ***dieting***, effects on normal development, reasons for the failure of excessive dieting, and the potential link with the development of EDs. *Session 4:* about eating disorders, their diagnostic criteria, clinical features and treatments. Session 5: prevention of EDs. *Session 6:* ***media*** and its impact on their own beliefs about beauty, thinness, fitness, health, and wellbeing. **Delivery:** Facilitated by teachers. Overview of the topic, group discussions, written summary post session **Control:** Non-treatment condition		
Grave et al., (2001)	**Duration:** 6 x 2hr group sessions over 6 weeks **Content:** *Aim 1:* increase knowledge on sociocultural ***pressure to be thin***, cognitive distortions (e.g., extreme concern for ***shape and body weight***, ***low self-concept***, ***perfectionism***, and dichotomous thinking), effects of ***dieting*** and EDs. *Aim 2:* help avoid developing an ED by reducing the importance of shape and body weight in self-evaluation. **Delivery:** Facilitated by two psychologists. First 30 minutes were dedicated to the educational materials, the remaining time was devoted to practical activities, group discussions and revision of homework. **Control:** Comparator condition is unclear	<u>Primary Outcomes</u> Global EDE-Q scores significantly decreased over time in both groups (p <.050). Eating concerns in the intervention group significant decreased post-intervention compared to the control group (p <.010). EAT scores significantly decreased over time in both conditions (p < .010). Scores decreased significantly post-intervention in the intervention group compared to the control group (p <.010). <u>Secondary Outcomes</u> Self-esteem scores changed significantly over time (p < .010) without significant differences between groups.	<u>Primary Outcomes</u> No significant differences in EAT scores, global or subscale EDE-Q between groups at either 6-month or 12-month follow-up.
Gonzalez et al., (2011)	**Name of intervention:** ML and ML + NUT **Duration:** 2hr weekly group sessions *(ML = 4 sessions; NUT + ML = 5 sessions).* Length of sessions unknown. **Content:** *ML components:* beauty throughout history, recent changes in the criteria for beauty, sizes of models, ***thinness*** of the West, ***advertising messages***, real effectiveness of ***diets*** and their effects, manipulation of advertisements, association between beauty and happiness, and	<u>Primary Outcomes</u> Participants in ML group (p = .009) and ML + NUT (p = .002) group showed significantly lower ED pathology scores than the control group. No differences between ML and ML + NUT groups on ED pathology. <u>Secondary Outcomes</u> Participants in the ML group (p = .001) and ML + NUT (p = .004) showed significantly lower CIMEC	<u>Primary Outcomes</u> ML group scored lower than the control group for ED pathology and CIMEC at both 7-month (ED; p = .025, CIMEC; p <.001) and 30-month (ED; p = .002, CIMEC; p = .016) follow-up assessments. ML + NUT group scored lower than the control group for ED pathology and CIMEC at both 7-month (ED; p = .022, CIMEC; p = .001) and 30-

Study	Descriptions of Interventions ***Core Psychopathology/Risk factors addressed***	End-of-treatment	Follow-up
	real women: a variety of sizes. *NUT components:* definition of balanced eating, ***nutrition*** and eating, nutrients, food Pyramid and foods, water, analysis of menus and final recommendations. **Delivery:** Facilitated by authors of programme. Interactive format with a PowerPoint multimedia display, group discussions, and letter writing. Two activities and tasks between sessions. **Control:** Non-treatment condition	scores than the control group. No differences between ML and ML + NUT groups on CIMEC. Post-treatment ML participants displayed lower scores than the control group for CIMEC, whereas ML+NUT participants did not differ from the control group.	month (ED; p <.001, CIMEC; p = .037) follow-up assessments.
Gumz et al., (2017)	**Duration:** 3 x 2hr group sessions over 2 weeks **Content:** *Session 1:* origin and maintenance of western beauty ideals, costs and benefits of these ideals, and strategies for coping with pressure from family, peers and media. *Session 2:* ***body perception***, sources of ***self-esteem***, consequences of being ***under/overweight***, healthy ***nutrition***, coping with *peer pressure*, ***healthy physical exercise***, self-expression in ***social media***, coping with ***negative emotions and stress***. *Session 3:* information on EDs including risk factors and symptoms, treatment options, coping with ED peers, and competence for help-seeking. **Delivery:** Facilitated by 1 member of the Center of the Prevention of Addiction, and 1 member of the research team. Overview of the topic, group discussions, individual reflections, interactive interventions, nine station parcour (session 2) and videos. **Control:** Non-treatment condition	<u>Primary Outcomes</u> No significant differences were observed in intervention or control group in ED pathology from baseline to post-treatment (p = .410). Significant interaction (gender x time x grade) indicated that in both groups, 8th grade females exhibited increased ED pathology post-intervention, whereas in 8th grade males, the risk decreased post-intervention (interaction p <.001). <u>Secondary Outcomes</u> Intervention group showed significantly greater improvements in anxiety symptoms over time (p <.010). Post-treatment participants showed a greater reduction in anxiety (p = .020, d = .11) compared to the control group. The intervention group showed significantly greater increase in experienced pressure due to internalisation of Western beauty ideals post-intervention (p <. 010, d = .04) compared to the control group. Depression (p = .640), self-concept (p = .370), internalisation of body ideals (p = .100), and awareness of body image (p = .118) did not	<u>Primary Outcomes</u> No significant differences were observed in intervention or control group in ED pathology from baseline to follow-up. Significant interaction (group x time x grade) (p = .049) with both 11th grade boys and girls in the intervention group exhibiting lower ED pathology than those in the control group at 6-month follow-up. While 8th grade boys and girls showed the opposite trends (interaction p = .012). Significant interaction (gender x time x grade) indicated that in both groups, 8th grade females exhibited increased ED pathology at follow-up, whereas in 8th grade males, the risk remained stable (interaction p <.001). At 6-months follow-up, there was no significant difference in anxiety (p = .510) or experienced pressure due to internalisation of Western beauty ideals (p = .300) between conditions.

Study	Descriptions of Interventions ***Core Psychopathology/Risk factors addressed***	End-of-treatment	Follow-up
		significantly change over time between the intervention or control group.	
Lopez-Guimera et al., (2011)	**Name of intervention:** ML and ML + NUT **Duration:** *ML:* 2 x 90-min group sessions + 2 x 60-min activity group sessions. *NUT + ML:* 1 x 90-min group session) **Content:** *ML Session 1:* feminine beauty ideal, ***thinness*** in Western culture and the beauty ideal in the media. *ML Session 2:* advertising analysis. *ML Session 3:* how to deal with ***media*** messages. *ML Session 4:* complaint letters to the media. *NUT Session:* balanced eating concept, the concepts of eating and ***nutrition***, nutrients, the food pyramid and foods, the importance of water, and analysis of diet **Delivery:** Facilitated by two authors of the intervention. The two activities were facilitated by teachers. Overview of the topic, critical analysis, group discussion, and letter writing. **Control:** Non-treatment condition	<u>Primary Outcomes</u> Only EAT diet subscale showed effects between conditions. Median of change for the diet subscale in the NUT+ML group is significantly higher post-treatment than the median of change for the non-treatment group (p <.050, d = .37). No significant differences were observed in interventions or control group for BMI post-intervention.	<u>Primary Outcomes</u> Median of change for the diet subscale in the ML group is significantly higher at follow-up than the median of change for the non-treatment group (p <.050, d = .37). No significant differences were observed in interventions or control group for BMI at 6-month follow-up.
Perez-Vazquez et al., (2023)	**Name of intervention:** e-Health psychoeducation **Duration:** 3 x 55min group sessions over 2 weeks **Content:** *Session 1:* promoting healthy eating attitudes and behaviours. ***Dieting, fasting*** and the risks involved. *Session 2:* benefits of regular activity for better health, and how activity improves our body satisfaction and how it reflects on self-esteem. Sleep hygiene. *Session 3:* discussing body ideals, the wide range of different body shapes during adolescence, the development of coping skills to address sociocultural ***pressures to be thin*** and to critically assess ***media*** and ***societal attitudes about body shape and weight*** **Delivery:** Facilitated by teachers but intervention was entirely online. Modules accessible 24/7 via Moodle platform (for 3 months). Each month a module was unlocked, and students had set class	<u>Primary Outcomes</u> Intervention group saw significant reductions in total EAT (p <.050, d = .32) and oral control subscale (p <.050, d = .33) compared to WLC. No significant differences by sex between groups on ED symptomology. No significant differences were observed in the intervention or WLC group for BMI. <u>Secondary Outcomes</u> No significant differences were observed in the intervention or WLC group for self-esteem.	No follow-up.

Study	Descriptions of Interventions ***Core Psychopathology/Risk factors addressed***	End-of-treatment	Follow-up
	period to engage with module activities including videos and knowledge questionnaires. **Control:** WLC		
Raich et al., (2008)[d]	**Name of intervention:** AMC + ML and AMC + ML + NUT **Duration:** 2 x 90min group sessions over 2 weeks **Content:** *NUT Session:* definition of balanced eating, definition and differentiation between ***nutrition*** and eating, nutrients, food Pyramid and foods, water, and analysis of menus. *AMC + ML Session:* beauty throughout history, recent changes in the criteria for beauty, sizes of models, ***thinness*** of the West, ***advertising messages***, real effectiveness of ***diets*** and their effects, manipulation of advertisements, association between beauty and happiness, and ***real women: a variety of sizes***. **Delivery:** Facilitated by 2 coaching members of the team. Psychoeducational programme including group debate, and visual presentations. **Control:** Class as usual	<u>Primary Outcomes</u> No significant differences between groups at post-intervention on total EAT (p = .257), or subscales of diet (p = .053), bulimia (p = .838), or oral control (p = .973). <u>Secondary Outcomes</u> Significant group x time effect for nutritional knowledge (p < .001), with knowledge significantly increasing for participants in the AMC + ML + NUT condition compared to the control group (g = .60).	<u>Primary Outcomes</u> No significant differences between groups at follow-up on total EAT (p = .368), or subscales of diet (p = .839), bulimia (p = .373), or oral control (p = .296). <u>Secondary Outcomes</u> No statistically significant differences in knowledge of nutrition between groups (p = .322).
Rutsztein et al., (2023)	**Name of intervention:** PIA-2 **Duration:** 3 x 90min group sessions over 3 weeks **Content:** *Session 1:* critical analysis of magazine ads and Instagram images, the physical consequences of trying to achieve a ***thin ideal*** and coping strategies against social pressure towards thinness. *Session 2:* food groups and the importance of including them in meals and the advantages of avoiding ***restrictive diets*** and regular meal skipping. *Session 3:* discussions around ***physical activity***. **Delivery:** Facilitated by 2 authors of the paper. Overview of the topic, critical analysis, videos, group discussions, role-play activities, and games. **Control:** Class as usual	<u>Primary Outcomes</u> A significant effect of time on ED risk (p <.001). On average, participants decreased .42 units of ED risk month by month. No significant differences were observed in intervention or control group for ED risk over time, when controlling for age (p = .980). <u>Secondary Outcomes</u> Thin-ideal internalisation changed significantly over time (p <. 001). Thin-ideal internalisation did not significantly change month by month between the intervention or control group (p = .520).	

Study	Descriptions of Interventions ***Core Psychopathology/Risk factors addressed***	End-of-treatment	Follow-up
Sharpe et al., (2013)	**Name of intervention:** Me, You, & Us **Duration:** 6 x 50min group sessions over 6 weeks **Content:** *Session 1:* definition of beauty and how ideas about beauty are shaped by images in the media. *Session 2:* negative effects of ***media*** on body confidence. *Session 3:* why people tend to ***'fat talk'*** and their effects. *Session 4:* reducing the amount of fat talking adolescents engage in. *Session 5:* personal strengths and how to put personal strengths to better use. *Session 6:* happiness and where it comes from. **Delivery:** Facilitated by teachers. Overview of the topic, group discussions, in-session activities, power point presentations, and videos. **Control:** Class as usual	<u>Primary Outcomes</u> No significant differences were observed in intervention or control group for binge eating (p = .230) or compensatory behaviours (p = .220). <u>Secondary Outcomes</u> No significant differences were observed in intervention or control group for depression (p = .500), peer support (p = .400), appearance conversations (p = .900), or body esteem (p = .070). Girls in the clinical range for body esteem showed greater reliable change in the direction of improvement in the intervention group (32%) compared with the control group (7%) (p = .020). This was the same for girls in the normal body esteem range (p = .010) Thin-ideal internalisation scores were significantly lower in the intervention group compared to the control group post-intervention (p = .040, d = .17).	<u>Secondary Outcomes</u> Thin-ideal internalisation scores were significantly lower in the intervention group compared to the control group at follow-up (p = .050, d = .16). Girls in the intervention group had significantly higher body esteem compared to the control group at follow-up (p = .006).
Svantorp-Tveiten et al., (2021)	**Name of intervention:** Healthy Body Image **Duration:** 3 x 90min group sessions over 9 weeks **Content:** *Session 1:* body image awareness and ***'fat talk'***, peer and family influences, appearance and social comparison, ***self-esteem*** and ***social media***. *Session 2:* how to make social media a positive experience and how adolescents influence their peers on social media. *Session 3:* ***exercise***, supplement use and ***nutrition***. **Delivery:** Facilitated by 2 clinical psychologists. Overview of the topic, presentations, and classroom activities. **Control:** Class as usual	<u>Primary Outcomes</u> Group x gender interaction on ED symptomology (p = .048). Girls benefitted from the intervention (p = <.001, d = .21) whereas boys did not (p = .470, d = .05). No difference in ED symptomology post-intervention between groups (p = .093). <u>Secondary Outcomes</u> Intervention group anxiety & depression scores maintained over time (p <.001, d = .20) whilst the control group scores increased. There were no significant differences in anxiety & depression scores post-treatment (p = .993). Self-esteem significantly differed over time between groups (p = .022). Compared to the	<u>Primary Outcomes</u> The intervention group scored significantly lower than the control group at both 3-month (p = .022, d = .17) and 12-month (p <.001, d = .27) follow-ups. <u>Secondary Outcomes</u> The intervention group showed significantly greater improvements in anxiety and depression symptoms (p <.001, d = .31) and self-esteem (p <.001, d = .33) at 12-month follow-up, but not 3-months compared to the control group. Girls from the intervention group significantly increased body image flexibility at 12-month follow-up compared to control girls (p < .001, d = .47). Control girls' body image flexibility

Study	Descriptions of Interventions ***Core Psychopathology/Risk factors addressed***	End-of-treatment	Follow-up
		intervention group the control group saw a significant decrease in self-esteem post-intervention (p = .020, d = .15). The intervention group had significantly lower drive for leanness scores than the control group at all measurement time points (p = .003, d = .12). The intervention group had significantly higher body image flexibility than the control group at all measurement timepoints (p < .001). A significant group x time x gender effect for body image flexibility (p = .011). Girls from the intervention group significantly increased body image flexibility posttreatment compared to control girls (p = .024, d = .18). The intervention group reported significantly lower media pressure than the control group at all measurement time points (p <. 001). Significant group x gender interaction with girls reporting significantly lower media pressure than boys at all measurement time points (p = .036). The intervention group reported significantly lower thin internalisation than the control group at all measurement time points (p <. 001). Significant group x gender interaction (p = .040) with girls reporting significantly lower thin internalisation than boys at all measurement time points (p <. 001, d = .24). The intervention group reported significantly lower muscular internalisation than the control group (p = .001, d = .15).	significantly decreased between 3-month and 12-month follow-up (p = .004, d = .21). Whilst boys in the intervention group significantly increased body image flexibility at 3-month follow-up compared to control boys (p = .003, d = .34). The immediate effect posttreatment for boys (p =. 029, d = .24) faded whereas the effect among girls sustained across 3-month (p <. 001, d = .40) and 12-month follow-ups (p <. 001, d = .44). Weekly frequency of protein supplement usage in intervention boys remained stable, whilst it increased for control boys at 3-month (p < .001, d = .50) and 12-month (p =. 020, d = .43) follow-ups. Weekly frequency of creatine supplement usage increased for control boys at 3-month (p =. 003, d = .40) and 12-month (p =. 045, d = .32) follow-ups.

Study	Descriptions of Interventions ***Core Psychopathology/Risk factors addressed***	End-of-treatment	Follow-up
		No main or interaction effects were observed for diet aid use.	
Warschburger & Zitzmann (2018)	**Name of intervention:** Potsdam Prevention at Schools **Duration:** 9 x 45min group sessions over 9 weeks **Content:** *Session 1:* healthy ***nutrition*** and ***physical exercise***, reflection of own eating habits, and reduction of myths about eating and ***dieting***. *Session 2:* promotion of a critical distance from beauty ideals in ***media***. *Session 3:* critical reflection of ***slimness ideal***, recognition of the diversity and multidimensionality of the concept of attractivity and self-concept, and discussion of the importance of one's own appearance for the ***self-esteem***. *Session 4:* acceptance of own strengths and weaknesses reflection of the link between general wellbeing and body acceptance and enhancing self-esteem. *Session 5:* deepening of knowledge about ***stress*** and coping, checking the appropriateness of own coping strategies, and discovery of appropriate strategies. *Session 6:* discovery and application of steps to solve problems. *Session 7:* sensitisation for motives and consequences of teasing. *Session 8:* individual empowerment in dealing with and teasing and peer pressure. *Session 9:* consolidating knowledge, and self-esteem stabilisation. **Delivery:** Facilitated by teacher. Overview of the topic, playful learning, group discussions, critical reflection, in-session and home-based activities. **Control:** WLC	<u>Primary Outcomes</u> No significant differences were observed in intervention or control group at post-intervention for ED pathology (p = .093, d = .11), drive for thinness (p = .090, d = .11) or bulimic symptoms (p = .478). Over time girls in the intervention group saw a significant reduction in both ED pathology (p = .006, d = .23) and bulimic symptoms (p = .017, d = .17). <u>Secondary Outcomes</u> No significant differences were observed in intervention or control group for perceived weight-related teasing (p = .462), thin-ideal internalisation (p = .085), or perceived teasing (p = .462). No gender differences. Significant interaction observed for the emotional element of exercise (p = .005), with values significantly reducing in the intervention group post-intervention (p = .005, d = .17) compared to the control group. Significant interaction observed for perceived media pressure (p = .008), with values significantly reducing in the intervention group post-intervention (p = .012, d = .16) compared to the control group where values increased. No gender differences. Significant interaction observed for social comparison (p = .005) between conditions and over time.	<u>Primary Outcomes</u> No significant differences were observed in intervention or control group for ED pathology (p = .038, d = .13), drive for thinness (p = .090, d = .11), or bulimic symptoms (p = .090, d = .11) at 12-months follow-up. <u>Secondary Outcomes</u> The emotional element of exercise significantly reduced in the intervention group at follow-up (p = .007, d = .16). Perceived media pressure significantly reduced in the intervention group at follow-up (p = .009, d = .16) compared to the control group where values increased. Social comparison remained stable in the intervention group at follow-up, whilst scores continuously increased in the control group (p = .024, d = .14).
Weiss & Werthei	**Duration:** 4 x 100min group sessions over 4 weeks	<u>Primary Outcomes</u> High-risk intervention group saw significant improvements in body dissatisfaction (p <.010),	<u>Primary Outcomes</u> No significant interaction (group x risk) on any EDI outcomes at follow-up.

Study	Descriptions of Interventions ***Core Psychopathology/Risk factors addressed***	End-of-treatment	Follow-up
m (2005)	**Content:** *Session 1:* **body image** or ***eating problems*** and introduction to ***self-esteem***. *Session 2:* feeling good about your body and develop strategies to manage situations that can have a negative effect on body/self-esteem. *Session 3:* dangers of EDs and how to recognise onset of problems. ***Dieting*** and what a healthy lifestyle and healthy eating. *Session 4:* emotional eating, management of ***emotions*** effectively, impact of peers, particularly boys on body-esteem, and of programme celebration with sharing of healthy foods and inspirations. **Delivery:** Facilitated by psychologist (first author). Group rules discussed, overview of the topic, group discussions, and small group activities. **Control:** Non treatment condition	drive for thinness (p <.001), and interoceptive awareness (p <.002) compared to low-risk intervention group. High-risk intervention group saw significant improvements in drive for thinness (p <.020) compared to low-risk control group and interoceptive awareness (p <.010) compared with high-and-low risk control groups. <u>Secondary Outcomes</u> No significant main effect of risk status (p = .090), group (p = .930), or group x risk status interaction (p = .080) on food abstinence, purging, pressure to be thin, or self-esteem outcomes post-intervention.	<u>Secondary Outcomes</u> Significant effect of risk status on food abstinence (p = .020) and pressure to be thin (p = .030), with high-risk group improving significantly more than the low-risk group in both intervention and control groups at follow-up. No effect on purging between conditions at follow-up (p > .150). No significant difference in self-esteem between groups at follow-up.
Wilksch et al., (2015)	**Name of intervention:** Media Smart, Life Smart, and HELPP **Duration:** 8 x 50min group sessions over 4 weeks **Content:** *Media Smart Session 1:* magazines and stereotypes. *Session 2:* ***media*** advertising. *Session 3:* who places pressure on us and what can we do about it. *Session 4:* looking after ourselves and our peers. *Session 5:* putting pressure on the media. *Sessions 6 & 7:* is advertising harmful. *Session 8:* how to deal with media. *Life Smart Session 1:* health. *Session 2:* physical health and ***nutrition***. *Session 3:* sleep and ***exercise***. *Session 4:* identifying unhelpful thinking styles. *Session 5:* ***emotions***. *Session 6:* making connections with safe people. *Session 7: prepare for presentation* 'If someone is ***overweight***, they are unhealthy – agree or disagree? *Session 8:* bringing it all together and looking to the future. *HELPP Session 1:* appearance ideals. *Session 2:* appearance pressure and teasing. *Sessions 3 & 4:* introduction	<u>Primary Outcomes</u> Significant group × time × gender interactions were found for weight (p <.001), shape (p <.001), and eating concerns (p = .002). Only girls saw significant differences between groups over time. No effect post-intervention. Significant group × time × gender interactions were found for body dissatisfaction (p <.001, d = .17). Media Smart (d = .26) and Life Smart (d = .33) boys showed a significant improvement post-intervention for body dissatisfaction compared to control group. <u>Secondary Outcomes</u> Significant group × time × gender interactions were found for depression (p = .021), perceived social pressure (p <.001), dietary restraint (p = .001) and regular eating (p = .046). No significant differences post-treatment for boys or girls.	<u>Primary Outcomes</u> Both Media Smart and HELPP girls scored significantly lower than Life Smart but not control girls in both weight (MS: d = .34; HELPP: d = .43) and shape concern (MS: d = .33; HELPP: d = .42) at the 12-month follow-up. For eating concern, both Media Smart (d = .47) and control girls (d = .35) scored significantly lower than HELPP girls at 6-months while control girls scored lower than Life Smart girls (d = .33) at 12 months. No significant differences for boys or girls in body dissatisfaction between groups at either follow-up. <u>Secondary Outcomes</u> Boys in Media Smart (d = .51) and HELPP (d = .46) interventions showed significantly lower depression scores than Life Smart participants but not control group at 6-months follow-up. At 12-months follow-up Media Smart boys scored

Study	Descriptions of Interventions ***Core Psychopathology/Risk factors addressed***	End-of-treatment	Follow-up
	to ***'fat-talk'*** (appearance conversations) and their negative consequences. *Session 5:* media literacy and ***media pressure***. *Session 6:* appearance comparisons. *Session 7:* ***eating concerns***. *Session 8:* review and challenging appearance ideals. **Delivery:** Facilitated by postgraduate psychology students. Overview of the topic, videos, group discussions, presentations (by students), and role plays. **Control:** Class as usual	Significant group × time × gender interactions were found for perfectionism (p = .013). No significant differences post-treatment for girls, but Media Smart boys showed significant improvements in perfectionism post-intervention (d = .40). Significant interaction effect (group × time × gender) was found for media internalisation (p = .024). For boys only, Media Smart participants showed significant improvements post-intervention compared to Life Smart (d = .44) and control group participants (d = .68). HELPP participants showed significant improvements post-intervention compared to control condition (d = .47). Significant group × time × gender interactions were found for weight-related peer teasing (p = .018). Media Smart boys showed significant reductions in weight-related teasing post-intervention compared to HELPP boys (d = .57). Life Smart participants reported significantly more daily physical activity than control participants post-intervention.	significantly lower depression scores than the control group (d = .39). Girls in Media Smart (d = .45) and control (d = .44) interventions scored significantly lower perceived social pressure than HELPP girls at 6-months. No significant differences in perfectionism between groups or boys and girls at either follow-up. Boys in Media Smart saw significant improvements in media internalisation scores at both 6-month (d = .61) and 12-months follow-up (d = .46) compared to control group boys. Media Smart boys saw significant improvement at 6-month follow-up compared to Life Smart boys (d = .44). HELPP participants showed significant improvements at 6-month follow-up compared to control condition (d = .50). Media Smart participants reported significantly more exercise than both HELPP and control participants at 6-month follow-up.
Wilksch et al., (2017)	**Name of intervention:** Media Smart, Life Smart, and HELPP **Duration:** 8 x 50min group sessions over 4 weeks **Content:** See Wilksch et al., (2015) for content of interventions. **Delivery:** Facilitated by postgraduate psychology students. Overview of the topic, videos, group discussions, presentations (by students), and role plays. **Control:** Class as usual	<u>Primary Outcomes</u> Significant group × risk × time interactions were found for weight (p = .003), shape (p = .010), and eating concerns (p = .009). Media Smart participants with high SWC scored significantly lower eating concerns than both control (d = .60) and Life Smart (d = .58) participants post-intervention. A significant interaction effect (group × risk × time) was found for body dissatisfaction (p = .010). Participants in Media Smart (d = .34) and Life	<u>Primary Outcomes</u> Significant differences observed in high SWC participants only. Media Smart (d = .58) and control (d = .46) participants scored significantly lower eating concerns than HELPP participants at 6-month follow-up. At 12-months follow-up Media Smart (d = .58) and control (d = .55) participants scored significantly lower eating concerns than Life Smart participants. Media Smart (d = .38) and HELPP (d = .35) participants scored significantly lower than Life Smart participants for weight concerns at 12-months follow-up. Media Smart

Study	Descriptions of Interventions ***Core Psychopathology/Risk factors addressed***	End-of-treatment	Follow-up
		Smart (*d* = .31) with low SWC scored significantly lower body dissatisfaction than control group post-treatment. <u>Secondary Outcomes</u> A significant interaction effect (group × risk × time) was found for depression in boys only (*p* = .043). No significant differences post-treatment. Significant interaction effect (group × risk × time) was found for dietary restraint (*p* = .038) and perfectionism (*p* = .001). Post-hoc testing found no significant differences but lower scores found for lower SWC Media Smart compared to control participants. Significant interaction effect (group × risk × time) was found for regular eating (*p* = .036) and physical activity (*p* = .003). No significant interaction effects for media internalisation (*p* = .564), weight-related peer teasing (*p* = .104), or perceived social pressure (*p* = .347).	participants scored significantly lower than Life Smart (*d* = .36) participants for shape concerns at 12-months follow-up. No significant differences in body dissatisfaction between low and high SWC or groups at either follow-up. <u>Secondary Outcomes</u> Media Smart boys with low shape and weight concerns reported significantly lower depressive symptoms at 12-month follow-up than both Life Smart (*d* = .26) and control boys (*d* = .28). In high SWC participants only, both Media Smart (*d* = .40) and control participants (*d* = .43) regular eating significantly improved compared to HELPP participants at 12-month follow-up. Control participants significantly improved regular eating compared to Life Smart participants at 12-month follow-up (*d* = .34). At 6-month follow-up Media Smart participants reported significantly more physical activity than control (*d* = .38) and HELPP participants (*d* = .54). No follow-up.
Wiseman et al., (2004)	**Duration:** 5 x group sessions over 6 weeks. Length of sessions unknown. **Content:** *Session 1:* healthy living and issues other than ***body weight, shapes and dieting***. Discussion around media figures that are healthy and unhealthy. Importance of ***exercise***, hygiene, ***nutrition***, sleep and ***mental health*** in maintaining a healthy body. *Session 2:* **Social media**, magazine photographs of female models, and importance of valuing oneself. *Session 3:* nutritional guidelines and challenging perceptions of their sleep, dietary, and ***physical fitness***	<u>Primary Outcomes</u> Drive for thinness changed significantly over time in both conditions (*p* <.001). Italy participants in the intervention group showed a significant decrease in drive for thinness (*p* = .017) at post-intervention compared to the control condition. No other significant effects were found for Italy or USA participants. <u>Secondary Outcomes</u>	

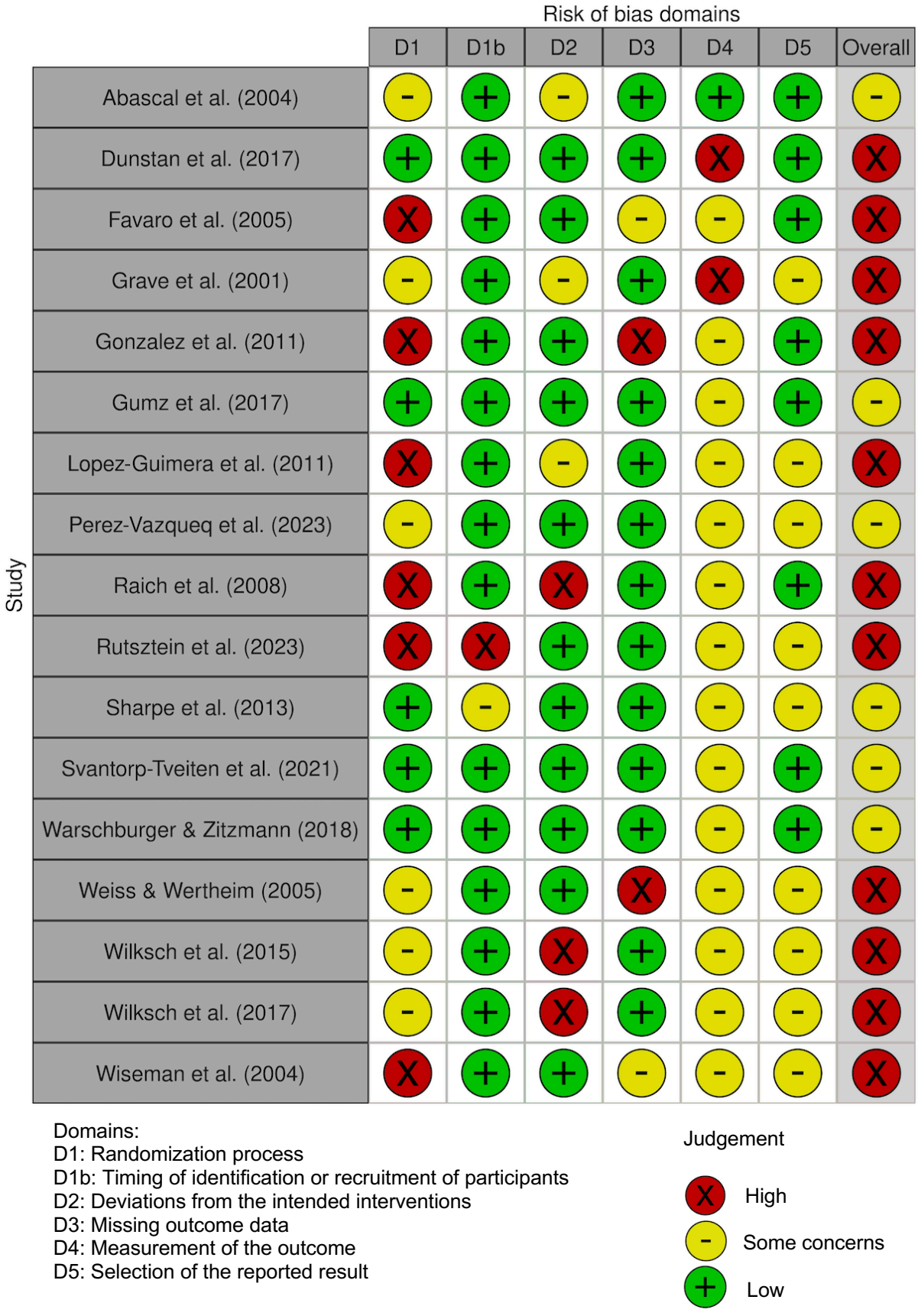
Study	Descriptions of Interventions ***Core Psychopathology/Risk factors addressed***	End-of-treatment	Follow-up
	needs. The topic of dieting, its popularity and misconceptions were discussed. *Session 4:* what are EDs and their physical and mental consequences. *Session 5:* what is a healthy body, eating healthily and healthy exercise. Valuing oneself other than by appearance and what are the consequences of dieting? **Delivery:** Facilitated by psychologist/psychiatrist. Overview of the topic, group discussions, critical reflection, and in-class activities. **Control:** Health lectures	No significant effects of intervention, country, time or any interactions for self-esteem or eating behaviours.	

Abbreviations: AMC; Aesthetic Model Criticism, BMI; Body Mass Index, CIMEC; Questionnaire on Influences of Aesthetic Body Ideal, DT; drive for thinness, EAT; Eating Attitude Test, ED; eating disorder, EDE-Q; Eating Disorders Examination Questionnaire, EDI; Eating Disorder Inventory, ES; effect size, HELPP; Helping, Encouraging, Listening and Protecting Peers Initiative, HRHM; higher-risk and higher-motivated group, HRHM-C; higher-risk and higher-motivated combined group, ML; media literacy, NUT; nutrition, Other-C; Other-combined group, PIA-2; prevenci onintegrada de trastornos alimentario y obesidad [Integrated prevention of eating disorders and obesity], SWC; Shape and weight concerns, WLC; waitlist control

[a] Authors combined Classes 1 and 3 to form a single HRHM-only group (HRHM-C) and a single Other-only (Other-C) group. HRHM-C and Other-C are analysed separately without statistical comparison between them.
[b] Authors did not report which effect size measure was used. Authors were emailed but reviewers did not receive a reply.
[c] Authors combined the co-educational and single-sex intervention conditions to create one intervention condition to compare against the non-treatment control.
[d] Analysis uses change scores

Figure 1.3

Risk of Bias Domains created using Robvis (McGuinness & Higgins, 2020)



Eating Disorder Psychopathology Outcomes

Eating Disorder Examination Questionnaire (EDE-Q)

Two studies measured global EDE-Q and one trial total Ch-EDE-Q. Whilst total scores significantly improved over time in both intervention and control group (Grave et al., 2001), neither Svantorp-Tveiten et al. (2021) or Gumz et al. (2017) found differences in ED psychopathology between the groups post-intervention. Additionally, two studies found contradicting gender differences. Svantorp-Tveiten et al. (2021) reported girls benefitted from the intervention with scores significantly lower than the control at 3-and-12-month follow-ups (small ES), whereas ED psychopathology reduced in 8th grade boys post-intervention, but increased in 8th grade girls (Gumz et al., 2017). Furthermore, both 11th grade intervention boys and girls exhibited lower ED psychopathology than those in the control at 6-month follow-up and in both groups, 8th grade girls exhibited increased ED psychopathology at follow-up.

There were significant improvements in subscales including restraint, weight, shape, and eating concerns post-intervention in three studies. Abascal et al. (2004) reported girls in the higher-risk and higher-motivated combined group (HRHM-C) saw significant improvements in restraint and shape concerns. In addition, boys and girls in the intervention group reported significant decreases in eating concerns compared to the control (Grave et al., 2001). Using shape and weight concern (SWC) as a moderator, Media Smart participants with high SWC scored significantly lower post-intervention in eating concerns than both control and Life Smart participants with medium ESs (Wilksch et al., 2017). Media Smart and control participants with high SWC scored significantly lower (small ESs) in eating concerns than Helping, Encouraging, Listening and Protecting Peers Initiative (HELPP)

participants at 6-month follow-up and Life Smart at 12-months follow-up (Wilksch et al., 2017). Finally, Media Smart and HELPP participants scored significantly lower than Life Smart participants for weight concerns and only Media Smart scored significantly lower for shape concerns than Life Smart participants at 12-month follow-up, all with small ESs. However, Wilksch et al. (2015) found Media Smart and HELPP girls scored significantly lower than Life Smart, but not control, in both weight and shape concern at 12-month follow-up with small ESs. Additionally, both Media Smart and control girls scored significantly lower in eating concerns than HELPP girls at 6-months, while control girls scored lower than Life Smart girls at 12-months, with small ESs.

Eating Attitudes Test (EAT) (Garner et al., 1982)

Seven trials reported total EAT scores. Compared to control conditions only three studies' interventions significantly improved scores posttreatment (Gonzalez et al., 2011; Grave et al., 2001; Perez-Vazqueu et al., 2023). ES, where reported, were small. Gonzalez et al. (2011) found Media Literacy (ML) and Media Literacy + Nutrition (ML+NUT) groups scored significantly lower than control for ED psychopathology at 7-and-30-months follow-ups. However, there were no significant differences between ML and ML+NUT groups on ED psychopathology at either time point (Gonzalez et al., 2011).

Studies including subscales reported mixed results. Lopez-Guimera et al. (2011) found participants in the ML+NUT group reported significantly higher median of change dieting score compared to non-treatment condition at post-intervention. At 6-month follow-up, participants in the ML group reported significantly higher median of change compared to the non-treatment condition. Both ESs were small. Favaro et al. (2005) showed a significant improvement in bulimic symptoms compared to the

control at post-intervention; whilst Perez-Vazqueu et al. (2023) reported significant reductions with a small ES in oral control only compared to WLC. No differences appeared between groups at post-intervention or follow-up on total EAT or subscales (Raich et al., 2008; Warschburger & Zitzmann, 2018). Across four mixed gender trials, only one study found significant reductions in ED psychopathology with a small ES for girls in the intervention group compared to boys (Warschburger & Zitzmann, 2018).

Eating Disorder Inventory (EDI) (Garner & Olmsted, 1984; Garner et al., 1983; Garner, 2004)

Across seven trials, multiple EDI subscales were adopted interchangeably. Five studies utilised the body dissatisfaction subscale, with three studies reporting significant body dissatisfaction improvements from intervention conditions compared to controls, with small ESs (Dunstan et al., 2017; Wilksch et al., 2015; 2017). Media and Life Smart boys showed significant improvements post-intervention for body dissatisfaction compared to control with a small ES (Wilksch et al., 2015) whilst participants in Media and Life Smart with low SWC reported significantly lower (small ES) body dissatisfaction than control at post-intervention (Wilksch et al., 2017). In contrast, the high-risk intervention group saw significant improvements in body dissatisfaction compared to the low-risk intervention group post-intervention, but not control groups (Weiss & Wertheim, 2015). However, no effects were maintained at follow-ups.

Four studies measured the subscale drive for thinness. Participants in the HRHM-C condition reported significant improvements post-intervention (Abascal et al., 2004) whilst Weiss and Wertheim (2015) found the high-risk intervention group superior in reducing drive for thinness compared to the low-risk intervention group

and both high-and-low control groups. Only Italian participants in the intervention group showed a significant decrease in drive for thinness post-intervention compared to the control group (Wiseman et al., 2004). Warschburger & Zitzmann (2018) found no drive for thinness differences in either condition over time.

Three studies that measured bulimic symptoms found no differences between groups at any timepoint (Abascal et al., 2004; Warschburger & Zitzmann, 2018; Weiss & Wertheim, 2015). However, over time girls in the intervention group saw a significant reduction in bulimic symptoms (Warschburger & Zitzmann, 2018) but ES was minimal.

Two studies reported on interoceptive awareness. Whilst Weiss & Wertheim (2015) reported significant improvements in the high-risk intervention group compared to the low-risk intervention group and both high-and-low control groups posttreatment, Wiseman et al. (2004) found no effect for this or other subscales including maturity fears, interpersonal distrust, or perfectionism. Finally, no significant differences were observed in either intervention or control conditions for ED risk over time when controlling for age (Rutsztein et al., 2023).

Eating Disorder Diagnostic Scale (EDDS) (Stice et al., 2000)

Sharpe et al. (2013) found no differences between intervention or control group on binge eating or compensatory behaviours post-intervention.

Physical Health Outcomes

Only three studies measured changes in BMI, finding no significant differences across conditions and time. Two studies were girls only (Favaro et al., 2005; Lopez-Guimera et al., 2011) whereas Perez-Vazqueq et al. (2023) included a mixed-gender sample. One study recorded follow-up data, but no significant differences were reported.

Broader Psychological Wellbeing Outcomes

Studies utilised several broader psychological outcomes including weight management behaviours, body image, and psychological distress.

Weight Management Behaviours

Eating Behaviours. Five trials measured eating behaviours across multiple questionnaires. Wilksch et al. (2017) found high SWC participants in Media Smart and control groups saw significant improvements with small ESs in regular eating at 12-month follow-up compared to HELPP participants. In addition, control participants' regular eating significantly improved (small ES) compared to Life Smart participants at 12-month follow-up (Wilksch et al., 2017). Consistent with risk group classifications, Weiss & Wertheim (2005) report high-risk girls improved significantly over low-risk girls on food abstinence across intervention and control groups at follow-up. However, there were no differences in purging behaviours at each timepoint across conditions (Weiss & Wertheim, 2005). Researchers did not report breakdown analysis for the interaction effect of gender and SWC on dietary restraint and regular eating (Wilksch et al. 2015; 2017). Remaining studies found no significant differences in dietary restraint (Dunstan et al., 2017) or eating behaviours (Wiseman et al., 2004) between conditions or over time.

Exercise. Three studies measured exercise. Warschburger & Zitzmann (2018) found, compared to the control, the emotional element of exercise significantly reduced in the intervention group both post-intervention and at 12-month follow-up. However, the ES was minimal. Both HELPP and control groups appear more effective in reducing exercise across both Wilksch et al. (2015; 2017) trials. Life Smart participants reported significantly more daily exercise than control participants post-intervention, while Media Smart participants reported significantly more exercise

than both HELPP and control participants at 6-month follow-up (Wilksch et al., 2015). At 6-month follow-up Media Smart participants reported significantly more exercise than control and HELPP participants (Wilksch et al., 2017).

Nutrition. Basic knowledge of nutrition was measured by Raich et al. (2008) showing a significant increase for participants in the Aesthetic Model Criticism (AMC)+ML+NUT condition compared to the control at post-intervention only, with a medium ES. Svantorp-Tveiten et al. (2021) reported weekly frequency of protein and creatine supplement usage in control boys significantly increased at both follow-up timepoints. No main or interaction effects were observed for diet aid use.

Body Image and Acceptance

Beliefs about one's own body. Five trials measured adolescents' views on their own body image. Svantorp-Tveiten et al. (2021) reported girls' body image flexibility increased at post-intervention and both follow-up timepoints compared to girls in the control condition with small ESs. Results were largely similar for boys and girls, except at the 12-month follow-up, where boys in the intervention group did not demonstrate the same effect as girls (Svantorp-Tveiten et al., 2021). In contrast, Sharpe et al. (2013) found no significant improvement posttreatment, but girls in the intervention group had significantly higher body-esteem compared to the control at follow-up. Girls in both clinical and normal body-esteem ranges showed greater reliable improvement in the intervention group compared to the control group, however; no effect was found for significant improvement changes. Of the five trials that measured internalisation of the thin-ideal, three studies reported significant improvements (small ESs) at all time points in the intervention groups compared to control conditions (Dunstan et al., 2017; Sharpe et al., 2013; Svantorp-Tveiten et al., 2021). The posttreatment effect for boys (d = .24) faded whereas the effect among

girls sustained across 3-month (*d* = .40) and 12-month follow-ups (*d* = .44). Rutsztein et al. (2023) reported thin-ideal internalisation changed significantly over time in both conditions, but the intervention was not superior to CAU. In addition, Gumz et al. (2017) found no effect for internalisation of thin ideals between groups. Finally, Svantorp-Tveiten et al. (2021) reported significantly lower drive for leanness scores at all timepoints and muscular internalisation post-intervention and 3-month follow-up in the intervention group compared to the control condition. However, ESs were small.

Perceived pressure on body image. Eight trials assessed adolescents' body image comparisons, appearance-related talk, and perceived sociocultural pressure. Girls in the intervention group scored significantly lower on appearance comparison posttreatment and at follow-up (Dunstan et al., 2017), whilst in Warschburger and Zitzmann's (2018) trial scores remained stable at follow-up for boys and girls in the intervention group. Moreover, neither intervention groups were superior in reducing conversations on body image for girls compared to controls (Dunstan et al., 2017; Sharpe et al., 2013).

Four mixed gender studies focused specifically on perceived pressure from the media and found those in the intervention groups consistently reported lower media pressure than control groups at multiple timepoints. However, whilst Warschburger and Zitzmann (2018) reported no gender distinction, only girls in the intervention group reported significant improvements at all timepoints (Svantorp-Tveiten et al., 2021), whereas Wilksch et al. (2015) conversely found only boys reported improvements here. Across the 3 intervention groups, Media Smart boys showed significant improvements in media internalisation compared to Life Smart at post-intervention and 6-month and compared to control boys at all timepoints with

small to medium ESs (Wilksch et al., 2015). In addition, HELPP boys showed significant improvements (medium ES) compared to the control condition at post-intervention and 6-month follow-up (Wilksch et al., 2015), whereas Wilksch et al. (2017) found no effects between conditions.

In a broader focus, four mixed gender trials assessed perceived sociocultural pressures on body image. Whilst boys' and girls' awareness of societal standards of attractiveness did not change over time between conditions, the intervention group showed significantly greater increase (small ES) in experienced pressure of Western beauty ideals post-intervention only compared to the control group (Gumz et al., 2017). Only girls who received Media Smart intervention or CAU scored significantly lower on perceived sociocultural pressure than HELPP girls at 6 months follow-up with small ESs, but not other timepoints (Wilksch et al., 2015) whereas Wilksch et al. (2017) found no interaction effect on this measure. Lastly, post-intervention, ML adolescents reported significantly lower sociocultural pressure on body image concerns than the control group, while ML+NUT adolescents showed no difference (Gonzalez et al., 2011). At 7-month and 30-month follow-up assessments, both ML and ML+NUT groups had lower scores than the control group (Gonzalez et al., 2011).

Body shaming/weight related teasing. Four trials measured weight-related teasing. Wilksch et al. (2015) found Media Smart boys showed significant reductions compared to HELPP boys at post-intervention only with a small ES. Remaining studies did not observe differences in perceived teasing over time between interventions (Dunstan et al., 2017; Warschburger & Zitzmann, 2018; Wilksch et al., 2017).

Psychological Distress

Mood, Depression, and Anxiety. Five studies reported changes in psychological distress. Sharpe et al. (2013) reported no significant differences in girls' depression scores in either intervention or control group. Wilksch et al. (2015) report boys in the Media Smart and HELPP interventions showed significantly lower depressive symptoms than Life Smart participants but not control group at 6-months follow-up with small and medium ESs. At 12-months follow-up Media Smart boys scored significantly lower (small ES) on depression than the control (Wilksch et al., 2015). Media Smart was superior (small ES) in significantly reducing depressive symptoms in boys with low SWC concerns at 12-month follow-up compared to Life Smart and control boys (Wilksch et al., 2017). Remaining studies report no gender differences. Gumz et al. (2017) found the intervention group was superior to the control group in significantly reducing anxiety symptoms directly after intervention, but not at follow-up and ES was minimal. In addition, no significant differences in either group presented for depression scores over time. Svantorp-Tveiten et al. (2021) found the inverse with no significant differences in anxiety or depression scores between intervention and control group at post-treatment, but at 12-month follow-up those in the intervention group showed greater improvements compared to the control with small ESs.

Self-esteem and Self-identity. Here, seven trials measured self-esteem and self-identity. Dunstan et al. (2017) found girls' self-esteem in the intervention group improved at post-intervention and follow-up. Similarly, boys' and girls' self-esteem in the intervention group significantly increased at 12-month follow-up compared to the control with a small ES (Svantorp-Tveiten et al., 2021). However, these effects were not found subsequently. Grave et al. (2001) reported self-esteem scores changed over time but without significant differences between groups. Remaining studies

found no significant differences of self-esteem between intervention or control conditions over time (Gumz et al., 2017; Perez-Vazqueq et al., 2023, Weiss & Wertheim, 2005; Wiseman et al., 2004).

Perfectionism. Perfectionism was measured in two studies. Compared to the control, Media Smart boys reported significant improvements in perfectionism post-intervention with a small ES (Wilksch et al., 2015), although not maintained at either follow-up. Whilst Wilksch et al. (2017) reported SWC was a moderator between group and time, the breakdown of this effect was not reported.

Social Support. Sharpe et al. (2013) found no significant differences in perceived support from friends between the intervention or control group overall.

Discussion

The review's purpose was to synthesise RCTs on the use of universal secondary school-based interventions addressing transdiagnostic core ED psychopathology and at least one other psychological risk factor. Importantly, most studies included in this review were rated overall as high RoB, indicating methodological weaknesses limiting the confidence of findings. Thus, results from this review should be interpreted with caution. The narrative synthesis found that whilst most interventions showed an improvement post-intervention in one or more ED symptomology or broader wellbeing outcomes, effects were mostly small or non-existent and not maintained at follow-up. A few interventions (Gonzalez et al., 2011; Lopez-Guimera et al., 2011; Perez-Vazquez et al., 2023; Svantorp-Tveiten et al., 2021; Wilksch et al., 2017) were superior to the control, but again effects were small or not maintained. There were no significant changes in BMI. These findings are consistent with previous reviews (Berry et al., 2025; Schwartz et al., 2019; Yager et al., 2013).

Interventions demonstrated greater efficacy in improving body dissatisfaction and weight, shape, eating concerns compared to other ED symptomology. The same was found for body image concerns compared to other broader wellbeing outcomes, supporting the transdiagnostic view of disordered eating and EDs (Breton et al., 2022; Munkholm et al., 2016). This is likely due to most interventions focusing on body image acceptance, dieting, exercise, and social media, and similar across previous reviews (Berry et al., 2025; Pursey et al., 2021). Facilitators and programme duration were variable with no clear trends towards intervention efficacy based on facilitators or number of sessions. However, research suggests professionals are more suited to deliver ED-specific content than teachers (Chua et al., 2020; Pursey et al., 2022). Given the limited time in school curriculum and other competing demands (Yager & O'Dea, 2005), the current finding offers teachers flexibility in the implementation of interventions.

The only studies that yielded medium ESs were Wilksch et al. (2015; 2017). This could be related to interventions being delivered twice weekly, or programmes being concise with fewer risk factors targeted (Wilksch et al., 2015). With this review highlighting the potential value of addressing weight, shape, or eating concerns in addition to body image dissatisfaction, dieting, exercise, and social media, schools should consider such factors when developing interventions. Furthermore, targeting specific ED psychopathology or risk factors may facilitate greater personalisation, which is highly relevant in universal school-based interventions whereby individual needs vary widely. A modular approach may offer a promising model for universal school-based ED interventions; allowing adolescents to engage in modules that align with personal concerns, interests, or perceived knowledge gaps. Additionally, adopting this approach will likely facilitate testing of specific theoretical pathways

which will continue to enhance understanding of the most effective factors for reducing ED symptomology in universal interventions.

Interestingly, Gumz et al. (2017) found age differences in response to interventions. Boys and girls in 11th grade reported significantly lower ED psychopathology at follow-up, compared to an increase in symptoms in 8th grade girls. Research suggests adolescents aged 12-15 experience the most prominent rise in symptoms (Breton et al., 2022) aligning with the beginning of puberty and environmental stressors, which have been shown to influence the development of psychopathology (Graber, 2013; Marcos et al., 2013). Given participants' average age was 14 in this review, the lack of effects may be explained by this developmentally sensitive time or inclusion of a broad age range. Both researchers and schools may wish to consider narrowing the age range based on developmental trajectories.

Whilst universal interventions can provide short and long-term benefits, floor effects and interpretation of effect sizes may impact the recognition of significant effects within the context of population-level implementation (Andrade, 2021; Koreshe et al., 2021). By design, universal interventions target entire populations rather than at-risk individuals. Therefore, even small effects, as seen in this review, have the potential to shift population norms and reduce overall prevalence, ultimately benefiting many young people. Given this, the lack of effects for BMI likely reflect participants' BMI scoring within the 'healthy range', suggesting substantial changes were neither necessary nor expected. However, the utilisation of BMI in CYP, particularly those without an ED, has commonly cited criticism (Ikeda et al., 2006; Rothman, 2008; Tatum et al., 2021). Firstly, around 85% of individuals with an ED are not underweight (Fairburn et al., 2003) nor does one's body size predict the

development of an ED (National Institute of Mental Health, 2024). Whilst weight and BMI can be useful in clinical settings (The Royal College of Psychiatrists, 2022), concerns regarding weight-stigma and possible development of disordered eating have been raised in school-based programmes (Tatum et al., 2021; Turner et al., 2024). This ethical dilemma raises the debate around potential harm of universal interventions in schools. Researchers within the field propose awareness-raising campaigns and universal school interventions can have unintended consequences related to issues of overidentification and increases in reported rates of mental health problems and negative effects (Foulkes & Stringaris., 2023, Guzman-Holst et al., 2025). Authors argue a move towards (1) targeted interventions focusing on at-risk populations; (2) opt-in interventions to reflect adolescents' desire for autonomy, (3) indirect interventions focusing on risk factors such as bullying; or (4) approaches that increase treatment access outside of school (Andrews & Foulkes, 2025). Furthermore, future research may warrant focusing on positive body image components rather than negative aspects of body image considering their protective influence against ED symptoms (Linardon, 2021).

Eight studies recruited boys and girls, but not all conducted analysis according to gender. Findings from this review suggest girls experienced greater benefits than boys, which supports previous meta-analyses (Chua et al., 2020; Pursey et al., 2021). Gumz et al. (2017) incorporated gender-specific content and reported significant reductions in ED symptomology post-intervention for boys compared to an increase for girls. The absence of gender-tailored sessions may explain previous lack of effects and indicate the value of providing gender-specific content (Nebel-Schwalm & Brown, 2021). Whilst risk factors across genders are similar, clinical presentation and function of behaviour differs (Forsén et al., 2017;

Nagata et al., 2021); whilst girls typically strive for the ‘thin-ideal’, research suggests boys are driven by muscularity (Griffiths et al., 2013; Karazsia et al., 2017; Tiggemann et al., 2007). This may explain the baseline differences between boys and girls in included studies. Male interventions have focused on challenging the ‘male appearance ideal’ and included discussions on steroids and men’s health magazines, yielding medium to large effects (Brown & Keel, 2015; Jankowski et al., 2017). However, gender is not a binary construct (Ansara & Hegarty, 2014; Hyde et al., 2019). Research suggests interventions should group transgender and gender diverse individuals together and be led by clinically-trained professionals who can foster judgment-free environments, address multiple dimensions of gender and positive body image through discussion of diverse ideals. (Gordon et al., 2024). Thus, caution is advised when adopting included interventions in school settings. Clinicians should develop gender-affirming content and consider facilitation in schools whereby cisgender and transgender and gender diverse CYP are present.

Most participants were Caucasian. The exclusion of non-English studies likely explains the underrepresentation of diverse cultural contexts. However, where other ethnicities were included, they formed a minority of the sample. Whilst there is a lack of research in non-western countries (Alfalahi et al., 2022), EDs are common in these populations (Makino et al., 2004; Melisse et al., 2020) and differences in symptomology exist. Asian American women report higher body dissatisfaction related to arms, breasts, height, and facial features compared to Caucasian women (Mintz & Kashubeck, 1999) and reduced fear of fatness or weight gain (Lee et al., 2010; Nakai et al., 2014). Given cultural differences in clinical presentation and the focus on universal interventions, the findings of this review should be interpreted with caution. It is imperative clinicians and schools consider intersectionality and

facilitation in a universal context. They may wish to provide culturally competent clinicians that can explore the impact of cultural contextual factors (e.g., stigma and relationships in ED development and maintenance), and adopt a culturally flexible model (Acle et al., 2021; Channa et al., 2019; Chen & Tao, 2010).

The RoB-2 tool highlighted methodological concerns. The process of randomisation remains problematic and of high-risk (McErlean et al., 2023). However, conducting high-quality RCTs in schools presents unique challenges (Okello et al., 2013; Styles & Torgerson, 2018), with informed consent and non-blinding of facilitators inevitably increasing bias. To improve write-up of the randomisation process, researchers suggest 100-200 protected words to allow for adequate description of randomisation (McErlean et al., 2023). Additionally, some studies failed to measure and report global or subscale scores. Questionnaires in this review individually measure a broad spectrum of ED psychopathology, therefore excluding data reduces the validity of findings (Aardoom et al., 2012). Austin et al. (2023) recommends measuring ED cognitions and behaviours, body image, and symptom severity, thus future research should utilise the EDE-Q or equivalent shorter versions. Researchers could also consider parental reports given CYP can under-report symptoms (Couturier et al., 2007; Salbach-Andrae et al., 2008), particularly restrictive-type symptoms (Swanson et al., 2014) and utilise male specific outcomes considering measures were developed and validated in women (Murray et al., 2017). Some studies selectively report the analysis undertaken; whilst this occurred in older papers and on secondary aim outcomes, this reporting bias has the potential to skew conclusions (Kirkham et al., 2018). To reduce the risk of publication bias and ensure the integrity of evidence-based research, future studies should provide complete transparency in all planned outcomes. Additionally, most studies

did not report SES and ethnicity data. Given the continued under-representation of non-western cultures in literature, future research should accommodate further subanalyses of minoritised groups. Finally, whilst WLC or non-treatment conditions are acceptable at the initial stage of trials, they impact the quality of results (Ovosi et al., 2017). Further research should seek to compare interventions to active controls and report longer-term follow-ups.

This review has several important strengths including a comprehensive search strategy and inclusion of gold standard RCT methodology (Akobeng, 2005; Hariton & Locascio, 2018). Seven studies were also assessed in previous reviews (Berry et al., 2025; Chua et al., 2020). Overall bias ratings are consistent with those reported earlier, suggesting similar methodological limitations identified across independent researchers. This review builds on previous syntheses (Berry et al., 2025; Chua et al., 2020; Yager et al., 2013) by expanding the focus to universal interventions targetting ED symptomology in addition to other psychological risk factors.

Despite the strengths, this review is not without limitations. Firstly, in line with systematic review recommendations (Uttley et al., 2023), future reviews should include non-English and grey literature studies. Secondly, although researchers were transparent and reported deviations of intended methods, the refinement of inclusion criteria limits the breadth of available evidence and the generalisability of findings. The absence of meta-analytic techniques also limits synthesis to a more narrative and subjective interpretation of findings without the combination of synthesising results with statistical models (Cheung & Vijayakumar, 2016; Liberato et al., 2009). The description of interventions lacked clarity at times, making it difficult to establish the inclusion of core ED psychopathology. Many studies referred to the term ‘body

image' but it remained unclear whether the focus was on weight, shape, eating concerns or a broader emphasis around appearance-related concerns (Buerger et al., 2019; Garbett et al., 2021; Krebs et al., 2025). Authors therefore adopted a conservative approach and studies that clearly stated the inclusion of core ED psychopathology were included. Thus studies might have unknowingly been excluded on this basis. Future studies should provide a full description of included interventions (Hoffmann et al., 2014), whilst future reviews may wish to research broader conceptualisations of body image. Similarly, studies were excluded if they did not utilise a validated measure of ED symptomology. In order to facilitate our understanding of the most effective universal school-based ED interventions, it is imperative studies measure ED symptomology using validated, evidence-based measures. Furthermore, Wilksch et al. (2015; 2017) used the same data set. Given the increased likelihood of false positives when repeating analyses, it is important to highlight caution around interpretation of these findings.

Overall, there is mixed evidence for the effectiveness of universal school-based ED interventions on reducing ED psychopathology and broader wellbeing outcomes, with no changes on BMI. Girls appeared to benefit more than boys, but interventions lacked gender-specific content. However, the high RoB limits the confidence of findings. Future research would benefit from adopting active comparison groups and longer follow-ups. Whilst core ED psychopathology in addition to the risk factors of body image dissatisfaction, dieting, exercise and social media appear consistent factors to include in universal interventions, future researchers may wish to adopt a modular approach to facilitate testing of specific theoretical pathways and to enhance our understanding of the most effective factors for reducing ED symptomology in universal school-based interventions.

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Service Improvement Project

"It's sometimes so overwhelming you just cry": Understanding Staff Experiences of Compassion on an Older Adult Inpatient Ward

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Abstract

Background: Working with older adults on mental health inpatient wards can be highly rewarding. Yet the complexity of this patient group, alongside wider NHS challenges, can create threat-based environments whereby staff experience work-related stress and reduced wellbeing. Understanding and experiencing the role of compassion in healthcare staff can improve wellbeing and job retention.

Methodology and Aims: This service improvement project was conducted in an older adult inpatient ward within Oxford Health NHS Foundation Trust. It sought to understand staff experiences of compassion and to recommend how compassion to self and others can be improved. Ten multidisciplinary staff participated in semi-structured interviews, with their accounts analysed using Reflexive Thematic Analysis.

Results: Four themes were inferred from analysis. (1) what compassion means to me, (2) “people are running around like headless chickens basically”, (3) (relentless) dedication to the role, and (4) “it’s just as important looking after yourself as it is looking after others”.

Conclusions: The results of this project provide detailed understanding and experiences of compassion on an older adult inpatient ward. Based on this, recommendations to the leadership team were given. This project is a foundation for future research to deepen our understanding of experiences of compassion for healthcare staff.

Introduction

The National Health Service (NHS) is under ever-increasing pressure (Cooksley et al., 2023). Waiting lists in England are longer than ever before (Baker, 2024) and the number of individuals in contact with mental health services has risen by 24% since 2019/20 (Baker & Kirk-Wade, 2024). Several factors including an ageing population, government funding cuts, staffing issues, the Covid-19 pandemic and the current cost of living crisis are amongst those attributed to increased demand (Baker, 2019; Baker & Kirk-Wade, 2024). Such pressure is impacting those working in the NHS.

The effects of Covid-19, which included increased demand on services and witnessing deaths of patients and colleagues, has led some healthcare staff to experience psychological distress, trauma, and moral injury[1] (French et al., 2022; Liberati et al., 2021; Sattar et al., 2023), with the long-term impact on staff unknown. Healthcare staff consistently face increasing demands and often work in threat-dominated work environments (Tane et al., 2022), with an impact on both professional and personal lives (Cocker & Joss, 2016). A recent survey showed that 44.8% of staff felt unwell as a result of work-related stress and 56.6% went into work in the last three months despite not feeling well enough to perform their duties (NHS, 2023). Fostering supportive work environments and prioritising staff wellbeing have been linked to improved staff retention (Ajemba et al., 2024).

[1] Moral injury is thought to be strong cognitive and emotional responses that can occur after a traumatic event that violates an individual's moral or ethical code (Litz et al., 2009). Such events include an individuals own, and others' acts of omission or commission, or betrayal by a trusted individual during a high-stakes situation (Williamson et al., 2021).

One way of conceptualising stress experienced in healthcare staff is through Gilbert's (2005, 2010) affect regulation systems model as part of the wider compassion-focused therapy framework. There are three distinct emotion regulation systems:

- Threat: The dominant system triggered by perceived threat which facilitates self-protection and survival.
- Drive: The system that motivates a person towards resources, goals and achievements.
- Soothe: The system associated with feelings of calmness, safety and compassion.

Although the systems are distinct, they continuously interact in response to perceived or actual internal and external threats, signals, or environments. Gilbert (2009) proposes emotional dysregulation and behaviours can occur when the systems become imbalanced. Nurturing the soothing system, through Compassionate Mind Training (CMT) and activation of the parasympathetic nervous system can reduce the threat and drive systems, in turn eliciting compassion (Gilbert, 2005, 2009). Based on this model, feelings of stress and burnout in healthcare staff can be explained through the overactivation of both the threat and drive systems, and underactivation of the soothing system (Henshall et al., 2018).

Compassion is defined as 'a sensitivity to suffering of self and others, with a commitment to try to alleviate and prevent it' (Gilbert, 2017, p.73). Underpinned by his model, Gilbert (2014) describes how compassion flows in three directions: giving compassion to others, receiving compassion from others, and having compassion for oneself (self-compassion). Compassion can be a protective factor for mental health (MacBeth & Gumpley, 2012), physiological health (Klimecki et al., 2014) and

interpersonal relationships (Yarnell & Neff, 2013). In healthcare settings, self-compassion has been shown to indirectly reduce anxiety, depression, and burnout in nurses and students (Abdollahi et al., 2021; Luo et al., 2019).

A core value underpinning healthcare is the giving of compassion to colleagues, patients, and their families. However, giving and receiving compassion to self and others can be difficult for some healthcare staff to navigate (Egan et al., 2019; Stylianou & Reddy, 2023). As humans, when operating from a threat-based mindset, it becomes more challenging to activate the soothing system and instead the drive system becomes too exhausted to manage the threat state. Crawford and colleagues (2013) found, when discussing experiences at work, that healthcare staff rarely used words describing compassion (e.g., kind and warm). Authors concluded that staff working in threat-dominated work environments struggle to engage with a compassionate mentality (Crawford et al., 2013).

Despite the concept of compassion deriving from Buddist teaching, healthcare staff experiences of compassion have largely been researched in Westernised cultures (Kariyawasam et al., 2021). With around 42% of NHS medical staff originating from a range of cultures and backgrounds outside of the UK (NHS, 2021), there is a clear need for mutual understanding of compassion amongst teams and colleagues. Service-specific research has found that compassion is, for much of the time, everday acts of support, e.g., being non-judgmental and being present for the team (Wilson, 2024). Yet whilst many staff work tirelessly to provide compassionate care, the ward environment might not always be conducive to creating psychological safety (Maddox & Barreto, 2022).

Collective understanding of compassion, and the ability to express emotions safely, have been shown to positively impact staff confidence, wellbeing, and

enabling compassion towards colleagues and patients (de Zulueta, 2021; Ostergard et al., 2023). There is also a clear ambition, outlined within the NHS Long Term Plan (2019) and NHS People Plan (2020), to develop ‘Compassionate Leadership’. This aims to lead to improvements in healthcare staff wellbeing and quality of patient care. To do this, it is important to understand experiences of compassion in teams and invite staff to gain a shared understanding of compassion.

Service Context

The service is a 20-bed inpatient ward for people over the age of 65 experiencing distress in the context of dementia or who have severe mental health difficulties. This setting alone brings many challenges as staff often look after both patients’ emotional and physical needs, such as personal care, adjusting their approach to accommodate for cognitive impairment, and managing interpersonal conflict and behaviours that challenge. The average length of stay on the ward is 90-100 days. The multidisciplinary team (MDT) comprises approximately 37 employed staff, with 10 student doctors and nurses on placement, and five agency staff at any one time.

The service leadership team identified a high turnover of staff and were keen to increase job retention as part of service improvement. Although a recent survey seeking staff views on working for the Trust found improvements in providing compassionate care (Oxford Health NHS Foundation Trust, 2023), staff morale fell below the national average. Ward psychologists noted there was little compassion-based talk and behaviour amongst staff, with inadequate spaces to discuss the working environment impact on themselves and colleagues. As every team is unique, the service was keen to explore staff members’ understanding and experiences of compassion on the ward, to inform recommendations, with the hope

of improving staff members' working environment, and ultimately job retention. Following interviews with staff on the ward, it was hoped that creating a reflective space with staff to present themes of commonality and discuss approaches to increase compassion would increase understanding and awareness of staff's mutual and self-support.

Aims and Questions

The broad aim was to understand staff experiences of compassion on an older adult inpatient ward, and to recommend how compassion to self and other can be improved. Specific questions were as follows:

Phase 1:

1. How do staff understand and define the concept of compassion?
2. How do staff, from a range of cultures and backgrounds, experience compassion as a staff member on an older adult inpatient ward?

Phase 2:

1. What compassion approaches would staff like to be implemented on the ward?

Materials and Methods

The project was approved and registered by Oxford Health Research and Development Team as a service evaluation, and the appropriate referral received via email (Appendix 2.2). The project was split into two phases, guided by the Plan-Do-Study-Act (PDSA) framework (Healthcare Quality Improvement Partnership, 2015), utilising a mixed-methods approach.

Phase 1: Individual interviews with staff to understand experiences of compassion on the ward.

Participants

All staff working on the older adult inpatient ward, for over one month, were invited to take part. Ten staff participated using purposive sampling. Participant information is in Table 1. Most participants were female, yet covered a range of ages, ethnicities and experience. The lead researcher (MS) had previously worked alongside all staff on placement.

Procedure

MS attended an MDT meeting to inform staff about the project. Subsequent reminders were sent to the leadership team, alongside posters (Appendix 2.3) placed in staff-facing areas. Due to demands on the ward, three days were prearranged with the ward manager whereby MS attended the ward for data collection. Staff were informed of these days in advance and permission was given, by the leadership team, for staff to complete the interview during working hours. Participants were fully briefed on the aims of the research and had the opportunity to ask questions. Consent was obtained verbally before completing an individual interview at a time convenient for the participant.

Interview Schedule

A semi-structured interview schedule was constructed by the research team (Appendix 2.4) and subsequently reviewed by clinicians working in a similar inpatient setting. Both supervisors (RV and CC) have experience of working in older adult services and adopting a compassion-based approach in clinical practice. The questions explored staff members' understanding of compassion (Q1), their experiences of compassion on the ward (Q2-7), and suggestions to increase

compassion for self and others (Q8). Participants were asked all eight questions, yet the interview schedule was designed to be adaptive, allowing MS to follow participants' answers and follow up for more in-depth information as suitable.

Data Analysis

Interviews were audio recorded on Microsoft Teams and transcribed verbatim by MS. Transcripts were analysed by MS using Reflexive Thematic Analysis (Braun & Clarke, 2006; 2022) to identify themes within the data. Following initial coding, codes of four interviews were checked by the internal supervisor (RV) to account for consistency and interpretation of the data. Themes and sub-themes were created by MS and discrepancies amongst themes were discussed within the research team to facilitate a reflexive and iterative process. MS journaled a reflexive log throughout the project (Appendix 2.5).

Phase 1: Results

Survey Data

Participant interviews (Table 2.1) lasted on average 31 minutes (range 21-40 minutes). Four themes were identified, (1) what compassion means to me, (2) "people are running around like headless chickens basically", (3) (relentless) dedication to the role, and (4) "it's just as important looking after yourself as it is looking after others". Each theme had subthemes (Figure 2.1). Appendix 2.6 includes additional quotes from the interviews.

Table 2.1

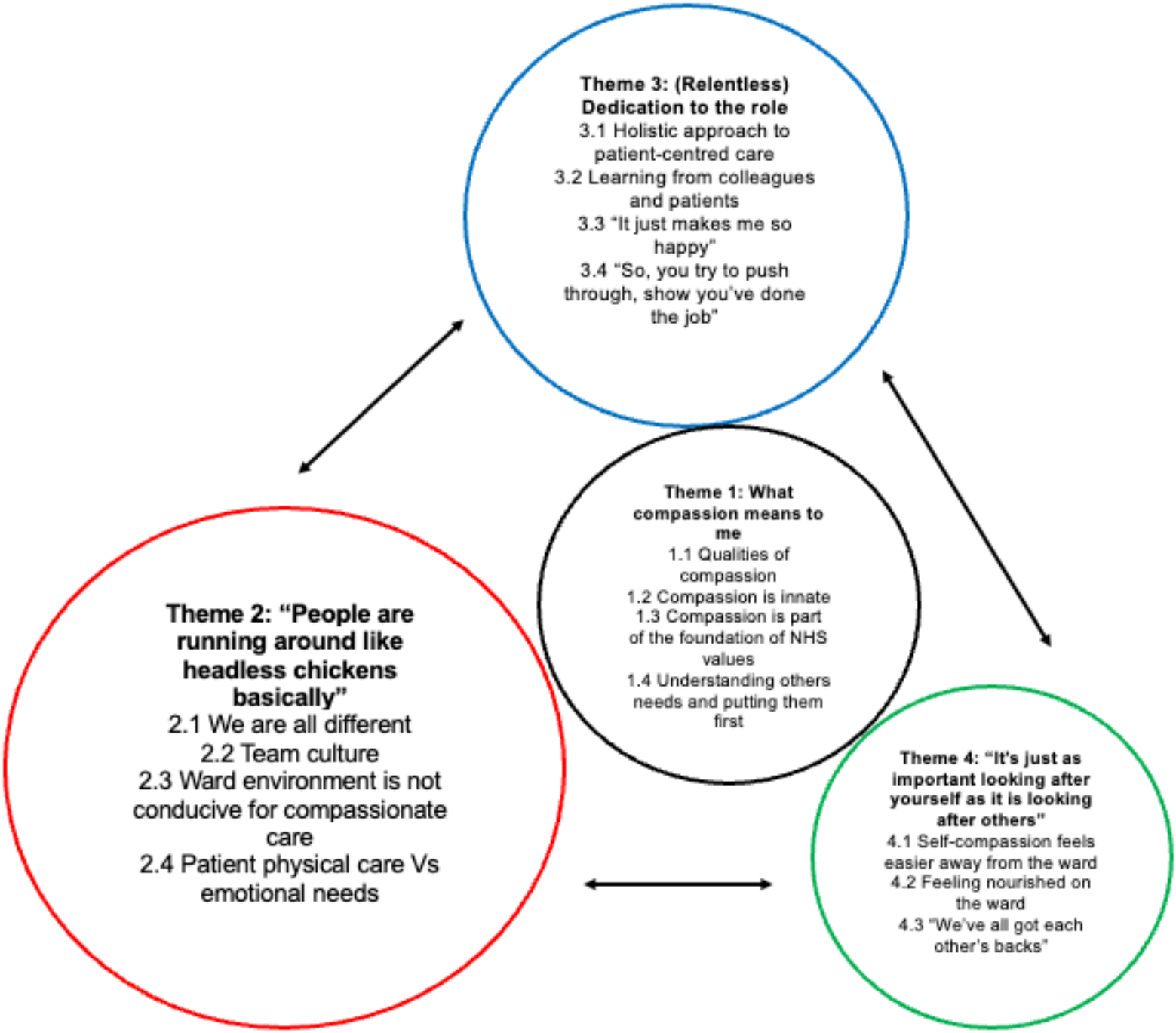
Participant Demographics

Demographics	Frequency *n*	Percentage %
Sex		
Female	8	80
Male	2	20
Age		
20 – 29 years	3	30
30 – 39 years	2	20
40 – 49 years	4	40
50 – 59 years	1	10
Ethnicity		
Black African	3	30
Black British	1	10
Chinese	1	10
White British	4	40
Mixed Ethnic Background	1	10
Job Titles		
Assistant Psychologist	1	10
Healthcare Assistant	1	10
Nursing Associate	1	10
Occupational Therapist	1	10
Physiotherapy Instructor	1	10
Staff Nurse	2	20
Support Worker	2	20
Ward Manager	1	10

Note. N =10. Participants were on average 37.3 years old (*SD* = 11). Participant NHS experience ranged from 6 months to 22 years (*M* = 5.4 years, *SD* = 6.79). Participant time working in current role ranged from 4 months to 10 years (*M* = 3.1 years, *SD* = 3.74).

Figure 2.1

Thematic Map showing Main Themes and Subthemes



Qualitative Analysis

Theme 1: What compassion means to me. This theme summarises staff members' understanding of compassion.

1.1: Qualities of compassion. To be compassionate, staff commented how one needs to be "a good listener" (Participant 1), "caring" (Participant 4), and "not to be judgemental" (Participant 2), which speaks to several qualities underpinning compassion.

1.2: Compassion is innate*.* Staff reflected on how compassion is perhaps innate whereby "you have it, or you haven't" (Participant 1). Having compassion means it "is everywhere, every time" (Participant 8) and "it's just kind of the way you are" (Participant 3).

1.3: Compassion is part of the foundation of NHS values. More than half of staff acknowledged compassion is "part of the six C's in healthcare" (Participant 5); "is part of the foundation" (Participant 1) and "the majority of your role" (Participant 4) in the NHS.

1.4: Understanding others needs and putting them first. Whilst participants recognised the above, when giving compassion, staff commented it is important to "understand where the person is coming from and what the person is going through" (Participant 10). Yet staff also acknowledged compassion goes that one step further and you must be motivated to "look out for others and put other's needs before your own" (Participant 4).

Theme 2: "So people are like running around like headless chickens basically". This theme highlights how individual values and circumstances in combination with working in a busy, challenging environment can impede the giving or receiving of compassion, and impact on staff and patients. Staff spoke to four

separate, yet interconnected systems – the individual, interpersonal relationships, ward environment, and community.

2.1: We are all different. Many staff acknowledged how individual "cultural differences" (Participant 1) and "personal values" (Participant 3), alongside "having own challenges" (Participant 10) may impede experiences of the giving or receiving of compassion. One staff member commented that "some of the nurses from different cultures, they can be a bit abrupt at times, but that's their culture and they're not being rude" (Participant 3). This highlights the importance of understanding differences in culture and diversity and the negative assumptions people can make without good awareness.

2.2: Team culture. Staff commented on the challenges, and culture within the team. The ward was described as divided between healthcare disciplines with staff feeling relationally "a bit removed" (Participant 3) from other team members simply because of the nature of job roles. Subsequently, this impacted staff support for each other. Many staff members noted a lack of communication between colleagues. "A big one is communication" (Participant 4), with staff recalling during handovers or ward rounds important clinical information is not passed over, leaving staff feeling "frustrated" (Participant 4). Moreover, "a team and how it communicates and relates to each other, that can make a big difference" (Participant 8), with staff commenting that attitudes, tone, and non-verbal forms of communication are just as important when it comes to compassion.

2.3: Ward environment is not conducive for compassionate care. The complex, stressful and under-supported working environment was a dominant narrative throughout. Most staff reflected on the ongoing daily pressures– "it's lots of things you have to do, all the time, it sometimes is really stressful and it's too much"

(Participant 9). Such pressure left staff “stretched” (Participant 9) and at times unable to attend to patient needs or “even get a chance to go to the toilet” (Participant 6). Staff acknowledged the complexity of patients and almost accepted the risk of getting “a lot of abuse, verbal abuse, physical abuse” (Participant 10). Staff are mindful of the impact such a working environment has on their own threat responses and feel remorseful when being “a bit snappier” (Participant 6). This leaves staff questioning “what am I doing, why am I here, like this isn’t what I signed up for” (Participant 6). Yet there appeared a barrier in staff feeling able to vocalise their own needs. Taking “five minutes” (Participant 4) to oneself, although needed, is suffused by thoughts around “who’s going to take on my role” (Participant 10), other staff perceptions, and an intrinsic nature to carry on. Systemic issues including inadequate resources appear to have a direct impact on ward pressures and the ability to be compassionate towards oneself and others. Staff were passionate about obtaining enough staff and resources “so that everyone gets the care they need” (Participant 6), yet voiced concerns around agency staff who perhaps do not have enough or “any experiences in working with people like ours” (Participant 1). However, staff also acknowledged team members appeared reluctant to physically support others if the job “is not my role” (Participant 8).

2.4: Patient physical care Vs emotional needs. The above points leave staff working in a threat-dominant work environment. Whilst staff value patient emotional needs, they are often forgotten or delayed with physical care taking priority. Staff acknowledged how the nursing team have “got loads of things to do like medicine, handover sheets…” (Participant 2) meaning they can “just forget” (Participant 5) emotional needs. However, when staff do get the opportunity to speak with patients, even about “general things” (Participant 9), staff found patients feel

cared for, “happy” (Participant 10), with one patient feeling “glad because he felt listened to” (Participant 10).

Theme 3: (Relentless) Dedication to the role. In contrast to the above, this theme captures the drive staff have for providing compassionate care and the emotions received when this is achieved, albeit often at an expense to themselves.

3.1: Holistic approach to patient-centred care. All staff members spoke of the holistic and collaborative patient-centred care they provide patients and their families. They reflected that “adaptations” (Participant 1) are made to ensure patient needs are met and aim to “increase independence” (Participant 3) where possible. Adaptations for those with dementia bring difficult moral and ethical decisions which staff must carefully consider in the patients’ best interests. One staff member articulated these difficult situations; “the person whose like husband died, just you don’t want to lie and say, ‘oh no he’s coming later on’, but then you don’t want to tell them the exact truth” (Participant 3). Staff will try to foster a sense of community on the ward by engaging patients in recreational activities – “sometimes we listen to music” (Participant 4) or “just dance with [patients]” (Participant 5). Other times staff might “get like a group discussion going” (Participant 2) or “have a chat” (Participant 1) with patients individually. Investing and spending time with patients enables staff to get to know the patients, which felt important. Staff commented having a shared understanding of patients’ needs and wishes is vital, but also helps staff to have compassion for patients during challenging interactions.

3.2: Learning from colleagues and patients. Most staff valued learning from colleagues and patients. They reflected that other staff can “teach me things that I didn’t know before” (Participant 4) and “learning a lot” (Participant 3) from one another. There was a sense that learning is not only important for the self-

development but also passing that information on. One staff member commented how learning is bi-directional and irrelevant of banding and hierarchy, because everyone “still has room to learn” (Participant 8).

3.3: “It just makes me so happy”. Supporting patients and “seeing [patients] discharged home and well” (Participant 6) elicits positive emotions and “just makes me so happy” (Participant 2). Staff feel valued as a team member and “it makes you want to come back” (Participant 5).

3.4: “So, you try to push through, show you’ve done the job”. Despite the above, many staff voiced a palpable pressure to “just get on with it” (Participant 4). A handful of staff reflected on wanting to “go an extra mile” (Participant 8) when supporting patients, yet this comes at the expense of wellbeing and self-compassion. Staff felt it was easier to “push through and show you’ve done the job” (Participant 1) but acknowledged “the problem is when you go home” (Participant 6) with many feeling “shattered, drained and tired” (Participant 7).

Theme 4: “It’s just as important looking after yourself as it is looking after others”. Staff described feeling connected and valued both when giving and receiving compassion. Despite recognising the importance of self-compassion, staff often sidelined their own wellbeing in favour of patient priorities or viewed self-compassion as a separate entity away from the ward.

4.1 Self-compassion feels easier away from the ward. Some staff voiced “I’ve never thought of compassion for myself” (Participant 8), whilst other staff acknowledged “it’s just as important looking after yourself as it is looking after others” (Participant 4). However, a distinct narrative prevailed whereby staff felt that self-compassion was easier when away from the ward. Most staff spoke to the importance of “having a break off the ward” (Participant 3) and removing oneself

"from the situation" (Participant 3) during stressful situations. Yet, there was a sense that it is only if the situation is "like quite bad then maybe I would like go outside" (Participant 4) so "you can cry and just get it out" (Participant 7). Whether taking time out or working through the challenges, many staff voiced positive affirmations to themselves, such as "you are a better version of yourself than yesterday" (Participant 5) or "I try not to beat myself up about things I don't know" (Participant 10). Non-verbal forms of self-care too are important as "when I'm upset, I just smile, I smile a little" (Participant 5) because "that's therapy to me" (Participant 7). However, staff appeared more invested in self-care activities once their shift was over. Many staff engage in stress-releasing activities like "listening to music" (Participant 2), "the gym" (Participant 4), whilst others might choose to "just shower, lie down on the sofa and then be watching television" (Participant 7).

4.2 Feeling nourished on the ward. All staff emphasised the significance of feeling nourished. Compassion to or from colleagues involves many "offerings to make a cup of tea" (Participant 2) and "always a box of chocolate" (Participant 5) on the ward. Lunchtimes might be shared with colleagues as "lots of us sit together at lunch" (Participant 3) and staff enjoy team building activities, "like a competition where they just bring cakes in" (Participant 5). Another way staff feel nourished is through small, yet regular check-ins, "just like when you come in the morning, to say good morning" (Participant 3). It might sound "just small stuff like that" (Participant 3), but it's the "little things like that just show that you care" (Participant 10).

4.3: "We've all got each other's backs". Being both physically and emotionally nourished switches on staff members' affiliative side as it makes them feel like "I'm part of the team" (Participant 2). Most staff noted the importance of being there for each other and having "each other's backs" (Participant 6). One staff

member described being supported as “a weight lifted off my shoulder” (Participant 4). There is a consensus that the ward staff are “generally caring people” (Participant 6) and to staff “it [the ward] feels like family” (Participant 5).

Phase 2: Workshop and Feedback Session

A workshop session was facilitated by MS and external supervisor (CC) to present themes of commonality and discuss approaches to improve compassion (see Appendix 2.7). It was hoped this could increase understanding and awareness of how staff support themselves and others. This one-hour session was open to all staff. Recommendations from the interviews and session were presented to the leadership team.

Staff were asked four questions around their understanding of compassion and awareness of giving and receiving compassion on the ward, before and after the session (see Appendix 2.8).

Phase 2: Results

Six members of staff attended including an administrator, student nurse, HCAs, and assistant psychologist. None of the nursing team or management attended due to being short-staffed and nursing training.

Across all four questions, neither understanding or awareness of compassion shifted post session for any staff members (Table 2.2). Staff (strongly) agreed they had a good understanding of the concept of compassion. Likewise, staff (strongly) agreed they were aware of ways they might give and receive compassion. Staff were slightly less aware of ways to show self-compassion. Although most staff agreed to being aware of ways to show compassion to themselves, one staff member was undecided.

Table 2.2

Staff Understanding and Awareness of Compassion before and after Workshop Session

Questions pre and post		Strongly agree		Agree		Neither agree nor disagree		Disagree		Strongly disagree	
		n	%	*n*	%	*n*	%	*n*	%	*n*	%
I have a good understanding of compassion	Pre	2	40	3	60	0	-	0	-	0	-
	Post	2	40	3	60	0	-	0	-	0	-
I am aware of ways that I might receive compassion from others	Pre	4	80	1	20	0	-	0	-	0	-
	Post	4	80	1	20	0	-	0	-	0	-
I am aware of ways that I can show compassion to others	Pre	3	60	2	40	0	-	0	-	0	-
	Post	3	60	2	40	0	-	0	-	0	-
I am aware of ways that I can show compassion to myself	Pre	0	-	4	80	1	20	0	-	0	-
	Post	0	-	4	80	1	20	0	-	0	-

Discussion

The overarching aim of this research was to explore staff members' understanding and experiences of compassion on an older adult inpatient ward and to provide recommendations as to how staff compassion to self and others can be improved.

Interviews provided a detailed account of staff members' views and experiences of compassion, and highlighted staff members' commitment to providing compassionate, patient-centred care, despite facing consistent ward and systemic barriers, and often at the expense of their own self-compassion. Results support

previous research in the field (Egan et al., 2018; Kneafsey et al., 2015; Maddox & Barreto, 2022; Marshman et al., 2024; Wilson, 2024). The key findings are summarised below.

1. Staff viewed compassion as a general construct and a foundational part of being a healthcare worker. While understanding the needs of others was deemed important, staff acknowledged that compassion requires the motivation to set aside their own needs and be present for others.
2. The dominant narrative throughout staff experiences of compassion was a sense of consistently working against individual, team, and systemic barriers, thus impeding the giving or receiving of compassion for patients and staff. Barriers notwithstanding, staff voiced dedication to providing compassionate, patient-centred care, often experiencing happiness in seeing patients improve, although often at personal expense followed by post-shift stress relief. Staff valued small acts of compassion (e.g., checking in with each other) when supported by colleagues.
3. Based on the interviews and workshop findings, some actionable recommendations for the ward are outlined below (Table 2.3). Recommendations were made for all staff (e.g., continue to ‘check in’ with each other), management (e.g., develop staff support systems), and wider service considerations (e.g., increased training opportunities).

Table 2.3

Recommendations for the Ward

Staff Group	Recommendations
Recommendations for all staff	• Continue 'checking in' with each other daily as staff appreciate these small gestures. Even when the ward feels unmanageable everyone can foster positive interactions with colleagues. However, take a step back one day if needed, and allow for a colleague to step in. • Regardless of banding or job role, treat all colleagues with kindness and respect. Speak to others the way you would like to be spoken to. • Remember staff wellbeing is just as important as patient's.
Recommendations for management	• In team meetings or supervision, try to open up conversations around staff morale and validating the impact this work has on us. • Create staff support systems whereby staff have a safe space to voice any difficulties or concerns. A whole team group could help team cohesiveness, and individual groups, separated into job roles, could enable staff in similar roles to support each other. • Develop regular mindfulness sessions for staff, or CFT-informed sessions for self-care, with the aim of providing psychological safety. To achieve this, a focus around creating an open and trusting environment is important. This could also have a continued focus on the giving or receiving of compassion amongst colleagues. • Organise a staff away day to bring the team together, engage in team building activities and continue discussions around compassion on the ward.
Wider service considerations	• Staff feel valued when training opportunities are offered. Invest in staff training and development.

Feedback from the Leadership Team

The research team aimed to meet with the leadership team during project completion, but scheduling conflicts necessitated a re-scheduled feedback meeting following completion. The ward manager related to the challenges experienced by staff, and there was a discussion about changes leadership could implement and continuation of current soothing practices (Appendix 2.9).

Strengths and Limitations

There are several strengths of this study. Firstly, the use of a PDSA framework allows for a structured, experimental approach to delivering improvements using iterative cycles (Reed et al., 2016). In addition, despite using a data-driven methodological approach to thematic analysis, data clearly mapped onto Gilbert's (2005, 2010) affect regulation systems model, supporting the theory within a healthcare setting. Due to NHS difficulties on being on an instituitional, local, and individual scale, it is a strength that this study makes recommendations focused at both group and individual level. In addition, the study considers how MDT staff can feel valued and heard at all levels.

However, this study is not without limitations. The project was conducted in one older adult inpatient ward and speaks to specific understanding and experiences of compassion within the team; findings cannot be generalised to other healthcare services. In addition, data collection occurred when the ward had been without psychology input for six months, which may have impacted staff experiences of compassion. The previous psychologist had made significant developments on the ward, for both patients and staff, and their departure appeared to affect the team. Furthermore, the lead researcher had prior relationships with most staff members having previously worked on the ward, which could have impacted direction of questioning or staff engagement in interviews, in addition to unconscious biases during interpretation of the data. As the lead researcher pre-scheduled interview days, this restricted staff numbers for interview. Finally, due to demand on the ward, only 40 minutes could be given for the workshop session, no staff higher than band 5 attended the session, and staff members came in and out of the workshop due to ward demands. Thus, increases in understanding and strategies to improve

compassion for staff were unlikely to change following this workshop. To have a chance of improving compassion on the ward, all staff need to be invested, with more time allocated to such conversations.

Implications & Future Directions

This study aims to be a foundation for future research to deepen our understanding of experiences of compassion for healthcare staff. Whilst recommendations for management are generalisable across healthcare settings, leadership teams should consider specific recommendations which reflect team experiences of compassion. A similar inpatient ward within Oxford Health NHS Foundation Trust plans to replicate the study with similar methodology. However, future studies should consider delivery of the workshop session to maximise staff experiences of being heard and understood.

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Theory Driven Research Project

Attachment and Self-Compassion in Adolescents and their Prediction on Help-Seeking Intentions for Emotional Difficulties in Schools

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Internal Supervisor: Dr Emily Reeves

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Proposed Journal: This paper is intended for submission to *Child and Adolescent Mental Health* (See Appendix 3.1 for Author Guidelines). This journal has been chosen due to publishing evidence-based clinical practice and research with children, adolescents, parents and families. Appendix 3.2 contains keywords and a key practitioner message.

Abstract

Background: Mental health difficulties are rising substantially in young people. Schools are a likely provision for seeking support, yet teachers often feel deskilled, and many young people face barriers to accessing support. Attachment styles and self-compassion have been explored as predictors of help-seeking for mental health difficulties in adults but have yet to be investigated in adolescents. The current study explored possible predictors of young people intending to seek support for emotional difficulties in schools.

Method: One hundred and twenty-nine 14-16 years olds currently attending mainstream secondary school completed a questionnaire measuring factors thought to influence help-seeking intentions including anxious and avoidant attachment, self-compassion, mental health literacy, gender, emotional wellbeing, help-seeking intentions, ethnicity, stigma, and help sought previously for difficulties.

Results: Altogether, multinominal logistic regression analysis found variables to significantly explain 41.3% of the variance in the model. Individually, emotional wellbeing and mental health literacy were significant predictors of informal help-seeking intentions, with the latter a barrier in formal help-seeking too. However, all other variables did not individually predict help-seeking intentions in this population.

Conclusion: These findings have implications for schools helping adolescents accessing support for emotional wellbeing. Limitations of the current study were discussed.

Introduction

Around 720,00 young people are accessing mental health (MH) services in the UK (NHS Digital, 2023). One in six young people, aged seven to 16 years have a MH difficulty, rising from one in nine in 2017 (Newlove-Delgado et al., 2022). Cisgender girls report a higher prevalence of MH difficulties than cisgender boys (Van Droogenbroeck, Spruyt, & Keppens, 2018) and adolescents from an ethnic minority background are at greater risk of developing a MH problem (Lu et al., 2021). Such difficulties are associated with reduced academic, social, physical and family functioning (Sellers et al., 2019; Sulkowski, Joyce, & Storch, 2012). The reluctance to seek help for MH difficulties has widely been cited as a key barrier to early identification and intervention (Rickwood, Deane, & Wilson, 2007; Salaheddin & Mason, 2016). Whilst many barriers are outside of adolescents' control (e.g., long waiting times and inconsistencies in healthcare) (Radez et al., 2021; Velasco et al., 2020), access to different sources of support could mean young people have a more active role in help-seeking (Goodfellow et al., 2023; Rickwood et al., 2007).

With young people spending the majority of their weekdays at school, educational settings provide a unique opportunity to identify and address emotional difficulties (Patte et al., 2024; World Health Organization, 2017). However, evidence on adolescent help-seeking in schools is conflicting (Doan et al., 2020; Dardas et al., 2019; Mind, 2021; Patte et al., 2024), and teachers often feel deskilled and unsupported for MH in schools (O'Farrell, Wilson, & Shiel, 2022). With a Green Paper (Secretary of State for Health and Education, 2017) setting a clear ambition to improve intervention and prevention for MH in schools, it is important to understand the barriers and facilitators to adolescents seeking such support and to further inform policy and practice (Radez et al., 2021).

Predicting Help-Seeking in Adolescence

The theory of planned behaviour (TPB) (Ajzen, 1991) is an explanatory model that predicts various help-seeking intentions and behaviours (Bohon et al., 2016) across healthcare and lifespan (Armitage & Conner, 2001; Bohon et al., 2016; Breslin et al., 2022; Hui, Wong, & Fu, 2015; Mak & Davis, 2014; McEachan et al., 2011). However, researchers argue it does not sufficiently explain behavioural variability (Sniehotta, Presseau, & Araújo-Soares, 2014). Studies and systematic reviews identify several factors reducing adolescent help-seeking including self-report MH difficulties, lack of social support, stigma and the fear of embarrassment, negative family beliefs towards MH, confidentiality concerns, reduced school connectedness (Doan et al., 2020; Dougherty, 2024; Goodfellow et al., 2022; Gulliver, Griffiths, & Christensen, 2010; McPhail, Thornicroft, & Gronholm, 2024; Patte et al., 2024; Radez et al., 2021; Velasco et al., 2020) and poor mental health literacy[1] (MHL) (Jorm et al., 1997).

Girls tend to seek help more than boys, although literature is mixed (Bosco et al., 2020; MacLean, Hunt, & Sweeting, 2013; Velasco et al., 2020). Theorists suggest girls have increased MHL, leading to disclosure and seeking help more frequently (Lynch, Long, & Moorhead, 2018; MacLean et al., 2013). ‘Masculine’ gender norms may account for boys perceiving help-seeking as a threat to identity, thus in turn deciding to not seek support (MacLean et al., 2013). However, Bosco et al. (2020) found boys tended to seek help from those they trust (e.g., friends/parents)

[1] Introduced by Jorm (1997), MHL consists of several components including: (a) the ability to recognise MH difficulties; (b) knowledge about risk factors; (c) knowledge of self-help interventions; (d) knowledge of professional help; (e) attitudes towards help-seeking; and (f) knowledge of how to seek information.

and girls from professionals, with stigma moderating the decision to seek professional help due to feelings of shame, inadequacy or perceived failure. Additionally, adolescents from an ethnic minority background are less likely to seek help, citing parental perceptions, cultural values and relationship with healthcare professionals as barriers (Dardas et al., 2019; Lu et al., 2021). At-risk adolescents or most in need of support are also less likely to seek it (Doan et al., 2020; Rickwood et al., 2007; Velasco et al., 2020). Contributing factors include prior experiences of seeking support or services and increased feelings of guilt, hopelessness and reduced cognitive functioning in relation to MH symptoms (Velasco et al., 2020).

Self-Compassion, Attachment & Help-Seeking in Adolesence

Within the adult literature, self-compassion and attachment have been explored as predictors of help-seeking for MH difficulties (Adams, Wrath, & Meng, 2018; Cheng, McDermott, & Lopez, 2015; Dschaak et al., 2019; Wadman et al., 2019), but these variables are understudied in adolescent populations and across educational settings.

Developed by Ainsworth (1969) and Bowlby (1969), attachment can be understood through an evolutionary context, aiding in survival. The theory focuses on relationships, proposing that attachment bonds are innate (Bretherton, 1992), and the need to form bonds with one or more consistent caregivers provides safety and security to the child (Pasco Fearon & Roisman, 2017). This emotional bond forms early in childhood as the foundation for forming adult relationships (Cassidy & Shaver, 2016), with children's intrapersonal and interpersonal relationship styles developing from internalised experiences with caregivers (Mikulincer & Shaver, 2019). Four attachment styles are proposed: *secure attachment* (positive view of self and others); *insecure-anxious* (negative view of self and positive view of others);

insecure-avoidant (positive view of self and negative view of others); and *disorganised* (negative view of self and others) (Skrobinska, Newman-Taylor, & Carnelley, 2024; Wadman et al., 2019).

Compassion, as an alleviation of suffering, has a history in philosophical and spiritual writings (Dalai Lama, 1995; Lampert, 2005; Richard, 2015). *Compassion* is defined as "a sensitivity to suffering of self and others, with a commitment to try to alleviate and prevent it" (Gilbert, 2017, p.73). Gilbert (2014) proposes compassion flows in three directions: having compassion for oneself (self-compassion) and giving/receiving compassion from/to others. Drawing on evolution, attachment theory, and neuroscience, compassion describes both internal and external relationship with oneself and others, evolving from the interaction between threat, drive, and soothing systems (Gilbert 2014, 2020). Dysregulation of these three systems can lead to emotional and behavioural problems (Gilbert, 2009). Cultivating a soothing system can elicit self-compassion, creating a balance between the three systems (Gilbert, 2009). Self-compassion has been suggested to help in the self-regulation of health-related behaviours due to its emphasis on reducing self-blame (Terry & Leary, 2011).

Relational security has been associated with the ability to experience compassion across the three flows; whilst relational insecurity has been associated with lower self-compassion and fear of compassion (Gilbert, 2014, 2020). Theory suggests experiencing safeness, trust and secure early childhood relationships enables compassionate modelling and provides a foundation for self-compassion and the receiving and giving of compassion to others (Cassidy, 2018; Neff & McGehee, 2010). In the adolescent literature, Quinlan et al. (2021) found negative associations between self-compassion and attachment anxiety and avoidance,

suggesting high-risk adolescents with attachment anxiety and avoidance display lower levels of self-compassion. Secure attachment and higher levels of self-compassion have been found to predict adult and adolescent intentions to seek help for emotional difficulties (Cheng et al., 2015; Dschaak et al., 2021; Lane, 2023; Varzaneh et al., 2020; Wadman et al., 2019).

Study Rationale

As shown, adolescents' intentions to seek help for MH difficulties are shaped by a range of well-established factors. Previous research has consistently identified MHL, gender, emotional wellbeing, ethnicity, stigma, and help sought previously as significant predictors of help-seeking intentions and behaviours. However, willingness to seek help can also be influenced by the type and source of support (Allouche, Munson, & Long, 2021), thus it is important to include these variables in the present study to establish whether these factors predict intentions in educational settings. The current study also explores the roles of attachment and self-compassion – two theoretical constructs that have received growing attention but remain understudied in the context of adolescent help-seeking intentions in educational settings.

Aims and Hypotheses

1. The primary aim included examining the associations between individual variables of anxious and avoidant attachment insecurity, self-compassion, MHL, gender, emotional wellbeing, ethnicity, stigma, and help sought previously on adolescents' intentions to seek help across sources for emotional difficulties in school. It was hypothesised the variables of anxious and avoidant attachment insecurity, self-compassion, MHL, gender, emotional wellbeing, ethnicity, stigma, and help sought previously would individually

predict help-seeking intentions across sources for emotional difficulties in adolescents.

2. The secondary aim was to explore the extent to which these variables, collectively, predict intentions to seek help across sources for emotional difficulties in school. It was hypothesised the variables would collectively predict help-seeking intentions across sources for emotional difficulties in adolescents.
3. A third aim was to explore the relationship between anxious and avoidant attachment insecurity and self-compassion in adolescents. It was expected higher levels of anxious and avoidant attachment insecurity will be negatively correlated with self-compassion.

Methods

Procedure

This study was a mixed-method cross-sectional design where participants were invited to complete an anonymous online survey. Participants were recruited through schools, social media, and departmental contacts. Participants were aged 14-16 years enrolled in mainstream schools across England, Northern Ireland, and Wales. Exclusion criteria included adolescents who were not able to read or write in English and those who resided outside of England, Northern Ireland, or Wales.

School recruitment

Firstly, the lead researcher (MS) emailed the 69 Private and State schools in Oxfordshire between July 2024 and December 2024. Fifty-six schools did not respond, eight schools declined due to lack of resources and time, five schools expressed interest, and of those, three schools gave consent to take part.

Informed consent was gained from the school's head teachers. Information sheets and 'opt-in' forms were electronically distributed to all parents/carers of adolescents in Years 9-11 who met the study criteria. Adolescents received age-appropriate information sheets. For logistical reasons two schools only wanted Year 10 students recruited. Another school preferred to receive parental/carer 'opt-in' consent for adolescents aged 16+, although not required of ethics. Parents/carers were reminded of the study after two weeks. Schools were responsible for collating returned 'opt-in' forms and ensuring adolescents had received parental/carer consent. Day and time for data collection were pre-arranged and held during school hours between December 2024 and February 2025. MS and internal supervisor (ER) were present to provide an overview and answer questions. Adolescents were provided with a link which took them directly to the survey. Age-appropriate information sheets and assent or consent forms were provided beforehand. Adolescents had the opportunity to ask questions and knew they could withdraw at any point. Adolescents first completed demographic information before completing questions regarding emotional wellbeing, stigma, attachment insecurity, self-compassion, MHL, and help-seeking. The survey took approximately 30 minutes. Dependent on how risk-related questions were answered, different support signposting options were provided.

Social media & departmental recruitment

Given the challenges in securing school participation, recruitment strategy shifted to online methods. Participants were recruited via social media and departmental contacts between March and April 2025. Whilst parental consent was not required, participants had to be assessed as Gillick competent (Appendix 3.3)

before providing assent or consent. Participants completed the survey as outlined above.

Sample

A-prior power analysis was conducted using G*Power 3.1 (Faul et al., 2009) to determine the minimum sample size required for detecting the largest effects in a multinominal logistic regression model. The analysis was designed to assess the relationship between attachment insecurity, self-compassion, MHL, gender, emotional wellbeing, ethnicity, stigma, and help sought previously and the categorical outcome of help-seeking intentions (informal, formal, and no one). The odds ratio of 1.94 was calculated using data from previous research (Doan et al., 2020; Smith & Shochet, 2011) and the R^2 at 0.17 from (Cage et al., 2020). With an alpha level of .05, power .80, H0 = 0.42, expecting a normal distribution, and $\mu = 0$, and $\sigma = 1$, the required sample size was approximately $n = 108$ for the planned analysis.

Measures

Validated measures sequentially assessed emotional wellbeing, stigma, MHL, attachment insecurity, self-compassion, and help-seeking intentions (Table 3.1). Demographic information included age, gender, ethnicity, prior access to professional support, and diagnosed MH difficulties (Appendix 3.4). Two non-standardised questions were asked *“What would encourage you (or stop you) to seek help at school if you were feeling sad/anxious?"*

Table 3.1

Outcome Measures

Construct Measured	Measure Name	Description	Scoring	Psychometric Properties
Emotional Wellbeing	Young Person's Clinical Outcomes in Routine Evaluation (YP-CORE; Twigg et al., 2009)	Assesses young people's (aged 11-16) psychological distress related to wellbeing, symptoms, and functioning/risk	5-point Likert scale (*'not at all'* [0] to *'most or all of the time'* [4]). 10 items -3, 5, and 10 reverse scored. Scores summed to derive a total ranging from 0-40. Total score of 5+ suggests psychological distress, with higher scores representing increased severity	Good psychometric properties. In the present sample, Cronbach's alpha was .89
Stigma	Peer Mental Health Stigmatization Scale (McKeague et al., 2015)	Measures peer stigma towards young people (aged 9-16 years old) with MH difficulties	Two subscales: negative (16 items) and positive (8 items). Overall stigma score includes only negative items. Two factors: agreement with stigma (8 items) and stigma awareness (8 items). 5-point Likert scale (*'disagree completely'* [1] to *'agree completely'* [5]). Total score ranges from 16-80. Higher scores = higher levels of MH related stigmatising attitudes	Good retest and internal reliability. In the current study, Cronbach's alphas were .83 and .76 for stigma awareness and agreement, respectively
Mental Health Literacy	Knowledge and Attitudes to Mental Health Services (KAMHS; Simkiss et al., 2021)	Measures attitudes to MH services in adolescents (aged 13-14)	Knowledge (12 items), Good MH Behaviours (6 items), Stigma/attitudes (6 items), Self-stigma (6 items), Avoidant Coping (5 items), Help-seeking Behaviours (7 items), and Social Desirability (8 items). 5-point Likert scale ('*strongly agree'* to *'strongly disagree'*). <u>Scoring</u> Score of 4 = "correct" (defined by researchers as responses that are factually correct or show the least stigma etc) Score of 3 = if missed by one category (e.g., responding agree to a strongly agree) Score of 2 = if two categories out. 'don't know' always scores 2. High scores = positive MHL. Many items reverse scored. Total MHL scores calculated by summing each of the average subscales (excluding social desirability subscale)	Good internal constancy and moderate test-retest validity. In the present sample, Cronbach's alpha was .38 (self-stigma), .58 (avoidant coping), .72 (good MH behaviours), .76 (stigma/attitudes), .77 (knowledge), and .85 (help-seeking behaviours)
Attachment	Experiences in Close	Assesses adolescent	Two forms exist: mother and father. The current study uses 'parental	Strong internal consistency and

Construct Measured	Measure Name	Description	Scoring	Psychometric Properties
	Relationships Scale - Revised for Children (ECR-RC; Brenning et al., 2011)	(aged 8-16 years) attachment anxiety and avoidance	figure' (e.g., 'I'm afraid my parental figure will stop loving me'). 36 items, scored on a 7-point Likert scale (*'strongly disagree'* [1] to *'strongly agree'* [7]). 18 items for each scale of anxious and avoidance attachment. Across scales, 14 items are reverse scored. Mean scores calculated for each scale separately. Higher scores = greater attachment insecurity	validity. In the current study, Cronbach's alphas were .94 and .97 for attachment anxiety and avoidance, respectively
Self-Compassion	Self-Compassion Scale (Neff et al., 2019)	Assesses self-compassion in individuals aged 14+	6 subscales: self-kindness (5 items), self-judgment (5 items), common humanity (4 items), isolation (4 items), mindfulness (4 items), and over-identification (4 items). 5-point Likert scale (*'almost never'* [1] to *'almost always'* [5]). All items within the subscales of self-judgment, isolation and over-identification are reverse scored. Mean of each subscale is taken to compute a total mean (the average of six subscale means). Lower scores = lower levels of self-compassion	Good reliability, test-retest reliability and construct validity. In the present sample, Cronbach's alpha was .74 (over-identification), .75 (common humanity), .79 (mindfulness), .81 (isolation), and .87 (self-kindness & self-judgement)
Help-Seeking Intentions	General Help-Seeking Questionnaire (GHSQ) (Wilson et al., 2005)	Assesses individuals' likelihood of seeking help for personal and emotional problems from informal or formal sources	Adapted for school environments. Informal sources = best/close friends and friends Formal sources = tutor, head of year, health nurse, school counsellor/wellbeing lead, safeguarding lead, and special educational needs coordinator (SENCo) No one = would not seek help from anyone 7-point scale (*'extremely unlikely'* [1] to *'extremely likely'* [7]). Scores summed to drive a total from 10-70, with higher scores indicating increased likelihood of seeking help in school. Responses were categorised into three subscales (informal or formal source, or no one)	The measure has satisfactory reliability and validity. In the current study, Cronbach's alphas were .85 and .87 for informal and formal help-seeking, respectively

Analysis

A multinominal logistic regression was conducted to test whether the proposed variables of anxious and avoidant attachment, self-compassion, MHL, gender, emotional wellbeing, ethnicity, stigma, and help sought previously could predict intentions to seek help from formal or informal sources or no one. The model's robustness was tested via the three assumptions of multicollinearity, independent of errors, and linearity of the logit. The same variables were also entered to predict overall help-seeking at school via a multiple regression model. The model's robustness was tested via the four assumptions of multicollinearity, residuals, outliers, and homoscedasticity.

To create binary categories (informal, formal, and no one), authors developed the following rules: (1) if participants only endorsed informal, formal, or no one, they were categorised into this group (e.g., only 'best friends' = informal help-seeking); (2) if participants highly endorsed across sources of support they were categorised into formal help-seeking (e.g., 'best friends', 'head of year' and 'no one' = formal help-seeking); (3) if participants highly endorsed informal and no one, they were categorised into informal help-seeking (e.g., 'friends' and 'no one' = informal help-seeking). The no one category was used as the reference, with comparisons made between informal and no one, and formal and no one. The variables of gender and ethnicity were recoded to ensure sufficient sample size. Ethnicity was recoded into five categories: White, Black, Asian, Mixed, and Other; with 'Other' used as the reference category. Gender was recoded into three categories: female, male, and other; with 'Other' used as the reference category. Comparisons were made between male and other, and female and other.

As assumptions were violated, to establish the relationship between self-compassion, anxious and avoidant attachment a Spearman's rank-order correlation was used. Content analysis (Berelson, 1952) was adopted to identify key categories of qualitative data. Data cleaning and analyses was conducted in IBM SPSS Statistic for Mac, Version 29.0 (IBM Corp, 2022). The study used the α level of 0.05.

Ethics

Ethical approval was granted from the Central University Research Ethics Committee at University of Oxford (Reference: R92774/RE001/2/3, Appendix 3.5). Informed assent or consent was obtained for all participants.

Patient and Public Involvement

Adolescents (n = 4) from the community were consulted regarding study methodology. They were asked to review questionnaires and forms on two occasions: developing the questionnaires and final draft. Adolescents provided valuable feedback on the appropriateness of documents for their age group including word changes, spacing of information, and inclusion of images in debrief sheets.

Results

Participant Characteristics

Three-hundred and fourteen adolescents started the questionnaire. For the online sample, 129 did not complete the survey, 43 were outside the age range, 36 did not pass the Gillick competency test, and two lived in excluded countries. One participant in the school sample ran out of time. Therefore, 133 adolescents completed the questionnaire. However, four respondents were removed because of invariant responding, thus 129 participants were included in analysis.

Demographic statistics are shown in Table 3.2. Most participants were White adolescents (66.70%), aged 14 or 15 years (75.2%), living in England (97.70%), and

identified as female (58.90%). 27.9% had a diagnosed MH condition, 49.6% self-identified as having a MH problem, and 47.3% had previously accessed support. Informal help-seeking were the most highly endorsed sources of support for participants (Table 3.3).

Table 3.2

Demographic Characteristics

	Frequency *n*	Percentage %
Age		
14 years old	46	35.7
15 years old	51	39.5
16 years old	32	24.8
Residence		
England	126	97.7
Wales	2	1.6
Northern Ireland	1	0.8
Gender identity		
Female	76	58.9
Male	41	31.8
Transgender Female	0	0
Transgender Male	3	2.3
Gender-fluid	1	0.8
Non-binary	2	1.6
Unsure	1	0.8
Prefer not to say	5	3.9
Ethnicity		
White (British/English/Welsh/Scottish/Northern Irish)	86	66.7
Irish	3	2.3
Italian	2	1.6
Bulgarian	1	0.8
Finnish & British	1	0.8
English & Eastern European	1	0.8
British Israeli	1	0.8
Ukrainian	1	0.8
Polish	1	0.8
Danish & English	1	0.8
European	1	0.8
Black (British/English/Welsh/Scottish/Northern Irish)	1	0.8
Black African	1	0.8
Indian	3	2.3
Pakistani	1	0.8
Bangladeshi	1	0.8
Chinese	2	1.6
Asian (British/English/Welsh/Scottish/Northern Irish)	3	2.3

	Frequency *n*	Percentage %
Any other Asian background	1	0.8
White and black Caribbean	1	0.8
White and black African	1	0.8
White and Asian	5	3.9
Cuban, Mexican, & British	1	0.8
Caribbean, African, & English	1	0.8
Canadian & South African	1	0.8
British & Turkish	1	0.8
Arab	2	1.6
Any other ethnic group	3	2.3
Accessed support from professionals		
Yes	61	47.3
No	56	43.4
Not sure	11	8.5
Prefer not to say	1	0.8
Told have a MH condition		
Yes	36	27.9
No	81	62.8
Not sure	10	7.8
Prefer not to say	2	1.6
Think have a MH condition		
Yes	64	49.6
No	40	31.0
Not sure	22	17.1
Prefer not to say	3	2.3

Table 3.3

Frequencies of Endorsed Tyles of School-Based Support

Type of Support	Frequency	Percentage
Best Friend	87	67.4
Friends	47	36.5
Form Tutor	24	18.7
Head of Year	16	12.5
School Health Nurse	26	20.2
School Counsellor	26	20.2
Safeguarding Lead	13	10.2
SENCo	13	10.1
Not Seek Help from Anyone	57	44.2
Seek Help from Others not Listed	57	44.2
Family Members	19	15.2
Specific Teacher	7	5.6
CAMHS	5	4
Romantic Partner	5	4
Online Help	2	1.6

Note. Participants *(N = 129)* could endorse more than one support type. Percentages reflect the proportion of participants who selected each type of support (i.e., likely, moderately likely, or extremely likely).

Hypothesis 1

Descriptive statistics are displayed in Table 3.4. To explore the individual associations between each predictor and the outcome variable, eight univariate multinominal logistic regressions were conducted (see Appendix 3.6). A multinominal logistic regression was used to test if the predictor variables (anxious & avoidant attachment insecurity, self-compassion, MHL, gender, emotional wellbeing, ethnicity, stigma, and help sought previously) were associated with adolescents seeking help for emotional difficulties from informal or formal sources or no one in school. Assumptions of multicollinearity, independence of errors, and linearity of the logit were assessed and met. To assess model performance, a classification table was

generated. The model correctly classified 62% of cases overall. It correctly predicted 77.4% of participants in informal help-seeking, 44% in formal help-seeking, and 55% in seeking support from no one (Table 3.5).

The overall model was significant (χ^2 (28) = 57.14, p < .001) and explained 41.3% of the variance in the model (Nagelkerke R^2 = .413). Goodness-of-fit statistics suggested an adequate model fit (Pearson χ^2 (228) = 224.05, p = .561; Deviance χ^2 (228) = 203.18, p = .880).

Likelihood ratio tests indicated that MHL and emotional wellbeing individually significantly contributed to the model (χ^2 (2) = 11.27, p = .004; χ^2 (2) = 5.99, p = .050) respectively. All other predictors were non-significant. Parameter estimates showed that compared to not seeking support from anyone, MHL significantly predicted the likelihood of being in the informal category (β = .796, W (1) = 8.98, p = .003, OR = 2.22, 95% CI [1.32, 3.73]). This indicates that a one-unit increase in MHL is associated with 2.22 times higher odds of informal help-seeking, reflecting a statistically significant and large effect. Additionally, compared to adolescents who reported no help-seeking, MHL significantly predicted the likelihood of being in the formal category (β = .591, W (1) = 5.70, p = .017, OR = 1.81, 95% CI [1.11, 2.93]). This indicates that a one-unit increase in MHL is associated with 1.81 times higher odds of formal help-seeking, reflecting a statistically significant and moderate effect. Emotional wellbeing significantly predicted the likelihood of being in the informal category versus no one (β = - .157, W (1) = 5.12, p = .024, OR = .854, 95% CI [.746, .979]). This indicates that a one-unit increase in emotional wellbeing is associated with .854 times lower odds of informal help-seeking, reflecting a statistically significant but less than small effect. The remaining variables were not significant

predictors of either informal or formal help-seeking (Appendix 3.7). A logistic regression was run for 'clear cut' help-seeking cases (*n* = 65) (see Appendix 3.8).

Table 3.4

Descriptive Statistics for Overall Scores on Each Measure (N = 129)

Measure	M	SD	Minimum	Maximum
Emotional wellbeing	17.55	9.32	.00	38.00
Stigma	44.36	7.85	16.00	61.00
Mental Health Literacy	16.00	1.79	9.27	20.36
Anxious Attachment	2.87	1.26	1.00	6.94
Avoidant Attachment	3.95	1.48	1.00	7.00
Self-Compassion	2.57	.75	1.24	5.00
Help-Seeking Intentions	31.40	8.52	15.00	54.00

Note. M = Mean; SD = Standard Deviation

Table 3.5

Classification Accuracy of the Multinomial Logistic Regression Model

	Predicted			
Observed	Informal	Formal	Noone	Percent Correct
Informal	48	10	4	77.40%
Formal	23	21	3	44.70%
Noone	6	3	11	55.00%
Overall percentage	59.70%	26.40%	14.00%	62.00%

Note. This table compares actual versus predicted group membership.

Additionally, a multiple regression was run to predict overall help-seeking at school from the same predictor variables. Assumptions of multicollinearity, residuals, outliers, and homoscedasticity were assessed and met. The multiple regression model statistically significantly predicted overall help-seeking (F (9, 119) = 2.14, p = .032, adj. R^2 = .074). Compared to no model, the predictor variables combined were statistically significant in explaining overall help-seeking, but individually the variables did not significantly predict overall help-seeking (see Appendix 3.9).

Hypothesis 2

Not all variables were normally distributed, as assessed by Sharpiro-Wilk's test ($p < .050$). Therefore, a Spearman's rank-order correlation was run to assess the relationship between anxious attachment, avoidant attachment, and self-compassion. Preliminary analysis showed the relationship to be monotonic, as assessed by visual inspection of a scatterplot. All variables were statistically significant ($p < .001$) (see Table 3.6).

Table 3.6

Spearman's Rank-Order Correlation for Attachment and Self-compassion

	Self-Compassion	Anxious Attachment	Avoidant Attachment
Self-Compassion		-.446**	-.484**
Anxious Attachment	-.446**		.722**
Avoidant Attachment	-.484**	.722**	

**. Correlation is significant at the 0.01 level (2-tailed)

Qualitative

Qualitative responses were provided by 92 (71.32%) and content analysis categorised responses within two broad themes - 'facilitators' and 'barriers' of help-seeking (Figure 3.1 and Table 3.7). Appendix 3.10 details all quotes.

Table 3.7

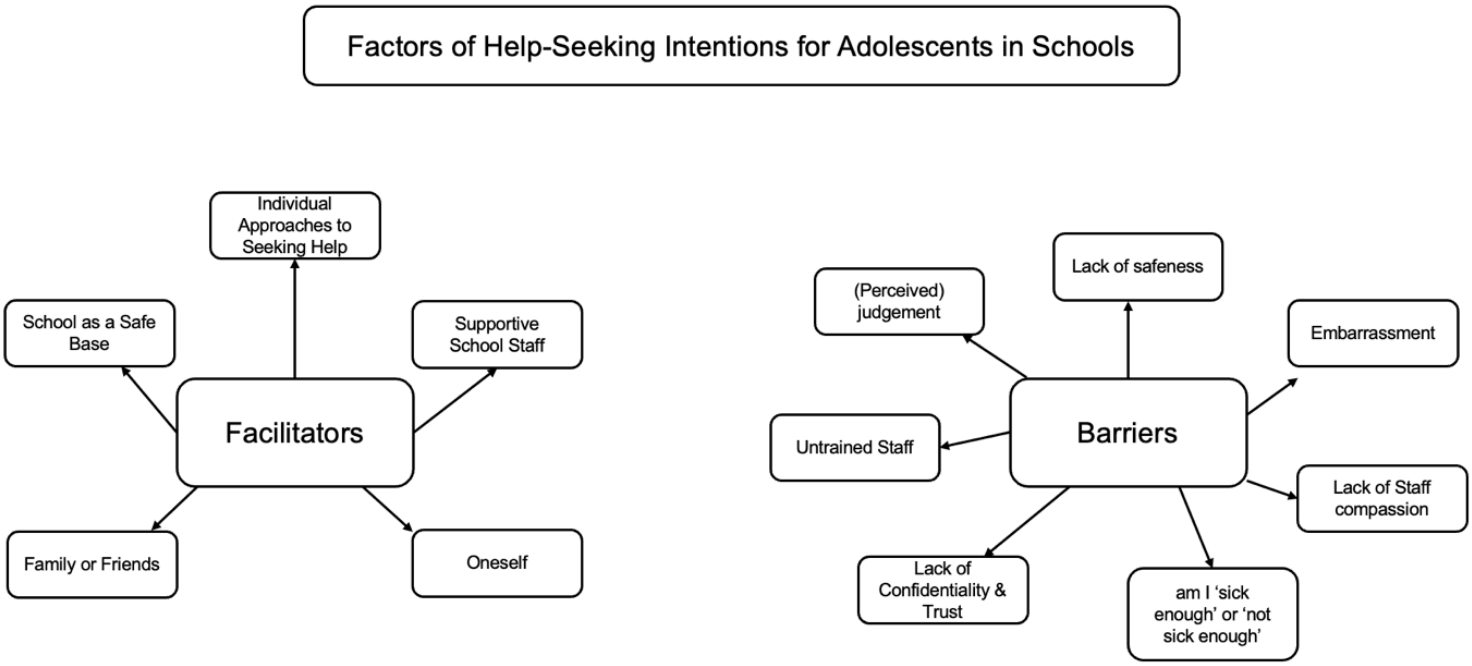
Narrative Description from Content Analysis

Theme	Narrative Description
Facilitators	Adolescents expressed help not being "forced upon you" (Participant 41), rather wanting "teachers to approach us" (Participant 34). "People asking if I'm okay" (Participant 82) and "regularly checking up on us" (Participant 31) were also highly endorsed facilitators. Both external (e.g., "my dad" [Participant 13] or "my friends" [Participant 30]) and internal facilitators (e.g., "myself [Participant 17] or "If I felt comfortable to" [Participant 37]) of help-seeking were described by participants. Additionally, adolescents voiced "favourite teacher(s)" (Participant 19) as facilitators of help-seeking and spoke of feeling validated with "my teacher being open about their own struggles" (Participant 55). Finally, some participants acknowledged the importance of having a "comfortable, welcoming environment" (Participant 11) and "an open communication system between students and teachers" (Participant 71).
Barriers	The highest endorsed theme was lack of confidentiality and trust. Adolescents voiced "nothing is completely anonymous" (Participant 4) which left participants feeling they couldn't "express how I feel to someone at school without them disclosing it to another person" (Participant 5). Participants described staff members "report[ing] kids to their parents for being queer" (Participant 79) and feeling "the fear that my words were not confidential" (Participant 35). The second highest endorsed theme was the perceived "judgement from others" (Participant 9) that adolescents "fear[ed]" (Participant 38). Linking with this, adolescents voiced not "knowing a safe space I could go to" (Participant 74), and areas where support is available "rude and judgemental people visit those areas often" (Participant 82) and "are very open and no safe space" (Participant 72). Participants also recalled "staff are not kind or nice" (Participant 75), "they're useless, transphobic, and incredibly dispassionate" (Participant 68) and find "teachers yelling at students who are struggling instead of helping them" (Participant 81). "If teachers actually listened" (P89), are "understanding" (Participant 67), or "having actually trained staff, knowing anything about the issues of kids today" (Participant 79) would encourage adolescents to seek support. There was a sense of untrained staff with adolescents voicing "teachers being slightly ableist towards those with MH disorders and/or learning difficulties" (Participant 74), "help only for non-masking people as teachers don't know about autism" (Participant 64) and "no beneficial help plans… for when I'm overwhelmed with noise" (Participant 81).

Theme	Narrative Description
	Finally, some adolescents felt “embarrassment” (Participant 5) and “awkwardness” (Participant 27) stopped them from seeking support at school.

Figure 3.1

Qualitative Themes



Discussion

This study explored predictor variables of adolescents’ intention to seek support for emotional difficulties in school and the association between anxious and avoidant attachment insecurity and self-compassion. Contextually, 47.3% reported previously accessing support and 49.6% suspected having a MH condition. Findings are considerably higher than previous research suggests (Doan et al., 2020; White, Soneson, & Fazel, 2024), however this study’s small age range coincides with the

peak onset of MH difficulties (Solmi et al., 2022), so results are likely to be higher. Regression models were significant, indicating the variables of anxious and avoidant attachment insecurity, self-compassion, MHL, gender, emotional wellbeing, ethnicity, stigma, and help sought previously altogether significantly predict intentions to seek help overall and across sources. However, only MHL individually predicted the likelihood of seeking informal and formal support, in addition to emotional wellbeing for informal support, suggesting other influential variables predict help-seeking intentions in this population. Furthermore, both anxious and avoidant attachment insecurity were significantly negatively correlated with self-compassion, supporting the study's hypothesis.

Consistent with previous research (Goodfellow et al., 2022), higher MHL predicted the likelihood of seeking support from both informal and formal sources versus no one and lower emotional wellbeing was found to predict the likelihood of seeking informal support (Velasco et al., 2020). However, neither MHL nor emotional wellbeing individually predicted overall help-seeking in this population. These results align with the study's qualitative data and may be explained by the lack of immediate formal support and awareness of designated support staff within schools (McPhail et al., 2024; Patte et al., 2024). Additionally, this developmentally sensitive stage is associated with feeling emotionally safer and more attached to peers than family or professionals (Wilson & Wilkinson, 2012). Thus, the nuances of this study may explain why emotional wellbeing and MHL are more influential variables when adolescents are deciding whether to seek support from specific sources, rather than the overall amount of support they intend to seek. Nonetheless, MHL and emotional wellbeing should be points of intervention focus.

Furthermore, individually the variables of gender, ethnicity, stigma, and help sought previously did not predict help-seeking across sources, contradicting previous research (Bosco et al., 2020; Doan et al., 2020; Dougherty, 2024; Lu et al., 2021; McPhail et al., 2024; Patte et al., 2024). Given MHL captures knowledge and beliefs about MH, including stigma and help-seeking behaviours, the addition of separate scales may have led to overlapping constructs and measurement redundancy, which may explain results. Furthermore, this study individually measured peer stigma, not self-stigma. Pfeiffer and In-Albon (2023) found greater self-stigma compared to public stigma in adolescents, thus self-stigma may warrant further research in this population but its inclusion should be approached cautiously due to the overlap with MHL. Findings too may relate to more external than internal barriers adolescents experience when intending to seek support. McPhail and colleagues (2024) report three main themes: ‘access-related factors’ (e.g.,misconceptions of support, confidentiality and trust) , ‘concerns related to stigma’ (e.g., anticipated stigma and navigating through it) and ‘the school setting’ (e.g., availability and access of care and competing academic schedules). Additionally, Patte and colleagues (2024) found adolescents struggled with knowing who to approach in schools or feeling comfortable talking to staff. Interestingly, these themes support the current study’s content analysis, suggesting further research may benefit from including such external variables when building predictive models of help-seeking in schools.

Notably, neither self-compassion nor attachment insecurity predicted help-seeking intentions across sources. The variables however significantly correlated each other, supporting theory and research in suggesting adolescents with lower levels of self-compassion display higher anxious and avoidant attachment styles (Pepping et al., 2015; (Raque-Bogdan et al., 2011). Unpredictability in help-seeking

intentions may be explained by our emotion regulation systems (Gilbert, 2005, 2010). For example, self-compassionate individuals can more easily engage in their soothing system, which activates the parasympathetic nervous system, reducing threat and drive systems (Gilbert, 2005, 2009). This process of self-regulation may reduce the perceived need for external support, by reducing self-blame and alleviating distress (Neff, Kirkpatrick, & Rude, 2007; Terry & Leary, 2011). However, Dschaak and colleagues (2019) suggest this facilitates help-seeking, which this study did not find. Furthermore, research suggests experiencing compassion from others is a key part of forming self-compassion, a process particuarly malleable or forming in adolescence and thus having a weaker impact in this population (Donald et al., 2018; Marsh, Chan, & MacBeth, 2017). Compassion from others or fear of compassion may be variables to explore in future research and points of intervention focus.

The ECR-RC questionnaire itself may too explain findings. By only measuring anxious and avoidant attachment, the model was unable to predict whether secure attachment could explain help-seeking intentions, as suggested by previous research (Dschaak et al., 2021; Varzaneh et al., 2020; Wadman et al., 2019). Interestingly, many adolescents' scores in the current study did not align with distinct anxious or avoidant classifications, indicating a trend toward secure attachment patterns with parental figures. Supporting previous research (Quinlan et al., 2021), correlation analysis also found a significant relationship between anxious and avoidant attachment. These findings align with current theoretical debates suggesting attachment is distributed across two-dimensions, rather than four dimensions (Jewell et al., 2019). Additionally, the ECR-RC measure adopts paternal-filial roles to assess attachment in young people. Adolescence is known for

emotional, cognitive and social transformations, with individuation from family and growing importance of peers and romantic relationships (Wilson & Wilkinson, 2012). Therefore, measures of assessing attachment in adolescence must consider the developmental trajectory of attachment systems and further research may benefit from utilising two-dimensional measures.

This study has several strengths and limitations. Alongside schools' lack of resources to support this research, parental consent was hypothesised as a barrier to engagement. Preserving a subset of adolescents who may seek school support, but not want parental figures to know, the approval to proceed without requiring parental consent was a noticeable strength of the study. Additionally, the model explained 41.3% of help-seeking intentions in this population, suggesting variables are influencing intentions, whilst other unknown factors also contribute.

One significant limitation is generalisability. Most participants resided in England, reflecting the location of study authors. Most participants were White British, all from mainstream schools. Whilst it is acknowledged many young people with special educational needs and disability (SEND) are in mainstream schools, special schools report higher worries and stress (Children's Commissioner, 2022) and the second highest referral to alternative provision schools is for MH difficulties such as depression and self-harm (Mills & Thomson, 2018). Future research should include a more heterogeneous sample to enhance the representativeness of this population. Most measures lacked validation for those aged 13 or under, thus participants aged 14-16 were selected. Additionally, whilst KAMHS is being explored in wider samples (Tullius et al., 2024), currently it is only validated in ages 13-14 years and in this study, the measure had poor internal consistency. As most MHL

measures are validated in adult populations, developing measures in younger people is imperative.

The current study also assumes MH difficulties or help-seeking intentions are static and that behavioural intentions are a reliable indicator of actual behaviour. Jerrim (2022) found MH concerns grow substantially as young people progress through secondary school. Whilst transitions to secondary school, increased academic pressure and decisions around leaving school are associated with the rise in difficulties (Chanfreau et al., 2013; McLellan & Galton, 2015; Wright et al., 2020), social and environmental contexts have been hypothesied as ‘buffers’ to declining wellbeing (Public Health England, 2015). Additionally, intention to access MH support does not always translate to taking action (Wang et al., 2024). Thus, measuring actual behaviour and longitudinal research would be benefical. To create binary categories, authors adopted arbitrary rules to assign participants to one of three support systems, based on their highest endorsed items. Whilst categorisation of continuous measures is widely criticised (Naggara et al., 2011), the GHSQ was designed as a flexible measure (Wilson et al., 2005) and authors included a multiple regression with the measure as a continuous dependent variable. Nonetheless this raises the issue of subjectivity, leading to potential inconsistencies of findings across studies.

Overall, the current study identified potential barriers adolescents face when intending to access support for emotional difficulties at school. Altogether, the model was a significant predictor of overall help-seeking intentions and across sources. Individually, lower emotional wellbeing and higher MHL were significant predictors of informal help-seeking intentions, with the latter a predictor in formal help-seeking too. However, all other variables did not individually predict help-seeking in this

population. Future research should consider the limitations discussed. Despite this, the study further contributes to our understanding of adolescents help-seeking and the factors to seeking support for emotional difficulties in schools.

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Executive Summary

Attachment and Self-Compassion in Adolescents and their Prediction on Help-Seeking Intentions for Emotional Difficulties in Schools

It is well known mental health difficulties in young people are increasing substantially and can have significant impacts on academic, social, physical and family functioning. Whilst many barriers to accessing support are outside of adolescents' control, reluctance to seek help is also a key barrier to early identification and intervention. Schools provide a unique opportunity to identify and address emotional difficulties, but teachers often feel deskilled and the factors that predict adolescent help-seeking in schools are under researched.

The theory of planned behaviour (Ajzen, 1991) is a highly utilised model to predict behavioural intentions and actions across healthcare settings and the lifespan. More recently however, other researchers and models have accounted for other factors related to help-seeking intentions and behaviours. The source of help, self-report mental health difficulties, social support, income, stigma, mental health literacy (MHL), and school connectedness have been identified to predict adolescent help-seeking in school. Additionally, attachment - the close bond we form with others, stemming from caregivers during early childhood (Ainsworth, 1969; Bowlby, 1969) and compassion - the alleviation of suffering (Gilbert, 2009) have been explored as predictors of adult help-seeking for mental health difficulties. However, these factors are understudied in the adolescent population and across educational settings.

The first aim of the study was to explore whether anxious and avoidant attachment insecurity, self-compassion, MHL, gender, emotional wellbeing, ethnicity,

stigma, and help sought previously predicted adolescents' intentions to seek help for emotional difficulties in school. We hypothesised all factors would individually predict adolescent help-seeking intentions for emotional difficulties in school. Secondly, we aimed to explore the relationship between anxious and avoidant attachment insecurity and self-compassion in adolescents. It was hypothesised adolescents with higher levels of anxious and avoidant attachment styles would experience lower self-compassion.

This study utilised a cross-sectional design. Adolescents were recruited from schools across Oxfordshire, departmental contacts, and through paid social media adverts on Instagram and TikTok. Twenty-nine adolescents from local schools and 104 adolescents via online recruitment completed basic demographic questions and six validated measures on attachment styles, self-compassion, MHL, emotional wellbeing, stigma, and help-seeking intentions. Four participants' data were removed, leaving 129 adolescents' data analysed. Of these, 92 adolescents provided qualitative feedback on what helps and stops them from seeking support at school for emotional difficulties. Responses were analysed using content analysis. A logistic regression was used to examine the factors of anxious and avoidant attachment, self-compassion, MHL, gender, emotional wellbeing, ethnicity, stigma, and help sought previously on predicting adolescents' intentions to seek help across sources for emotional difficulties at school. A correlation analysis was also run to examine the relationship between anxious and avoidant attachment insecurity and self-compassion in adolescents.

Taken altogether variables significantly explained about 41.3% of the results in the model. Contrary to the first hypothesis, only MHL and emotional wellbeing were found to individually significantly predict adolescent help-seeking intentions for

emotional difficulties at school. Both MHL and emotional wellbeing predicted informal help-seeking, however only MHL predicted formal help-seeking in this population. Concurrently, in support of the second hypothesis, both anxious and avoidant attachment insecurity were significantly related to self-compassion, suggesting those high in avoidant and anxious attachment experience lower levels of self-compassion. Qualitative analysis categorised responses into two themes – facilitators and barriers. Facilitators included family and friends, oneself, and seeing school as a safe base, whereas barriers to seeking support included lack of staff compassion, perceived judgement, and lack of confidentiality and trust.

In conclusion, the current findings support research in suggesting help-seeking intentions in this population can be explained by further factors outside of the theory of planned behaviour. Both MHL and emotional wellbeing were found to be significant factors that influence adolescent help-seeking intentions in schools, which is in line with previous research. However, gender, ethnicity, help sought previously, stigma, self-compassion, and anxious and avoidant attachment insecurity were not individually significant predictors of help-seeking, which contradicts the literature. As identified from previous research and this study's qualitative findings, the source of support available is an important factor, thus further investigation in educational settings is warranted to gain a deeper insight into the factors that predict help-seeking in this population.

Connecting Narrative

My enthusiasm for research grew during my undergraduate degree. Having taken on several research assistant roles prior to training, I entered the course excited to continue my research interests. Despite my enjoyment of both the diversity of research topics and their scope for development, the connecting narrative between projects initially created feelings of anxiety. Nonetheless, I stayed true to myself and navigated my way to finding projects that align with my values of compassionate, patient-centred care.

Having worked in eating disorder settings prior to training, I was drawn to applying my knowledge to a project that would contribute to this field and was fortunate to develop a systematic review in this population. However, I was also mindful of taking the opportunity to expand my awareness of further areas of clinical psychology. Having attended an 'Introduction to Compassion Focused Therapy (CFT)' course at The Compassionate Mind Foundation, this relatively new and upcoming theory sparked both a personal and professional interest, thus I was keen to explore its approach and application in different clinical settings. Luckily my older adult placement supervisor specialised in CFT and proposed an improvement project that aligned with my interests. Furthermore, having published studies researching the barriers and facilitators of students seeking help for mental health difficulties at university, I was also interested in investigating whether the predictors were similar in adolescents, with a focus on self-compassion and attachment for my main research project.

As I near the end of my three years and reflect on my research journey, what unifies all three projects is their grounding in institutional settings and focus on potential blocks and/or facilitators to help-seeking. By expanding my knowledge base

in both clinical and research settings it has allowed me to become a well-rounded clinical psychologist, which is a value I will continue to strive for throughout my career.

Service Improvement Project

"It's sometimes so overwhelming you just cry": Understanding Staff Experiences of Compassion on an Older Adult Inpatient Ward

From the first few hours working alongside staff members on the ward I noticed how individually, and as a collective, staff were working within a threat-based system. Being part of the psychology team, I felt protected from the distress the nursing team witnessed daily. To me, it felt important to understand their experiences and provide suitable recommendations that could help staff offer and receive compassion. Conducting psychological research in a team that reflects a medical model was challenging. However, conducting interviews with staff and bringing my open-minded, friendly self to the team highlighted the importance of authenticity and building rapport to get the "buy in" of participants, which I felt was a strength. In contrast, although previous research roles meant I was familiar with thematic analysis, I found myself feeling overwhelmed by the amount of data from interviews. Being a perfectionist, I noticed being drawn into wanting to analyse the data in the 'right way' rather than allowing myself to be driven by the data. It was however reassuring to hear staff could relate to the themes during the feedback workshop and I hope this research enabled staff to feel heard and their experiences validated.

Systematic Review of the Literature

Effectiveness of Universal Secondary School-Based Interventions addressing the Psychological Risk Factors of Eating Disorders in Adolescents

Having acquired skills from a previous intervention-based systematic review, I was keen to continue research within the field of eating disorders and its interventions. Narrowing the scope of this project in order to enhance the literature and offer insightful conclusions was difficult considering the breadth of previous reviews in this population. Despite this, I found the development aspect of this review particularly interesting as it allowed me the opportunity to consider what might be important for educational settings compared to my previous review in clinical settings. That said, I was not prepared for the number of papers identified from the search strategy despite this being co-developed with librarians. I have learnt for future reviews to allow more time on refining the search strategy before undertaking the title and abstract searches. I am pleased to see this review come together and hope findings can be helpful for researchers and schools.

Theory Driven Research Project

The Relationship between Attachment Security and Self-Compassion in adolescents and its prediction on Help-Seeking Intentions in Schools for Emotional Difficulties

This project was the last to commence and as someone who prefers visual learning environments, I struggled at the beginning to picture how this research project could come together. I knew I wanted to focus on help-seeking in adolescents, but narrowing this down was a particular difficulty for me. Nevertheless, I felt incredibly supported by my supervisors and I am happy with how the project developed. From the power analysis, I initially felt optimistic in recruiting 108 adolescents throughout Oxfordshire schools, but unfortunately many schools lacked resources to commit to the research, and we had to resort to online participation for wider dissemination. Naturally this involved amendments from ethics, and I wonder

whether the decision to move forward with Gillick competency requirements gave many more adolescents the opportunity to share their experiences without the barrier of seeking parental consent. Knowing this is possible in low-risk research is helpful to consider in further research and reaching minoritised groups.

General Reflections for the Future

Despite its challenges, I hold onto the experiences I have acquired throughout the three projects on the DClinPsy. I have gained further research skills that will be invaluable as I start qualified life in addition to a shared understanding and respect for clinicians pursuing research alongside clinical priorities. It is important to me that I work in a team that values research and continuously strives to improve the experiences and outcomes of service users and their families. I look forward to seeing where qualified life takes me in respect to both research and clinical experiences.

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They say, ‘it takes a village to raise a child’ and the same goes for this doctorate. Without these people below, this thesis would not exist.

I’d like to thank all the participants who generously gave their time to take part in these research projects. I hope I have accurately represented your shared experiences, and I hope this work contributes to meaningful change for those it represents.

Thank you to my research supervisors Dr Reena Vohora, Dr Joanna Adams, Dr Emily Reeves, Dr Clare Borsay, and Dr Catriona Craig for your continuous encouragement and support. Thank you to Professor Victoria Bourne for teaching statistics in a fun, meaningful way during my undergraduate degree. Who knew 10 years later lecture notes would get me through these projects.

To my ‘old’ university friends, thank you for putting up with my MIA status over the past 3 years. I’m back and I cannot wait to spend more time with you all. To my ‘new’ university friends – what a ride! They say you make lifelong friends on clinical training, and I couldn’t agree more. Thank you for the endless laughter, shared tears, and unwavering support throughout this journey. I love you all!

My family, where do I start. To my parents, thank you for always believing in me and being my cheerleaders. Chris, I could not ask for a more supportive brother and thank you for letting me have this academic win. To nan, thank you for making me smile and laugh when I needed it the most. A special thank you to my auntie, Dr Penny Pritchard for proofreading my entire thesis – your support means the world. My dogs – Jack, Barty, and Bungle, thank you for all the cuddles and kisses. Finally, to Grandad Clive, Nanny Lucy, and Grandad Bob – although you are no longer with me, I think of you and miss you every day. I hope I’ve made you proud!

Appendix 1.1 - Author Guidelines for *International Journal of Eating Disorders*

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This journal does not charge submission fees. Wiley Editing Services offers for a fee expert help with English Language editing, translation, manuscript formatting, figure illustration, figure formatting, and graphical abstract design – so you can submit your manuscript with confidence.

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DETAILED MANUSCRIPT PREPARATION GUIDANCE

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The Title Page of the manuscript should comprise:

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The Abstract provides a succinct summary of the article content. The recommended format and word limit vary by article type. Structured abstracts have a recommended maximum of 250 words and should be organized into: Objective: state the primary purpose of the article, or major question addressed in the study. Method: indicate the sources of data, give brief overview of methodology, or, if it is a review article, how the literature was searched and articles were selected for discussion. For research-based articles, briefly note study design, how participants were selected, and major study measures. If your data are based on a preregistered study, provide the preregistration number or link. Results: summarize the key findings. Discussion: indicate main clinical, theoretical, or research applications/implications.

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Note: Authors are encouraged to utilize publicly available data repository for data, scripts, or other artefacts used to generate the analyses presented in the paper; in such cases, authors should include a reference to the location of the material in the Method section (rather than in Supporting Information).

Appendix 1.2 – Keywords, Public Significance statement and Key Points/Summary

Keywords: School-Based Interventions, Universal, Eating Disorders, Systematic Review, Adolescents, Risk Factors.

Public Significance: Disordered eating behaviours are increasing rapidly in adolescents, leading to significant physical and social impairments. Educational settings can provide preventative interventions, but the factors to include show mixed findings. This review builds on previous reviews by evaluating the effectiveness of universal secondary school-based interventions that addresses multiple risk factors of eating disorders. Results suggests several factors that schools may wish to include when rolling out universal interventions for disordered eating.

Key Points:

- This systematic review evaluated the effectiveness of universal secondary school-based interventions that address core eating disorder (ED) psychopathology, in addition to at least one other psychological risk factor.
- Findings suggest there is mixed evidence for the effectiveness of universal school-based ED interventions on reducing ED psychopathology and broader wellbeing outcomes, and no changes on BMI. However, the high risk of bias limits the confidence of findings.
- Schools may wish to consider incorporating the risk factors of core ED psychopathology, body image dissatisfaction, dieting, exercise and social media in universal interventions. However, further understanding of the most effective risk factors to target in this population is needed.

- Future research would benefit from adopting active comparison groups and longer follow-ups.

Appendix 1.3 - Search Terms

Table 1.3A

Search Terms

1	(feeding and eating disorder*) OR (anorexia nervosa) OR anorexi* OR (binge eating disorder) OR bing* OR bulimi* OR "(bulimia nervosa) OR (eating disorder*) OR (feeding and eating disorders of childhood) OR purg* OR laxa* OR OSFED OR EDNOS OR BED
	OR
2	(body image) OR (body dissatisf*) OR (body satisf*) OR (body accept*) OR (body positive*) OR (body esteem) OR (body-esteem) OR (muscle esteem) OR (muscle-esteem) OR (body enhance*) OR (body self-esteem) OR (body self esteem) OR (muscle dysmorphia) OR (disordered eat*) OR (eating patholog*) OR (emotional eat*) OR (eating problem*) OR (eating disturbance*) OR (over eating) OR (over-eating) OR (weight concern*) OR (shape concern*) OR (weight complaint*) OR (shape complaint*) OR (Body Image Disturbance*) OR (Body Aware*) OR (Body Dysmorphi*) OR Dysmorphophobi* OR (Stress Eating) OR (Eating Behaviour*) OR (Eating Behavior*) OR (Eating Attitude*) OR (Binge Eating)
3	1 OR 2
	AND
4	Predispos* OR (Psychological Marker*) OR (psychosocial factor*) OR (psychological risk*) OR Premorbid* OR Susceptib* OR (Risk Factor*) OR Vulnerabilit* OR (at risk population*) OR (at-risk population*) OR (media literacy) OR (Social Media) OR Facebook OR Instagram OR TikTok OR Snapchat OR Perfect* OR (Self-Blame) OR (Self Blame) OR (Self-Perception) OR (Self Perception) OR (Self Concept) OR (Self-Concept) OR (Self Image) OR (Self-Image) OR (self Esteem) OR (Self-Esteem) OR (Self Criticism) OR (Self-Criticism) OR Obsess* OR Impulsive* OR (Food insecurity) OR (elite sport*) OR (Thin Ideal*) OR (Relationship with Food) OR anxi* OR (anxi* management) OR worr* OR (health anx*) OR (social anx*) OR shame* OR stress* OR (obsessive compulsive disorder) OR OCD OR (mental health) OR (youth mental health) OR depress* OR (major depress*) OR (low mood) OR wellbeing OR (well-being) OR distress* OR (emotional state*) OR emotion* OR (emotional regulation) OR (emotional management) OR (emotional control) OR (self regulation) OR (self-regulation) OR Diet* OR (Diet* Addict)" OR (Diet* Relation*) OR (Diet* Restrict*) OR (Diet* Restrain*) OR (Diet* Reduc*) OR Nutrition* OR Food* OR (Food Addict*) OR (Food Relation*) OR (Food Restrict*) OR (Food Restrain*) OR (Food Reduc*) OR (Excessive exercise*) OR (Compulsive* Exercise*) OR (Obsess* Exercise) OR (Increase* Exercise*) OR (Over Exercise*) OR (Exercise Addict*) OR Sport* OR Fitness
	AND
5	intervention* OR (early intervention*) OR program* OR prevent* OR educat* OR (educat* program*) OR treat* OR therap* OR group* OR (group intervention*) OR session* OR lesson* OR workshop* OR universal OR select* OR indicated OR school* or student* OR college* OR (college student*) OR (high school student*) OR (High-school student*) OR (international student*) OR (junior high school student*) OR (middle school student*) OR (school based) OR (School-based) OR (school based intervention*) OR (school-based intervention*) OR (Secondary School*) OR (Middle School*) OR (Middle-School*) OR (Junior School*) OR (Junior High) OR (junior high school*) OR (junior college student*) OR (High School*) OR (grade level) OR (sixth form*) OR (educ* student*)
	AND
6	Child* OR adolesc* OR (late adolesc*) OR teen* OR youth* OR Minor* OR (Young Person*) OR (Young People) OR Boys OR Girl* OR Pediatric* OR Paediatric* OR Schoolchild* OR Juvenile* ab.id.ti
	3 and 4 and 5 and 6

Appendix 1.4 - Data Extraction Form

Table 1.4A

Data Extraction Table

Authors	
Country	
Aims	
Demographics **Number of participants** **Age/Sex/Ethnicity**	
Type of intervention **Intervention descriptions**	
Risk factors	
Outcome measures **Time point for analysis**	
Completer or intention-to-treat **Outcomes** **Follow-up**	

Appendix 2.1 - Author Guidelines for *Issues in Mental Health Nursing*

About the Journal

Issues in Mental Health Nursing is an international, peer-reviewed journal publishing high-quality, original research. Please see the journal's Aims & Scope for information about its focus and peer-review policy. Please note that this journal only publishes manuscripts in English.

Issues in Mental Health Nursing accepts the following types of article:

- Research Article
- Methods
- Comments, Critique, and Inspiration Column
- Cultural Competence Column
- Psychotherapeutics Column
- Book Review

Issues in Mental Health Nursing conforms to the guidelines of the Publication Manual of the American Psychological Association (2010) regarding plagiarism and self-plagiarism. To wit,

”Just as researchers do not present the work of others as their own (plagiarism), they do not present their own previously published work as new scholarship (self-plagiarism) (American Psychological Association, 2010, p. 16). The potential for self-plagiarism is greatest when several aspects of a study are reported in different articles. To avoid this ethical violation, make sure that each article makes a unique contribution to the science. Clearly delineate where other articles about the study have been reported. Extensive duplication of one’s own words (for example, in a methods section) requires a citation of the previously published work.

IMHN also conforms to the criteria for authorship specified by the American Psychological Association (2010, p. 18): ”Individuals should only take authorship credit for work they have actually performed or to which they have substantially contributed.” All authors of a manuscript should include their full name and affiliation on the cover page of the manuscript. Please specify, in your cover letter, the role played by each author on the project (for example, formulated the hypothesis, collected data, participated in data analysis, wrote part of the paper). Individuals who did not play a major role (e.g., recruiting subjects, data entry) should be listed in ”Acknowledgments,” but not credited with authorship.

Authors should determine among themselves the order of authorship and settle any disagreements before submission of their manuscript. Any requests for changes in authorship after initial manuscript submission (i.e., order, addition, deletion of authors) should be discussed and approved by all authors. Such requests must be explained in writing in a letter to the editor, and received prior to the production deadline for the issue.

Manuscript and other requirements conform to the “Uniform Requirements for Manuscripts Submitted to Biomedical Journals” established by the International Committee of Medical Journal Editors (N Engl J Med 1991;324:424-8). Please note that “Comments, Critique, and Inspiration” columns will be reviewed by members of the editorial board.

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Preparing your Paper

All authors submitting to medicine, biomedicine, health sciences, allied and public health journals should conform to the Uniform Requirements for Manuscripts

Submitted to Biomedical Journals, prepared by the International Committee of Medical Journal Editors (ICMJE).

- *Issues in Mental Health Nursing* does not have a word limit or page limit. However, most manuscripts are about 25–30 double-spaced typed pages.
- Manuscripts may be supplied as single or multiple files. These can be Word, rich text format (rtf), open document format (odt), PDF, or LaTeX files. Figures and tables can be placed within the text or submitted as separate documents. Figures should be of sufficient resolution to enable refereeing. Please follow the referencing guidance available here: https://www.tandf.co.uk//journals/authors/style/reference/tf_APA.pdf
- Authors are requested to submit their paper in APA scholarly format.
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Checklist: What to include

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6. Data availability statement. If there is a data set associated with the paper, please provide information about where the data supporting the results or analyses presented in the paper can be found. Where applicable, this should

include the hyperlink, DOI or other persistent identifier associated with the data set(s). Templates are also available to support authors.

7. Data deposition. If you choose to share or make the data underlying the study open, please deposit your data in a recognized data repository prior to or at the time of submission. You will be asked to provide the DOI, pre-reserved DOI, or other persistent identifier for the data set.
8. Supplemental online material. Supplemental material can be a video, dataset, fileset, sound file or anything which supports (and is pertinent to) your paper. Articles with extenders, such as infographics or video summaries, are up to 108% more likely to be downloaded (based on data in May 2024 from Plain Language Summary of Publication and Clinical Trial Protocol articles published in Future Oncology in 2023). We publish supplemental material online via Figshare. Find out more about supplemental material and how to submit it with your article. Taylor & Francis Editing Services can help you create research promotion materials, including infographics, video abstracts, lay summaries and graphical abstracts, to support your article's impact. For more information, including pricing, visit this website.
9. Figures. Figures should be high quality (1200 dpi for line art, 600 dpi for grayscale and 300 dpi for colour, at the correct size). Figures should be supplied in one of our preferred file formats: PS, JPEG, TIFF, or Microsoft Word (DOC or DOCX) files are acceptable for figures that have been drawn in Word. For information relating to other file types, please consult our Submission of electronic artwork document.

10. Tables. Tables should present new information rather than duplicating what is in the text. Readers should be able to interpret the table without reference to the text. Please supply editable files.
11. Equations. If you are submitting your manuscript as a Word document, please ensure that equations are editable. More information about mathematical symbols and equations.
12. Units. Please use SI units (non-italicised).

Appendix 2.2 - Oxford Health Research and Development Team approval

Figure 2.2A

Project Registration Confirmation

New clinical audit registered

Hi Melissa,

A new audit has been registered and can now be accessed in YOUR AUDITS within the Clinical Audit & Improvement section on the AMaT system.

Your clinical audit facilitator will be in touch if there are any questions regarding the registration of this audit.

Audit title: Understanding Staff Experiences of Compassion on an Older Adult Inpatient Ward

Speciality: Bucks Older People MH Inpatient

Your role in this audit: Lead Participant

This notification has been sent to the Lead Participant, Participants, Mentor and Audit Lead detailed in the above audit.

Please follow this link to view this audit:
Click here to view this audit

Best regards,
Melissa Stock

** DO NOT REPLY TO THIS UNMANNED ADDRESS **

Generated with AMaT
Audit Management and Tracking

Figure 2.2B

Project Approval Email

From: Clinical Audit (RNU) Oxford Health <Clinical.Audit@oxfordhealth.nhs.uk>
Sent: Monday, July 10, 2023 14:30
To: Stock Melissa (RNU) Oxford Health <Melissa.Stock@oxfordhealth.nhs.uk>; Clinical Audit (RNU) Oxford Health <Clinical.Audit@oxfordhealth.nhs.uk>
Cc: Hunt David (RNU) Oxford Health <David.Hunt@oxfordhealth.nhs.uk>
Subject: RE: Service Improvement Project - Oxford Trainee Clinical Psychologist

Hi Melissa,

I've checked AMaT and can see your project has received approval (code: Bucks OA Inpatient/2023-24/01) and there are no additional approval comments.

If your interview questions need to form the pro forma please continue the process and begin the data collection. Any further queries please do not hesitate to make contact.

Best wishes,

Clinical Audit Team
Clinical.Audit@oxfordhealth.nhs.uk

Appendix 2.3 - Research Poster

Figure 2.3A

Research Poster



Appendix 2.4 - Interview Schedule

1. **In your own words, can you describe what the concept of compassion means to you?**
   Prompts
   - *What do you see as the key qualities of a compassionate (use the words from staff) person?*
   - *How might this apply to your personal life?*
   - *How might this apply to your professional life?*
   - *Definition of compassion: "...a sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it."*
   - *Do you agree/disagree with this term?*

2. **In your experience how might healthcare professionals show compassion in a work context?**
   Prompts
   - *Think about how healthcare workers show compassion (use the words from staff) to others? Show compassion to you?*
   - *How do you show compassion to yourself?*

3. **Can you think of any examples where you demonstrated compassion to colleagues or patients?**
   Prompts
   - *Example may be when you have witnessed a colleague demonstrating compassion.*

4. **Can you think of a time when colleagues may have been compassionate to you?**
   Prompts
   - *How did that make you feel?*
   - *Can you think of a time when you witnessed another staff member being compassionate to a colleague or patient?*

5. **Can you give me any examples of how you may apply compassion to yourself?**
   Prompts
   - *Example may be when you have experienced a difficult situation.*
   - *(shift/received racist comments from a patient/witnessed a difficult interaction/incident).*

6. **Is there anything that you think helps with being able to provide continued compassionate care on the ward?**
   Prompts
   - *What helps you to maintain compassion?*

- *(Ask about personally and as a team).*

7. **Do you think anything gets in the way of providing compassionate care on the ward?**
   Prompts
   - *How easy/difficult is it to be/offer compassion on the ward?*
   - *(Ask about personal/practical factors).*
   - *(Think about the flows of compassion).*

8. **Is there anything that you think would help strengthen compassion in the team?**
   Prompts
   - *Anything on the ward?*
   - *Is there anything you could do to help?*
   - *If you had a magic wand and could make the team more compassionate, what would you do?*

Is there anything else that you want to say?

Appendix 2.5 - Reflexive Log Key Points

Data Collection

- At the beginning of data collection, participants actively asked to take part in the research. However, this dropped off and had to approach staff members and ask if they would like to participate. With this I wondered whether I was giving staff members an opportunity to decline taking part, or if they felt obliged to participate.
- Staff members from psychology and OT were more willing to participate. It was more difficult to recruit staff members from the nursing, medical, and leadership team. Why might this be – demand on the ward perhaps or familiarity with engaging in research?
- I could hear the alarms going off and patients becoming distressed whilst conducting the interviews. I have been left thinking about how this might have impacted upon the interview process. I certainly felt pressure and guilt that I had taken away a staff member for them to take part in my research, especially when talking about barriers to providing compassion (e.g., lack of staff). Did staff members feel the pressure too or did they like sitting down, away from work for 30 minutes?

Transcribing Interviews

- I noticed staff members appeared to struggle more with answering questions around self-compassion. Is this because they haven't thought about this before? Is it because they do not receive/give compassion to themselves.
- I noticed participants struggled to answer some of the questions, despite asking myself to repeat the question(s) multiple times. This could be because the way I phrased the questions were too wordy, it could be that participants

had cognitive overload, or they might have been distracted from the situations happening on the ward. Interviews took place in the morning.

- There were times where I could have asked participants to explain further, however, I know I felt the pressure in the room to ask them the 8 questions within the 30 minutes because that was the time allocated and throughout alarms were going off and I knew other staff would be needing the support of the participant on the ward.

Initial Coding

- Despite conducting qualitative research before, I struggled at the beginning of coding as to how I was deconstructing the data. You can analyse the data from different perspectives and being a perfectionist, I was struggling to 'work out' the 'right way' to code the data. I took this to research supervision, and we discussed how there is no 'right way', and every researcher will interpret the data in their own way. However, it is important to be mindful of the way you are interpreting the data and any biases etc that you may have. Having internal supervisor (RV) code three interviews and seeing the consistency helped.

Initial Themes

- I felt quite overwhelmed by the amount of data and codes, and as sense that I didn't know where to start. Being a visual person, I had to lay all the codes out on my floor so I could start to see the patterns and themes. This way of collating themes really helped.
- I was also mindful that I didn't want to fit the data into preconceived concepts. However, from very early on in creating the initial themes, the data felt very much like staff members are battling threat, drive and soothe systems. With

threat being the dominant system and barriers having that ‘domino effect’ on staff and patients.

Developing the Final Themes

- As a research team we were having many discussions around the themes of ‘barriers to compassion’ and ‘threats to compassion’. At times these felt separate entities, whilst other times they felt too similar. We concluded how if, as the research team we were struggling to distinguish the two themes, for others reading the project this would feel confusing too. We therefore decided to combine the themes and reframe the subthemes to make the data feel more cohesive.

Appendix 2.6 - Thematic Analysis Results

Table 2.6A

Thematic Analysis

Themes	Subthemes	Quotes
1. What compassion means to me	1.1 Qualities of Compassion.	“And then being there to listen and making sure they felt that they’d been listened to” (Participant 2) "Caring, erm, understanding." (Participant 6)
	1.2 Compassion is innate.	"But it's much more than that, it’s you have it, or you haven't.” (Participant 1) "But like, in yourself. It's just kind of just the way you are" (Participant 3)
	1.3 Compassion is part of the foundation of NHS values.	"You have to show you are working with and that NHS you have to still show the compassion because it's part of our values." (Participant 7) "Erm so I know it’s part on the six C’s in healthcare" (Participant 5)
	1.4 Understand others needs and putting them first.	"If someone like asks for help, you spend a lot of time like trying to help them" (Participant 4) "So we just have to put them first" (Participant 5)
2. “People are running around like headless chickens basically.”	2.1 We are all different.	"So, I think it's a cultural and I’ve noticed they do the same. I think it's cultural and sometimes it can be the barrier." (Participant 1) “I have my own problem at home, so I don't want to stress myself too much whereby I go home and then you become more stressful." (Participant 7)
	2.2 Team culture.	"Sometimes I feel a bit removed from them. So, when an incident happens like I don't really see what happens after with them because they're kind of in their office and I’m kind of in the activity room. So, I don't always know like specifically what they're actually doing." (Participant 3) "Some people think they're better than others. So, that in itself, you don't give room to those who want to grow, those who don't know, because if I don't know and you're just putting me down, then it takes that interest away." (Participant 8)
	2.3 Ward environment is not conducive for compassionate care.	"Like it's there’s lots of thing going on and you have to constantly be, basically all the time and non-stop." (Participant 9) "Because sometimes when you feel so stressed out with patients, you're a bit more snappy and you don't want be snappy and you want to be nice because that's what we're here for, we're here for them, but sometimes you just find it hard because you need to let off some steam." (Participant 6) “So, like I just think like maybe if I take 5 then I’ve just got lots to do. If I don’t do it like are like people going to be annoyed. So, it’s probably more that. Like, I don't know how I feel in myself, so." (Participant 4)
	2.4 Patient PHYSICAL CARE Vs emotional needs.	"So, if they’ve got loads of things to do like medicine, handover sheets and things like that then they might not be going out and talking to the patients as much." (Participant 2)

		"So if they've got loads of things to do like medicine, handover sheets and things like that then they might not be going out and talking to the patients as much." (Participant 5)
3. (Relentless) Dedication to the role	3.1 Holistic approach to patient-centred care.	"So yeah, so you're trying to make adaptations and adjust yourself based on the service users erm, mental health. It's so, yeah." (Participant 1) "Involving me in my care, even if I don't have the capacity, but please let me know what you're doing." (Participant 10) "You can show compassion in other ways, like offering them a cup of tea or trying a conversation another day on inviting them to a group." (Participant 2)
	3.2 Learning from colleagues and patients.	"Do you know what is, the best thing like it just makes me so happy. When they come in and they're so poorly and then when they go home and then they back to their selves or they're better than their selves. And I'm just like, wow. Like just, it's amazing." (Participant 6) "It just makes me so happy when I see the support we give to patients" (Participant 2)
	3.3 "It just makes me so happy."	"So, I'm always help my colleagues, even if it's not my work to do, I'll tell the person I'm doing this, you do this, you do this, so that the task can be completed before we leave. I don't, so that's how I show compassion." (Participant 7) "So, what do you do? You try to push through. Get on with it. Just try not to complain, grumble too much." (Participant 1)
	3.4 "So, you try to push through, show you've done the job."	"I guess like seeing other staff members and like, because I've learnt a lot from X erm." (Participant 3) "Sometimes you can tell them some, sometimes after, like they [patients] can teach me a lot, something it really good." (Participant 9)
4. "It's just as important looking after yourself as it is looking after others."	4.1 Self-compassion feels easier away from the ward.	"First, I've never thought of it [laughs]. You know when they say 'ohh loving you.' I've never thought of compassion to myself. Erm, yeah. Hmm." (Participant 8) "Yeah. So, if I'm feeling a bit stressed erm I'll just take like 5 minutes to go for a walk like around the car park or something." (Participant 3) "Erm, I'm learning to shut down when I'm not at work. So, I'm still learning on that one, erm to shut down once I'm out of work." (Participant 10)
	4.2 Feeling nourished on the ward.	"Erm, just like when you come in in the morning to say good morning and like saying hello when you pass each other in the corridor. Just even like when you leave on a Friday, and they just say 'oh have a nice weekend' or just small stuff like that." (Participant 3) "I've said to her 'come on, let's go and have a chit chat, sit down, and have a chat and have a coffee'." (Participant 6)
	4.3 "We've all got each others backs"	"You feel like you're not on your own and then somebody to supporting you." (Participant 9) "That we all have each other's back. That if we need a bit of help there is somebody there." (Participant 2)

Appendix 2.7 - Workshop Session slides

Workshop Session

"Understanding Staff Experiences of Compassion on an Older Adult Inpatient Ward"

Melissa Stock (Trainee Clinical Psychologist)
Dr Catriona Craig (Principal Clinical Psychologist)
Dr Reena Vohora (Consultant Clinical Psychologist)

1

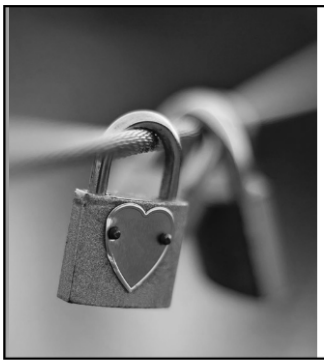
Aims of the session

- Overview of the research project
- What we heard from you
- How do we continue to build compassion on Amber Ward

2

Overview of the research project

3



What does compassion mean?

- "... a sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it."[1]
- "a strong feeling of sympathy and sadness for the suffering or bad luck of others and a wish to help them."[2]

Our background, culture, previous experiences all influence how we understand compassion! Not one definition is true for everyone.

1 Gilbert, P. (2017). *Compassion: Concepts, Research and Applications*. Florence: Taylor & Francis.
2 Cambridge Dictionary. (2024). *Compassion*. Cambridge Dictionary.

4

What does the literature tell us?

- A recent survey showed 44.8% of staff felt unwell as a result of work-related stress and 56.6% went into work in the last three months, despite not feeling well enough to perform their duties.[1]
- Fostering compassionate environments and prioritising staff wellbeing has been linked to improvement in staff retention (Ajemba et al., 2024).

1 National Health Service. (2023). *NHS Staff Survey National Results*. UK: NHS.
2 Ajemba, M., Nwaze, A., Arana, E., Inanya, E., Nwafo, O., & Fish, I. (2024). Improving staff retention in the research and development departments of NHS hospitals in the United Kingdom: A systematic review. *World Journal of Advanced Research and Reviews, 21*(1), 2156–2161. https://doi.org/10.30574/wjarr.2024.21.1.0166.

5

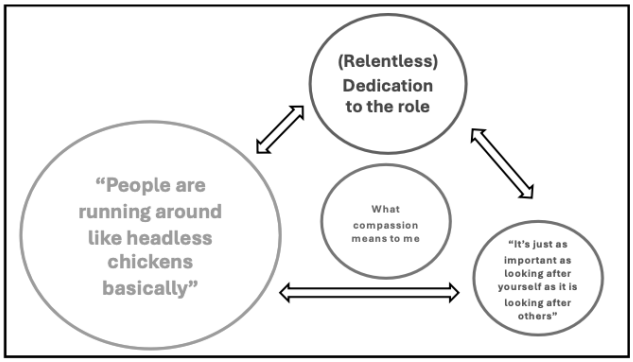
What did we do?

- Spoke with 10 members of the team
- Asked questions around
  - Understanding of compassion.
  - Experiences of compassion on the ward.
  - How to continue building compassion on the ward.

6

What we heard from you

7



8

Theme 1: What compassion means to me

Qualities of Compassion	Compassion is part of the foundation of NHS values	Compassion is innate	Understanding others needs and putting them first
"Not being judgmental."	"Erm, you have to have a bit of compassion for you to be able to do this kind of work anyway."	"Compassion, I think you have it, or you haven't. You have it in you, or you haven't. "	"So, understanding someone like how they might be feeling, why they might be feeling like that."
"Caring, erm, understanding."	"You have to show you are working with and that NHS you have to still show the compassion because it's part of our values."	"In all that compassion should always, for me, is everywhere, every time, it's the way you are."	"I would say you treat people the way you want to be treated if you are unwell."

9

Theme 2: "People are running around like headless chickens basically"

We are all different	Ward environment is not conducive for compassionate care	Team culture	Patient PHYSICAL CARE Vs emotional needs
"We all come with our own issues from home. We all have our challenges. And then you come to work, and work comes with its own challenges as well."	"I'm like I really need to go out and speak to the patients, but I know I've got all this work to do."	"And like, you say how you feel, and everyone comes together and says how you feel, but nothing gets done about it."	"But some of patients don't have anybody and I'd love to sit down and have a conversation with them. But you sometimes you just don't have the time."
"I guess like your own personal values and like how you were brought up."	"Ohh they're not, they not getting looked after properly. When you're worn out and short staffed, how can you look after like, give 100% to the patients, you can't."	"Again, when stressed, I sort of like, just get involved, just engage with staff, and then sort of like, do, I have one to one with patients as well, just even, even though talking, just listen."	"Having time to chat normally, but it depends how busy my workload is in terms of if there's like immediate things that need doing."

10

Theme 3: (Relentless) Dedication to the role

Holistic approach to patient-centred care	"It just makes me so happy"	Learning from colleagues and patients	"So, you try to push through, show you've done the job"
"I'm not saying aware, might not fully understand what you're doing, but you still have a duty to explain to them what you're doing. It does help a lot."	"Someone is happy because of a small thing that I did."	"And wanting to learn because then that betters me."	"But the ones here [staff] generally do go above and beyond for the patients."
"You know you need to understand where they're coming from and why they feel that way."	"My reward is seeing them discharged home erm well or happy."	"Like they [patients] can teach me a lot, something it really good."	"So, what do you do? You try to push through. Get on with it. Just try not to complain, grumble too much."

11

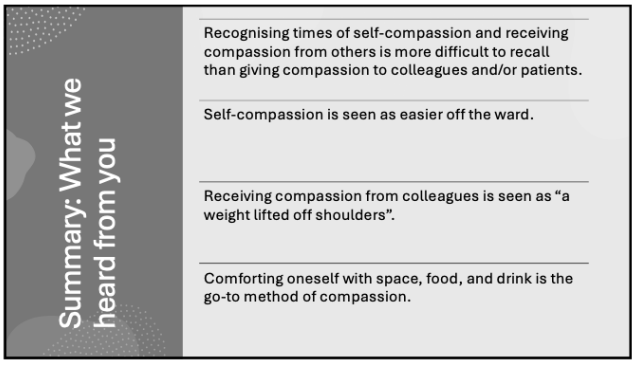
Theme 4: "It's just as important as looking after yourself as it is looking after others"

Self-compassion feels easier away from the ward	"We've all got each other's backs"	Feeling nourished on the ward
"To myself, I treat myself. So, whenever I'm off, I treat myself."	"I think it's just the staff that we've got, they are generally caring people, we've got a really good team."	"Good. Yeah, it does. It [receiving food/drink] really does make me feel like I'm part of the team. "
"I tend to reflect on them at the end of the day."	"Erm, that I'm part of a team. That I feel cared for. Yeah, that people care for me. It makes me feel happy. And yeah, like I want to be here."	"Erm, when staff are struggling to cope with burnout and stress, just listen to what they're talking about."

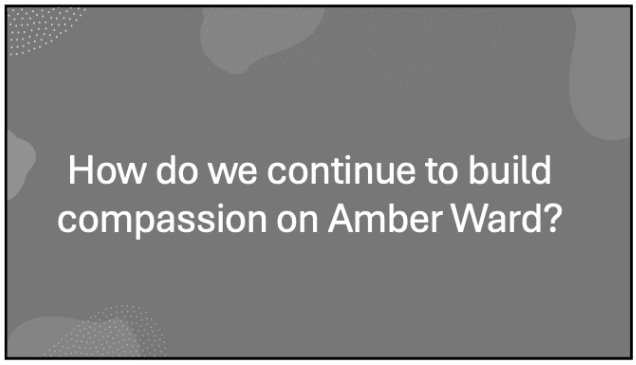
12


Summary: What we heard from you
Staff are committed to providing patient-centred care.
Amber Ward can be a difficult and challenging place to work. Combination between complexity of patients and lack of resources.
Working in 'threat' mode is almost accepted as part of role.
Helping patients, even the small things like making them a cup of tea provides staff satisfaction
Learning from colleagues is highly valued.

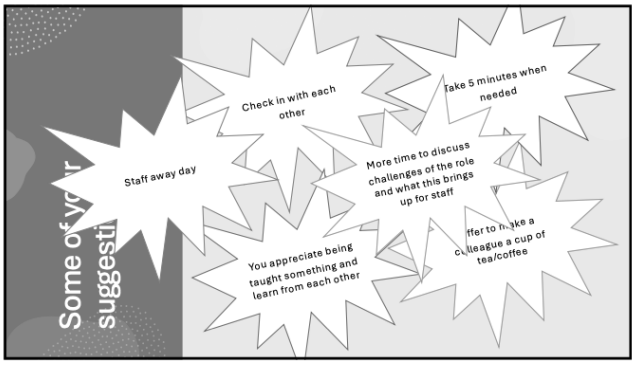
13


Summary: What we heard from you
Recognising times of self-compassion and receiving compassion from others is more difficult to recall than giving compassion to colleagues and/or patients.
Self-compassion is seen as easier off the ward.
Receiving compassion from colleagues is seen as "a weight lifted off shoulders".
Comforting oneself with space, food, and drink is the go-to method of compassion.

14


How do we continue to build compassion on Amber Ward?

15


Some of your suggesti
Check in with each other
Take 5 minutes when needed
Staff away day
More time to discuss challenges of the role and what this brings up for staff
You appreciate being taught something and learn from each other

16

Appendix 2.8 - Pre/Post Workshop Questions

Understanding Experiences of Compassion on Amber Ward

Thank you for attending this workshop.

Before we start the session, could we ask that you complete the following four questions by ticking/crossing your answer to each in the boxes below. We will ask you to complete the same four questions at the end of the session.

If you have any questions, please ask us.

1. I have a good understanding of compassion.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
☐	☐	☐	☐	☐

2. I am aware of ways that I can show compassion to others.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
☐	☐	☐	☐	☐

3. I am aware of ways that I might receive compassion from others.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
☐	☐	☐	☐	☐

4. I am aware of ways that I can show compassion to myself.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
☐	☐	☐	☐	☐

Now the session is finished, please could you complete the following four questions by ticking/crossing your answer in the boxes below based on what you have gathered from the session. We ask that you do not look at your previous answers for guidance. If you have any questions, please ask us.

1. I have a good understanding of compassion.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
☐	☐	☐	☐	☐

2. I am aware of ways that I can show compassion to others.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
☐	☐	☐	☐	☐

3. I am aware of ways that I might receive compassion from others.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
☐	☐	☐	☐	☐

4. I am aware of ways that I can show compassion to myself.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
☐	☐	☐	☐	☐

5. Any other comments?

Thank you for attending this workshop and participating. We hope you can take away something from the session

Appendix 2.9 - Feedback from the Leadership team

Feedback of the findings and recommendations were sought with the leadership team on Thursday 8th August 2024. Three members of the leadership team were invited (Matron, Ward Manager, and Deputy Ward Manager). Only the Ward Manager attended. The Deputy Ward Manager was off shift and the Matron was dealing with a high-risk case. The main discussion points were:

- Findings from the data mirror the ward managers' own experience of working on the ward and those of her colleagues.
- The ward manager was concerned relying on food and drink whilst on shift was unhealthy. MS and CC spoke to how food and drink is a natural, human response to suffering and can be an effective way of giving/receiving compassion.
- Upon feeding the findings back to the wider team both MS and CC were struck by staff members' experiences of separation between job roles whilst on shift and the lack of support received. The ward manager was aware of these difficulties and has invested in staff leadership training for members of the team. From the training it is hoped staff members will learn compassionate leadership and implement this on the ward.
- Upon hearing the findings, the ward manager was left wondering how the leadership team could further support staff members. The ward manager was pleased to hear the recommendations from the data, in particular the ward-centred nature of them.
- It was discussed how a whole team approach was needed to facilitate change. The power of modelling and acknowledging change takes time.

Appendix 3.1 - Author Guidelines for *Child and Adolescent Mental Health*

Contributions from any discipline that further clinical knowledge of the mental life and behaviour of children are welcomed. Papers need to clearly draw out the clinical implications for mental health practitioners. Papers are published in English. As an international journal, submissions are welcomed from any country. Contributions should be of a standard that merits presentation before an international readership. Papers may assume any of the following forms: Original Articles; Review Articles; Innovations in Practice; Narrative Matters; Debate Articles. CAMH considers the fact that services are looking at treating young adults up until the age of 25, with the evidence that brains continue to develop until the age of 25, as well as the fact that a lot of issues that affect young adults and students are also relevant and topical to older adolescents. CAMH offers a discretionary approach and will take into consideration papers that extend into young adulthood, if they are pertinent developmentally to the younger population and contribute further to a developmental perspective across adolescence and early adult years. Authors are asked to remember that CAMH is an international journal and therefore clarification should be provided for any references that are made in submitted papers to the practice within the authors' own country. This is to ensure that the meaning is clearly understandable for our diverse readership. Authors should make their papers as broadly applicable as possible for a global audience.

Original Articles: Original Articles make an original contribution to empirical knowledge, to the theoretical understanding of the subject, or to the development of clinical research and practice.

Submission of a paper to *Child and Adolescent Mental Health* will be held to imply that it represents an original submission, not previously published; that it is not being considered for publication elsewhere; and that if accepted for publication it will not be published elsewhere without the consent of the Editors. Manuscripts should be submitted online. Check for an existing account if you have submitted via Research Exchange before or have forgotten your details. If you are new to Research Exchange, please create a new account.

Disclosure of interest form

All authors will be asked to download and sign a full Disclosure of Interests form and acknowledge this and sources of funding in the manuscript.

Ethics

Authors are reminded that the *Journal* adheres to the ethics of scientific publication as detailed in the *Ethical principles of psychologists and code of conduct* (American Psychological Association, 2010). These principles also imply that the piecemeal, or fragmented publication of small amounts of data from the same study is not acceptable. The Journal also generally conforms to the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors (ICJME) and is also a member and subscribes to the principles of the Committee on Publication Ethics (COPE).

Informed consent and ethics approval

Authors must ensure that all research meets these ethical guidelines and affirm that the research has received permission from a stated Research Ethics Committee (REC) or Institutional Review Board (IRB), including adherence to the legal requirements of the study county. Within the Methods section, authors should indicate that ‘informed consent’ has been appropriately obtained and state the name

of the REC, IRB or other body that provided ethical approval. When submitting a manuscript, the manuscript page number where these statements appear should be given.

Preprints

CAMH will consider for review articles previously available as preprints. Authors may also post the submitted version of a manuscript to a preprint server at any time. Authors are requested to update any pre-publication versions with a link to the final published article.

Recommended guidelines and standards

The Journal requires authors to conform to CONSORT 2010 (see CONSORT Statement) in relation to the reporting of randomised controlled clinical trials; also recommended is the Extensions of the CONSORT Statement with regard to cluster randomised controlled trials). In particular, authors must include in their paper a flow chart illustrating the progress of subjects through the trial (CONSORT diagram) and the CONSORT checklist. The flow diagram should appear in the main paper, the checklist in the online Appendix. Trial registry name, registration identification number, and the URL for the registry should also be included at the end of the methods section of the Abstract and again in the Methods section of the main text, and in the online manuscript submission.

Manuscripts should be double spaced and conform to the house style of *CAMH*. The title page of the manuscript should include the title, name(s) and address(es) of author(s), an abbreviated title (running head) of up to 80 characters, a correspondence address for the paper, and any ethical information relevant to the study (name of the authority, data and reference number for approval) or a statement explaining why their study did not require ethical approval.

Summary: Authors should include a structured Abstract not exceeding 250 words under the sub-headings: Background; Method; Results; Conclusions.

Key Practitioner Message: Below the Abstract, please provide 1-2 bullet points answering each of the following questions:

- **What is known?** - What is the relevant background knowledge base to your study? This may also include areas of uncertainty or ignorance.
- **What is new?** - What does your study tell us that we didn't already know or is novel regarding its design?
- **What is significant for clinical practice?** - Based on your findings, what should practitioners do differently or, if your study is of a preliminary nature, why should more research be devoted to this particular study?

Keywords: Please provide 4-6 keywords use MeSH Browser for suggestions

Papers submitted should be concise and written in English in a readily understandable style, avoiding sexist and racist language. Articles should adhere to journal guidelines and include a word count of their paper; occasionally, longer article may be accepted after negotiation with the Editors.

Authors who do not have English as a first language may choose to have their manuscript professionally edited prior to submission; a list of independent suppliers of editing services can be found at http://authorservices.wiley.com/bauthor/english_language.asp. All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

Headings: Original articles should be set out in the conventional format: Methods,

Results, Discussion and Conclusion. Descriptions of techniques and methods should only be given in detail when they are unfamiliar. There should be no more than three (clearly marked) levels of subheadings used in the text.

All manuscripts should have an Acknowledgement section at the end of the main text, before the References. This should include statements on the following:

- *Study funding:* Please provide information on any external or grant funding of the work (or for any of the authors); where there is no external funding, please state this explicitly.
- *Contributorships*: Please state any elements of authorship for which particular authors are responsible, where contributorships differ between author group. (All authors must share responsibility for the final version of the work submitted and published; if the study include original data, at least one author must confirm that they had full access to all the data in the study and take responsibility for the integrity of the data in the study and the accuracy of the data analysis). Contributions from others outside the author group should also be acknowledged (e.g. study assistance or statistical advice) and collaborators and study participants may also be thanked).
- *Conflicts of interest:* The journal requires that all authors disclose any potential sources of conflict of interest. Any interest or relationship, financial or otherwise that might be perceived as influencing an author's objectivity is considered a potential source of conflict of interest. These must be disclosed when directly relevant or directly related to the work that the authors describe in their manuscript. Potential sources of conflict of interest include but are not limited to: patent or stock ownership, membership of a company board of directors, membership of an advisory board or committee for a company, and

consultancy for or receipt of speaker's fees from a company, in the past 5 years. The existence of a conflict of interest does not preclude publication. If the authors have no conflict of interest to declare, they must also state this at submission. It is the responsibility of the corresponding author to review this policy with all authors and collectively to disclose with the submission ALL pertinent commercial and other relationships.

References

References in running text should be quoted showing author(s) and date. For up to three authors, all surnames should be given on first citation; for subsequent citations or where there are more than three authors, 'et al.' should be used. A full reference list should be given at the end of the article, in alphabetical order.

References to journal articles should include the authors' surnames and initials, the year of publication, the full title of the paper, the full name of the journal, the volume number, and inclusive page numbers. Titles of journals must not be abbreviated.

References to chapters in books should include authors' surnames and initials, year of publication, full chapter title, editors' initials and surnames, full book title, page numbers, place of publication and publisher.

Tables

These should be kept to a minimum and not duplicate what is in the text; they should be clearly set out and numbered and should appear at the end of the main text, with their intended position clearly indicated in the manuscript.

Figures

Any figures, charts or diagrams should be originated in a drawing package and saved within the Word file or as an EPS or TIFF file.

See http://authorservices.wiley.com/bauthor/illustration.asp for further guidelines on

preparing and submitting artwork. Titles or captions should be clear and easy to read. These should appear at the end of the main text.
Footnotes should be avoided, but end notes may be used on a limited basis.

Original Articles

Original Articles make an original contribution to empirical knowledge, to the theoretical understanding of the subject, or to the development of clinical research and practice. Adult data is not usually accepted for publication unless it bears directly on developmental issues in childhood and adolescence.

Your Original Article should be no more than 5,000 words including tables, figures and related captions, excluding only references. Please note that for our own calculation of word counts, we include all text in the submitted paper, excluding only the references. Please note that for our own calculation of word counts, we include all text in the submitted paper, excluding only the references.

Appendix 3.2 - Keywords and Key Practitioner Message

Key Practitioner Message

- It is well known mental health difficulties in young people are increasing substantially and can have significant impacts on academic, social, physical and family functioning. Schools provide a unique opportunity to identify and address emotional difficulties, but teachers often feel deskilled and the factors that predict adolescent help-seeking in schools are under researched.
- Attachment and compassion have been explored as predictors of adult help-seeking for mental health difficulties. However, these factors are understudied in the adolescent population and across educational settings.
- Mental health literacy and emotional wellbeing were found to individually significantly predict adolescent help-seeking intentions for emotional difficulties at school. However, gender, ethnicity, help sought previously, stigma, self-compassion, and anxious and avoidant attachment insecurity were not individually significant predictors of help-seeking, which contradicts the literature.
- As identified from previous research and this study's qualitative findings, the source of support available is an important factor, thus further investigation in educational settings is warranted to gain a deeper insight into the factors that predict help-seeking in this population.

Keywords: Help-Seeking Intentions, Schools, Adolescents, Self-Compassion, Attachment

Appendix 3.3 – Gillick Competency Test

These ten questions are designed to assess whether you fully understand the purpose of the research, the potential risks and benefits of participation, and your right to make an informed decision about taking part without external pressure.

Section 1: Understanding the Study

1. **What is the purpose of this survey?**
    a. To collect information about young people's experiences (correct answer)
    b. To test you on your knowledge
    c. To sign you up for a programme
    d. I don't know
2. **What will happen if you take part?**
    a. You will complete a set of questions about your experiences (correct answer)
    b. You will be asked to meet with a doctor
    c. You will be given a test score at the end
    d. I don't know
3. **Can you choose not to take part in the survey?**
    a. Yes, and I won't get into trouble (correct answer)
    b. No, I have to take part
    c. I can stop, but I will be punished
    d. I don't know

Section 2: Reasoning and Decision-Making

4. **Why do you think we are asking you to complete this survey?**

a. To understand young people's experiences and opinions (correct answer)
b. To test your knowledge
c. To make you take part in a programme
d. I don't know

5. **What do you think could be the benefits of taking part in this survey?**
    a. Helping researchers understand young people's views (correct answer)
    b. Getting a reward or prize
    c. There are no benefits
    d. I don't know
6. **What do you think could be the risks of taking part in this survey?**
    a. There are no risks because my answers are confidential
    b. My answers could be shared without my permission
    c. I might feel uncomfortable answering some questions (correct answers)
    d. I don't know

Section 3: Appreciation of Consequences

7. **If you decide to take part in this survey, can you change your mind and stop at any time?**
    a. Yes, I can stop at any time (correct answer)
    b. No, once I start, I have to finish
    c. I don't know
8. **What will happen to your answers after you submit the survey?**
    a. They will be kept confidential and used for research (correct answer)
    b. They will be shared with my teachers and parents

c. They will be posted online

d. I don't know

Section 4: Consistency in Decision-Making

9. **If a friend was asked to complete a survey like this, what would you advise them to do?**

a. Read the information carefully and decide if they feel comfortable (correct answer)

b. Take part without reading anything

c. Refuse to take part no matter what

d. I don't know

10. **Do you feel confident that you understand what this survey is about and your rights in taking part?**

a. Yes (correct answer)

b. No

c. Not sure

Appendix 3.4 – Demographic Questions

1. **How old are you?** (this question will be asked at the very beginning of the survey and in the demographic section for age verification)

    [ ] Aged 13 years and under

    [ ] 14 years old

    [ ] 15 years old

    [ ] 16 years old

    [ ] Aged 17 years and over

2. **Where do you live in the UK? Please select one option from the below** (this question will be asked at the very beginning of the survey and in the demographic section for residency verification)

    [ ] England

    [ ] Scotland

    [ ] Wales

    [ ] Northern Ireland

    [ ] Other (please specify)

3. **How would you describe your gender?**

    [ ] Male

    [ ] Female

    [ ] Non-binary or other _____ (please specify if wished)

    [ ] Prefer not to say

4. **What is your ethnic group? Choose one option that best describes your ethnic group or background.**

[ ] White

[ ] English/Welsh/Scottish/Northern Irish/British

[ ] Irish

[ ] Gypsy or Irish Traveller

[ ] Any other White background, please describe _____

Black/African/Caribbean/Black British

[ ] African

[ ] Caribbean

[ ] English/Welsh/Scottish/Northern Irish/British

[ ] Any other Black/African/Caribbean background, please describe

Asian/Asian British

[ ] Indian

[ ] Pakistani

[ ] Bangladeshi

[ ] Chinese

[ ] English/Welsh/Scottish/Northern Irish/British

[ ] Any other Asian background, please describe _____

Mixed/Multiple Ethnic Groups

[ ] White and Black Caribbean

[ ] White and Black African

[ ] White and Asian

[ ] Any other Mixed/Multiple ethnic background, please describe

_____

Other ethnic group

[ ] Arab

[ ] Any other ethnic group, please describe _____

5. **To the best of your knowledge, have you accessed support from professionals in the past for any emotional difficulties (e.g., teachers, GP, doctors, therapists)?**

   [ ] Yes

   [ ] No

   [ ] Not sure

   [ ] Prefer not to say

6. **To the best of your knowledge, have you been told, by a professional, that you have a specific mental health problem? (e.g., anxiety, depression, eating disorder)?**

   [ ] Yes

   [ ] No

   [ ] Not sure

   [ ] Prefer not to say

7. **Do you think you have a specific mental health problem? (e.g., anxiety, depression, eating disorder)?**

   [ ] Yes

   [ ] No

   [ ] Not sure

   [ ] Prefer not to say

Appendix 3.5 – Ethical Approval granted by the Central University Research Ethics Committee at University of Oxford

MEDICAL SCIENCES INTERDIVISIONAL RESEARCH ETHICS COMMITTEE
Research Services, Boundary Brook House, Churchill Drive, Headington, Oxford, OX3 7GB Tel: +44(0)1865 616575
ethics@medsci.ox.ac.uk

CONFIDENTIAL 15 May 2024

Dr Emily Reeves & Melissa Stock
Oxford Institute of Clinical Psychology Training & Research
Isis Education Centre
Warneford Hospital
Oxford

Dear Dr Reeves and Melissa,

Research Ethics Approval - CUREC 1
Ethics Approval Reference: R92774/RE001

Study title: The Relationship between Attachment Security and Self-Compassion in adolescents and its prediction on Help-Seeking Intentions in Schools for Emotional Difficulties

Short title: Predictors of Help-Seeking Intentions in Adolescents for Emotional Difficulties

The above application has been considered on behalf of the Medical Sciences Interdivisional Research Ethics Committee (MS IDREC) in accordance with the University's procedures for ethical approval of all research involving human participants.

I am pleased to inform you that, on the basis of the information provided to the IDREC, the proposed research has been judged as meeting appropriate ethical standards, and approval has been granted from **15th May 2024** until **14th November 2025.**

Insurance-provided indemnity arrangements are in place for the duration of the approval stated above. It is your responsibility to ensure that you request an extension to the end date for indemnity to remain in place should you continue the research beyond the dates covered.

Amendments

Should there be any subsequent changes to the study, you should submit details to the MS IDREC for consideration and approval. Details of changes must be listed on an amendment form.

Yours Sincerely

DocuSigned by:
Leah Butts
9F14889D2BC549A...

Mrs Leah Butts

Research Ethics Administrator

for
Dr Helen Barnby-Porritt
Research Ethics Manager

Ethical Approval granted by the Central University Research Ethics Committee at University of Oxford (R92774/RE002)

Dear Melissa,

Thank you for submitting a request for an amendment to project R92774, which has been reviewed on behalf of the Medical Sciences Interdivisional Research Ethics Committee (IDREC).

I am pleased to inform you that your request to:

- revise the participant information sheets for 14-15 & 16 years olds, for completing the study on Qualtrics

has been judged as meeting appropriate ethical standards, on the basis of the information provided to the IDREC, and approval has been granted, under reference R92774/RE002. Please note that this email is your sole approval.

Finally. please find attached your PIS's, where upon I just made a couple of minor revisions – please save and use these versions.

Best wishes

Leah

UNIVERSITY OF OXFORD RESEARCH SERVICES

researchsupport.admin.ox.ac.uk

Mrs Leah Butts
Research Ethics Administrator, Medical Sciences
Research Services | Research Governance, Ethics & Assurance Team
University of Oxford, Boundary Brook House, Churchill Drive, Headington, Oxford OX3 7GB
T: 01865 616575 **E:** **ethics@medsci.ox.ac.uk**
Working days/hours (Tues-Fri)

Please refer to our **privacy notice** for details of how we capture, process and hold personal information in line with current UK data protection legislation.

Ethical Approval granted by the Central University Research Ethics Committee at University of Oxford (R92774/RE003)

Dear Melissa,

Thank you for submitting a request for an amendment to project R92774, which has been reviewed on behalf of the Medical Sciences Interdivisional Research Ethics Committee (IDREC).

I am pleased to inform you that your requests to:

- amend to include online recruitment
- add new documents for online recruitment
- remove requirement for parental consent for online participants
- revise the ethnicity question within the questionnaire

have been judged as meeting appropriate ethical standards, on the basis of the information provided to the IDREC, and approval has been granted, under reference R92774/RE003.

Please note that this email is your sole approval.

Best wishes

Leah

UNIVERSITY OF OXFORD RESEARCH SERVICES

researchsupport.admin.ox.ac.uk

Mrs Leah Butts
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Please refer to our **privacy notice** for details of how we capture, process and hold personal information in line with current UK data protection legislation.

Appendix 3.6 – Univariate Multinomial Logistic Regressions

Table 3.6A

Univariate Multinominal Logistic Regression Parameter Estimates

GHSQ Category[a]	Predictor Variable	Odds Ratio (Exp(B)	95% CI for OR
Informal	MHL	1.74***	1.27 – 2.38
	Anxious Attachment	.814	.543 – 1.22
	Avoidant Attachment	.670*	.463 - .969
	Stigma	.995	.933 – 1.06
	Self-compassion	1.20	.603 – 2.39
	Emotional Wellbeing	.910**	.855 - .968
	Boys	6.90	.903 – 52.74
	Girls	4.63	.689 – 31.05
		.	.
	White	2.23	.185 – 26.81
	Black	1.00	.034 – 29.81
	Asian	1.75	.099 – 30.84
	Mixed	.200	.011 – 3.66
		.	.
	Previously Accessed Support	1.29	.212 – 7.80
	Not Previously Accessed Support	.667	.120 – 3.69
		.	.
Formal	MHL	1.53**	1.21 – 2.08
	Anxious Attachment	1.07	.712 – 1.61
	Avoidant Attachment	.872	.598 – 1.27
	Stigma	1.00	.937 – 1.07
	Self-compassion	.982	.478 – 2.02
	Emotional Wellbeing	.959	.901 – 1.02
	Boys	1.11	.203 – 6.11
	Girls	.964	.212 – 4.38
		.	.
	White	3.64	.210 – 62.93
	Black	1.00	.020 – 50.40
	Asian	1.00	.034 – 29.81
	Mixed	.600	.027 – 13.58
		.	.
	Previously Accessed Support	3.11	.423 – 22.87
	Not Previously Accessed Support	.889	.128 – 6.18
		.	.

Note. OR = Odds Ratio. CI = Confidence Interval. Significance levels: $p < 0.05$ (*), $p < 0.01$ (**), $p < 0.001$ (***).

[a] The reference category is: Noone

Appendix 3.7 – Multinominal Regression Parameter Estimates

Table 3.7A

Multinominal Logistic Regression Parameter Estimates

GHSQ Category[a]		B	SE	Wald	df	p
Informal	Intercept	-9.330	7.541	1.531	1	.216
	MHL	.796	.266	8.977	1	.003
	Anxious Attachment	.572	.443	1.666	1	.197
	Avoidant Attachment	-.461	.394	1.370	1	.242
	Stigma	.068	.056	1.470	1	.225
	Self-compassion	-1.463	.841	3.023	1	.082
	Emotional Wellbeing	-.157	.070	5.122	1	.024
	Boys	2.620	1.557	2.830	1	.093
	Girls	2.154	1.290	2.786	1	.095
		0[b]	.	.	0	.
	White	.963	1.713	.316	1	.574
	Black	.790	2.499	.100	1	.752
	Asian	1.109	2.076	.286	1	.593
	Mixed	-2.815	1.987	2.006	1	.157
		0[b]	.	.	0	.
	Previously Accessed Support	.157	1.392	.013	1	.910
	Not Previously Accessed Support	-1.305	1.197	1.188	1	.276
		0[b]	.	.	0	.
Formal	Intercept	-8.601	7.302	1.387	1	.239
	MHL	.591	.248	5.700	1	.017
	Anxious Attachment	.635	.420	2.286	1	.131
	Avoidant Attachment	-.260	.378	.471	1	.493
	Stigma	.049	.055	.787	1	.375
	Self-compassion	-.954	.820	1.354	1	.245
	Emotional Wellbeing	-.108	.068	2.492	1	.114
	Boys	1.755	1.390	1.593	1	.207
	Girls	.843	1.079	.611	1	.435
	Other Gender	0[b]	.	.	0	.
	White	1.084	1.858	.340	1	.560
	Black	-.056	2.620	.000	1	.983
	Asian	.428	2.267	.036	1	.850
	Mixed	-1.557	2.049	.577	1	.448
	Other Race	0[b]	.	.	0	.
	Previously Accessed Support	1.407	1.411	.994	1	.319
	Not Previously Accessed Support	-.356	1.231	.084	1	.772
	Not Sure if Sought Help Previously	0[b]	.	.	0	.

Note. B = unstandardized regression coefficient; SE = standard error; W = Wald chi-square test statistic

[a] The reference category is: Noone

[b] This parameter is set to zero because it is redundant

Appendix 3.8 – Logistic regression for 'clear cut' help-seeking cases (n = 65)

Table 3.8A

Case Processing Summary

		N	Marginal Percentage
GHSQ Category	Informal	40	61.5%
	Formal	5	7.7%
	No one	20	30.8%
Gender	Male	25	38.5%
	Female	35	53.8%
	Other	5	7.7%
Ethnicity	White	47	72.3%
	Black	2	3.1%
	Asian	6	9.2%
	Mixed	7	10.8%
	Other	3	4.6%
Accessed Support Previously	Yes	26	40.0%
	No	30	46.2%
	Not Sure	9	13.8%
Valid		65	100%
Missing		0	
Total		65	

Table 3.8B

Model Fitting Information

	Model Fitting Criteria			Likelihood Ratio Tests		
Model	AIC	BIC	-2 Log Likelihood	Chi-Square	df	Sig.
Intercept Only	115.636	119.985	111.636			
Final	102.850	168.081	42.850	68.787	28	<.001

Table 3.8C

Goodness-of-Fit

	Chi-Square	df	Sig.
Pearson	40.221	100	1.000
Deviance	42.850	100	1.000

Table 3.8D

Pseudo R-Square

Cox and Snell	.653
Nagelkerke	.796
McFadden	.616

Table 3.8E

Likelihood Ratio Tests

Effect	Model Fitting Criteria			Likelihood Ratio Tests		
	AIC of Reduced Model	BIC of Reduced Model	-2 Log Likelihood of Reduced Model	Chi-Square	df	Sig.
Intercept	102.850	168.081	42.850[a]	.000	0	.
MHL	116.357	177.239	60.357	17.507	2	<.001
Anxious Attachment	115.263	176.146	59.263	16.413	2	<.001
Avoidant Attachment	119.399	180.282	63.399	20.549	2	<.001
Stigma	107.845	168.727	51.845	8.995	2	.011
Self-compassion	111.966	172.849	55.966	13.116	2	.001
Emotional Wellbeing	116.404	177.287	60.404	17.555	2	<.001
Gender	124.406	180.940	72.406	29.556	4	<.001
Ethnicity	111.694	159.530	67.694	24.844	8	.002
Previously accessed support	113.475	170.009	61.475	18.625	4	<.001

The chi-square statistic is the difference in -2 log likelihoods between the final model and a reduced model. The reduced model is formed by omitting an effect from the final model. The null hypothesis is that all parameters of that effect are 0.
[a] This reduced model is equivalent to the final model because omitting the effect does not increase the degrees of freedom.

Table 3.8F

Classification

	Predicted			
Observed	Informal	Formal	Noone	Percent Correct
Informal	37	0	3	92.50%
Formal	0	5	0	100.00%
Noone	7	0	13	65.00%
Overall percentage	67.70%	7.70%	24.60%	84.60%

Table 3.8G

Multinominal Logistic Regression Parameter Estimates

GHSQ Category		B	SE	Wald	df	p
Informal	Intercept	-4.543	11.133	.167	1	.683
	MHL	.595	.323	3.406	1	.065
	Anxious Attachment	.448	.610	.540	1	.462
	Avoidant Attachment	-.285	.520	.301	1	.584
	Stigma	.004	.069	.004	1	.949
	Self-compassion	-1.554	1.137	1.868	1	.172
	Emotional Wellbeing	-.173	.099	3.090	1	.079
	Boys	3.778	2.096	3.265	1	.071
	Girls	2.398	2.055	1.362	1	.243
		0[b]	.	.	0	.
	White	.806	1.817	.197	1	.657
	Black	-1.965	2.987	.460	1	.497
	Asian	-.253	2.769	.008	1	.927
	Mixed	-2.242	2.121	1.118	1	.290
		0[b]	.	.	0	.
	Previously Accessed Support	.897	1.502	.357	1	.550
	Not Previously Accessed Support	-.738	1.279	.333	1	.564
		0[b]	.	.	0	.
Formal	Intercept	-3058.760	39640.452	.006	1	.938
	MHL	96.811	1250.130	.006	1	.938
	Anxious Attachment	322.734	3831.567	.007	1	.933
	Avoidant Attachment	-349.435	4068.593	.007	1	.932
	Stigma	13.863	200.382	.005	1	.945
	Self-compassion	205.804	3304.956	.004	1	.950
	Emotional Wellbeing	33.047	397.010	.007	1	.934
	Boys	-32.870	2561.770	.000	1	.990
	Girls	-588.710	6940.061	.007	1	.932
	Other Gender	0[b]	.	.	0	.
	White	442.653	9399.978	.002	1	.962
	Black	775.966	.000	.	1	.
	Asian	83.995	10351.989	.000	1	.994
	Mixed	58.705	11622.953	.000	1	.996
	Other Race	0[b]	.	.	0	.
	Previously Accessed Support	-717.819	9531.268	.006	1	.940
	Not Previously Accessed Support	-125.228	1824.328	.005	1	.945
	Not Sure if Sought Help Previously	0[b]	.	.	0	.

Note. B = unstandardized regression coefficient; SE = standard error; W = Wald chi-square test statistic

Appendix 3.9 – Multiple Regression Results

Table 3.9A

Multiple regression results for overall help-seeking in schools

	B	SE	β	t	*p*
Constant	21.406	13.860	-	1.544	.125
MHL	.525	.500	.110	1.049	.296
Self-compassion	2.503	1.500	.219	1.668	.098
Anxious Attachment	1.420	.844	.211	1.683	.095
Avoidant Attachment	-1.007	.762	-.174	-1.321	.189
Stigma	-.114	.105	-.105	-1.087	.279
Emotional Wellbeing	.039	.132	.043	.299	.766
Gender	-.499	.729	-.065	-.685	.495
Ethnicity	-.219	.132	-.147	-1.664	.099
Previously accessed support	.836	1.267	.066	.660	.511

Note. B = unstandardized regression coefficient; SE = standard error; β = standardized beta

Appendix 3.10 – Qualitative Themes and Responses

Table 3.10A

Qualitative Themes and Responses: Facilitators

Subthemes	Qualitative responses
Individual Approaches to Seeking Help (*n* = 11)	"If people didn't force their help upon you and instead you approach them" (Participant 41) "Being asked directly" (Participant 8) "If a teacher approaches me first" (Participant 36) "If I was reached out to first" (Participant 66) "If a teacher or whoever initiated a conversation or something similar" (Participant 70) "For teachers to approach us. We have to go find them and ask for help now & if we don't go to them, they don't check in on us even if they know things aren't good" (Participant 34) "If the teachers regularly checked up on us" (Participant 31) "People asking if I'm okay and opening a space/ checking in instead of me having to reach out" (Participant 82) "Someone checking on me and taking me out for a talk" (Participant 92) "Being supported in the moment to seek help" (Participant 12) "People being too pushy about it" (Participant 69)
Family or friends (*n* = 10)	"My dad" (Participant 13) "My brother" (Participant 14) "Family support" (Participant 27) "Rather discuss with family" (Participant 7) "My friends" (Participant 2) "A friend" (Participant 6) "Friends" (Participant 26) "Friends" (Participant 28) "Friends" (Participant 30) "My friends recommending that I talk to a trusted teacher" (Participant 55)
Supportive School Staff (*n* = 10)	"Mentor" (Participant 17) "Erm probably my favourite teacher" (Participant 19) "Friendly teachers" (Participant 32) "Form tutor" (Participant 39) "My teacher being open about their own struggles" (Participant 55) "My science teacher" (Participant 62) "Decent teachers saying its fine" (Participant 68) "A teacher I like and enjoy talking to" (Participant 72) "School counsellor" (Participant 75) "My geography teacher has OCD, which I also suffer with, and my film teacher is very understanding and turns out we are on the same antidepressants. That helps a lot knowing their struggles and it feels good to talk to someone who experiences the same things. Help is easier as they have a

Subthemes	Qualitative responses
	better understanding of what would be beneficial, rather than a safeguarding lead or head of year who just follows a protocol that doesn't help" (Participant 91)
Oneself (*n* = 7)	"Myself" (Participant 17)
	"Myself" (Participant 1)
	"Thinking to myself and realising that I need someone else to talk to" (Participant 11)
	"I would do it only if I want to" (Participant 11)
	"If I felt comfortable to" (Participant 37)
	"Would try & seek support from someone myself" (Participant 57)
	"The concern for my own safety, I'd rather have help than be dead" (Participant 90)
School as a Safe Base (*n* = 4)	"Comfortable, welcoming environment" (Participant 4)
	"The people being more approachable" (Participant 40)
	"Them [school staff] making it more inviting" (Participant 65)
	"An open communication system between students and teachers - one where the taboo of mental health and seeking help is removed" (Participant 71)

Table 3.10B

Qualitative Themes and Responses: Barriers

Subthemes	Qualitative responses
(Lack of) Confidentiality and Trust (*n* = 34)	"I don't feel like I could express how I feel to someone at school without them disclosing it to another person" (Participant 5)
	"Nothing is completely anonymous" (Participant 4)
	"The first thing that came to mind was being anonymous" (Participant 6)
	"If I could report things online or anonymously" (Participant 9)
	"If there were more anonymous opportunities to indicate you needed help without having to say anything face to face" (Participant 24)
	"Them not telling my mother right afterward and getting me grounded for a year" (Participant 33)
	"Knowing that they would give information of what I said spoken to my parents/carers. If it is something personal I'd like to keep it between me and people, I chose to tell" (Participant 35)
	"Lack of confidentiality" (Participant 38)
	"Confidentiality (knowing what a counsellor would have to tell a parent/risks have to be shared before telling as can create more problems for young person" (Participant 56)
	"No trust that it would be kept confidential" (Participant 77)

Subthemes	Qualitative responses
	“They report kids to their parents for being queer” (Participant 79)
	“No anonymous ways to let out thoughts and emotions” (Participant 83)
	“Distrust” (Participant 1)
	“People I don’t trust” (Participant 13)
	“Not being able to trust the person” (16)
	“Information going home” (Participant 1)
	“I don’t want my parents to find out” (Participant 2)
	“It being shared with a lot of people” (Participant 4)
	“That they would share it to another person” (Participant 5)
	“School wouldn't keep it confidential” (Participant 7)
	“Them telling home” (Participant 9)
	“If I ask them to tell no one and they tell someone” (Participant 18)
	“The snitching” (Participant 20)
	“The fear that my words were not confidential” (Participant 35)
	“Fear of lack of confidentiality” (Participant 38)
	“Feeling like they are untrustworthy” (Participant 53)
	“Shared information between teachers” (Participant 55)
	“Confidential systems that aren’t actually confidential (many teachers have the ability to reveal the identity of students via confidential reporting platforms eg. “Tootoot”, which breaks down trust as students aren’t sure their information will be kept private” (Participant 60)
	“Sharing how I feel with other people” (Participant 67)
	“Likelihood to gossip” (Participant 72)
	“And they often have to follow protocol, which isn’t helpful as it mainly involves talking to parents and teachers about my issues” (Participant 80)
	“Safeguarding rules about confidentiality” (Participant 81)
	“Other people seeing me speaking to the teacher or pastoral lead” (Participant 40)
	“Promises being broken” (Participant 79)
(Perceived) Judgement (*n* = 22)	“Social sigma” (Participant 12)
	“Judgement from others” (Participant 9)
	“People judging me” (Participant 6)
	“Other people finding out” (Participant 14)
	“Judgement” (Participant 15)
	“What people would say” (Participant 17)
	“Being judged by other people” (Participant 26)
	“If the teacher was judgy” (Participant 36)
	“Fear of judgment” (Participant 38)
	“Judgement” (Participant 39)
	“The feeling that everyone is judging me for asking for help” (Participant 43)
	“Not wanting my classmates to know” (Participant 45)
	“Other students finding out” (Participant 6)

Subthemes	Qualitative responses
	“Other students” (Participant 47)
	“Judgement by anyone I’d talk to” (Participant 57)
	“Feeling judged” (Participant 58)
	“Being treated differently for my issues” (Participant 62)
	“Judgement” (Participant 65)
	“People’s judgments and opinions” (Participant 70)
	“Getting judged” (Participant 78)
	“Fear of judgement” (Participant 76)
	“Teachers being judgemental” (Participant 73)
Lack of Staff Compassion (*n* = 20)	“Lack of teachers that actually listen” (Participant 16)
	“The teachers actually listening and understanding” (Participant 67)
	“Staff are not kind or nice” (Participant 75)
	“Not nice people” (Participant 76)
	“Lack of people working who actually care and don’t outwardly blow things out of the water” (Participant 83)
	“Mean teachers” (Participant 25)
	‘Rude teachers” (Participant 36)
	“Lack of care from staff / lack of professionalism” (Participant 46)
	“Your school counsellor being guarded and not making an effort to seem good. Making a big stigma around the whole thing” (Participant 64)
	“Teachers and staff in charge of these wellbeing sectors treating kids unkindly (this has happened)” (Participant 66)
	“They’re useless, transphobic, and incredibly dispassionate” (Participant 68)
	“They don’t seem to be able to spend the time we need actually helping” (Participant 34)
	“Bad staff/not so safe environment” (Participant 4)
	“Favouritism of mental health workers to certain children while others clearly struggle more. Laughing at people struggling publicly” (Participant 72)
	“They aren’t very empathetic” (Participant 74)
	“When they trivialise my problems and just ignore me” (Participant 77)
	“When teachers just leave me completely alone/ignore me” (Participant 81)
	“Teachers yelling at students who are struggling instead of helping them” (Participant 73)
	“Staff denying requests for things that would help support students, teachers constantly telling students they have to have a 100% attendance and mental health issues aren't good enough reasons to cause problems in school or with attendance, teachers providing no support to students with difficult family lives/familial deaths” (Participant 74)
	“A lot of staff trained in mental health at school are all really strict teachers, which is scary” (Participant 80)
	“If teachers actually listened” (Participant 89)

Subthemes	Qualitative responses
Lack of safeness (*n* = 16)	“I don’t know a safe space I could go to” (Participant 74) “Knowing more about the staff I'm expected to go to” (Participant 82) “The fact I don’t really know them” (Participant 12) “More chances to speak to teachers and staff and know who I can speak to get individual support” (Participant 61) “Not knowing information about who I’m going to” (Participant 71) “I don’t know who there is for support” (Participant 18) “Scared to go and find them, don’t know how to start the conversation” (Participant 75) “Lack of designated areas for those who are struggling” (Participant 84) “The area they work in are very open and no safe space” (Participant 72) “If lots of people were around” (Participant 8) “Friends and people being around” (Participant 12) “Knowing there would be a direct help that would actually affect me positively and make a difference” (Participant 64) “Rude and judgemental people visiting those areas often” (Participant 82) “Not feeling comfortable with the people at school” (Participant 45) “Having to talk to people I don't feel comfortable” (Participant 53) “An uncomfortable environment” (Participant 61)
A constant negotiation: am I ‘sick enough’ or ‘not sick enough’ (*n* = 8)	“I would seek support if it wasn’t that serious” (Participant 2) “It would have to be bad – death of a loved one” (Participant 13) “If I was doing bad” (Participant 69) “Thinking that my problem isn't important” (Participant 11) “Fear that my problems are too difficult to help” (Participant 24) “Not knowing what would be done to help, or knowing if my problems are inadequate for support” (Participant 53) “Feeling as if my problems are not big enough” (Participant 54) “Feeling a burden” (Participant 75)
Untrained Staff (*n* = 8)	“I get the feeling nobody fully understands my problem and/or feelings” (Participant 8) “A talk on mental health in the school and how it can be improved” (Participant 9) “Having actually trained staff, knowing anything about the issues of kids today” (Participant 79) “Them to actually help when you do, from past experiences they just say they'll offer support and then don't (except my drama teacher, but that’s not her job!!)” (Participant 80) “Help is only for non-masking people as teachers don’t know about autism” (Participant 64)

Subthemes	Qualitative responses
	“Fear of untrained staff not having anything done about it” (Participant 76) “Teachers being properly informed/trained about how to handle students with mental health issues and supporting them” (Participant 84) “Teachers being slightly ableist towards those with mental health disorders and/or learning difficulties” (Participant 74) “There are no beneficial help plans like being able to step out of class or bringing in sensory toys or having small headphones/ earplugs when I’m overwhelmed with noise!” (Participant 81)
Embarrassment (*n* = 6)	“Embarrassment” (Participant 5) “Embarrassment, awkwardness” (Participant 27) “Fear of being embarrassed” (Participant 30) “Embarrassment” (Participant 38) “Fear/embarrassment” (Participant 44) “If I was embarrassed” (Participant 49)