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Executive Summary 518 words

Connecting Narrative 983 words

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Abstracts

Systematic Review of the Literature (SRL)

Together in isolation: How self, relationships and community protect rural young people from suicide

Purpose: Suicide among adolescents is a significant public health concern, particularly in rural areas where access to support is limited. This systematic review aimed to identify protective factors that mitigate suicide risk among young people in rural communities, with attention to how these factors operate across ecological levels.

Methods: Peer-reviewed empirical studies were included, these were published in English, focused on protective factors against suicidality among young people under 25 years from 'WEIRD' countries. Databases included PubMed, PsycINFO, Scopus, EMBASE, CINAHL and Medline, with the last search conducted in February 2025. Quality was assessed using the Mixed Methods Appraisal Tool (MMAT). Results were synthesised using narrative synthesis.

Results: Twelve studies met inclusion criteria (qualitative: n = 2; quantitative: n = 10). Protective factors included self-esteem, emotion regulation, interpersonal relationships and support, as well as cultural and community connectedness. These factors operated across individual, relational and cultural domains, with identity emerging as a central, cross-cutting theme.

Discussion: The findings highlight dynamic interplays between personal strengths, supportive relationships and cultural belonging mitigating suicide risk. Drawing on ecological and social identity theories, the review suggests that identity is co-constructed through interactions across multiple systems and serves as a foundation for psychological

wellbeing. Future research should focus on longitudinal studies and the impact of strength-based approaches within rural communities.

Implications and Contribution: This review underscores the multifaceted nature of suicide prevention in rural youth. Strengthening identity through self-esteem, emotion regulation, social support and cultural engagement may be key to reducing suicidality in this population.

Key words: Rural Mental Health, Young People, Suicide, Protective factors.

Funding: This review was not funded; the first author is a doctoral researcher.
Registration: PROSPERO registration number: CRD42023464049.

Service Improvement Project (SIP)

Psychologists' perception of systems, power, therapeutic engagement and hope in Forensic Services.

Background: Psychologists working in forensic settings navigate complex power dynamics shaped by systemic, professional and socio-political pressures. These dynamics can heighten feelings of powerlessness among Forensic Service Users (FSUs), impacting therapeutic engagement and recovery. Understanding the role of power and hope is critical for improving mental health support within these settings.

Design: This qualitative study explored psychologists' perceptions of systemic power in Thames Valley Forensic Services. Six one-to-one interviews were conducted and analysed using inductive thematic analysis.

Analysis and Results: Five main themes and fourteen subthemes were identified: *Systemic Power*, *Negative Impact of Power*, *Therapeutic Engagement*, *Mitigation of Power* and *Perspectives on Empowerment*. Findings illustrate the pervasive impact of power on both FSU's and staff, potentially contributing to disempowerment, learned helplessness and moral injury respectively.

Conclusions: The study highlights the importance of recognising and addressing power dynamics to enhance therapeutic engagement and support recovery in forensic services. Recommendations for service improvements and areas for future research are discussed.

Key words: Power; Forensic psychology; Therapeutic Engagement; Hope

Theory-Driven Research Project (TDRP)

Coping with stoicism: Understanding mental health in rural communities.

Objectives: Mental health challenges are disproportionately prevalent among UK farmers, yet the psychological mechanisms driving this disparity remain poorly understood. Rural areas face unique challenges compared to urban communities: limited access to services, inadequate transportation, social isolation and cultural beliefs inhibiting help-seeking.

Design & Method: This mixed-methods, cross-sectional study explored the role of stoic beliefs and coping styles in shaping mental health outcomes within rural populations, using the Transactional Model of Stress and Coping as a theoretical framework.

Analysis and Results: Data were collected from two occupational groups (farmers and teachers) via an online survey. There were no significant differences in mental health scores between the groups; therefore, data were combined for the main analyses. Hierarchical regression analysis showed that higher stoicism and greater use of avoidant coping were significantly associated with poorer mental health, with medium and large effect sizes, respectively. Mediation analysis indicated that avoidant coping may account for the relationship between stoicism and mental health. The mediation model explained over 50% of the variance in mental health scores, representing a large effect size. These findings highlight the potential role of avoidant coping as a mechanism through which stoic beliefs are linked to mental health outcomes.

Conclusions: Findings emphasise the importance of addressing avoidant-coping strategies in interventions targeting mental health in rural populations. They also highlight a need for context-sensitive mental health interventions focusing on adaptive coping to improve rural populations' wellbeing.

Practitioner Points:

- The study highlighted the importance of understanding cultural nuances in mental health research and service development, whilst providing valuable insights for developing tailored support services for rural communities.
- The findings suggest the need for context-sensitive mental health interventions, particularly for agriculture communities who notably struggle to access support. Intervention needs to account for a tendency for avoidant coping and stoic beliefs, both of which may inhibit engagement with services.
- Addressing avoidant coping strategies e.g., overworking, substance use, not sharing difficulties and promoting adaptive coping mechanisms, could improve mental health outcomes for farmers and rural populations.

Key words: Rural Mental Health; Transactional Model of Stress and Coping; Stoicism, Agriculture.

Systematic Review of the Literature

Together in isolation: How self, relationships, and community protect rural young people from suicide

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Proposed Journal: The **Journal of Adolescent Health** is a peer-reviewed, interdisciplinary publication focused on advancing the physical and mental well-being of teenagers and young adults. It features original research spanning a wide range of topics, from fundamental biological and behavioural studies to broader issues in public health and health policy relevant to this age group. See *Appendix A* for Author Guidelines.

Abstract:

Purpose: Suicide among adolescents is a significant public health concern, particularly in rural areas where access to support is limited. This systematic review aimed to identify protective factors that mitigate suicide risk among young people in rural communities, with attention to how these factors operate across ecological levels.

Methods: Peer-reviewed empirical studies were included, these were published in English, focused on protective factors against suicidality among young people under 25 years from 'WEIRD' countries. Databases included PubMed, PsycINFO, Scopus, EMBASE, CINAHL and Medline, with the last search conducted in February 2025. Quality was assessed using the Mixed Methods Appraisal Tool (MMAT). Results were synthesised using narrative synthesis.

Results: Twelve studies met inclusion criteria (qualitative: n = 2; quantitative: n = 10). Protective factors included self-esteem, emotion regulation, interpersonal relationships and support, as well as cultural and community connectedness. These factors operated across individual, relational and cultural domains, with identity emerging as a central, cross-cutting theme.

Discussion: The findings highlight dynamic interplays between personal strengths, supportive relationships and cultural belonging mitigating suicide risk. Drawing on ecological and social identity theories, the review suggests that identity is co-constructed through interactions across multiple systems and serves as a foundation for psychological wellbeing. Future research should focus on longitudinal studies and the impact of strength-based approaches within rural communities.

Implications and Contribution: This review underscores the multifaceted nature of suicide prevention in rural youth. Strengthening identity through self-esteem, emotion regulation, social support and cultural engagement may be key to reducing suicidality in this population.

Key words: Rural Mental Health, Young People, Suicide, Protective factors.

Funding: This review was not funded; the first author is a doctoral researcher.

Registration: PROSPERO registration number: CRD42023464049.

Introduction

Global prevalence of suicide in young people

Suicide remains a significant global health concern for young people (World Health Organisation (WHO), 2023). In the UK, suicide has consistently been one of the leading causes of death for people aged 10 to 24 years; between 2018 and 2022 an increase of 22.7% was observed (Office for National Statistics (ONS), 2024). Similarly, the US, Australia and Canada all display parallel trends with suicide being a prominent cause of death, with rates increasing (Australian Institute of Health and Welfare., 2022; Centers for Disease Control and Prevention., 2024; Government of Canada., 2022). The WHO's Mental Health Action Plan 2013–2020 set a target for member states to reduce suicide rates by 10% by 2020 (Saxena et al., 2013). According to the WHO's Mental Health Atlas 2020, this goal was not achieved; only 35 countries reported having a stand-alone suicide prevention strategy, policy or plan. Recognising this growing crisis, the WHO (2021) has emphasised the necessity of implementing comprehensive suicide prevention strategies tailored to young people.

There have been several recent intervention papers published aiming to address suicidality and youth mental health (e.g., Yen et al., 2019; Isaacs & Sutton, 2016; Shaw et al., 2024). Nonetheless, a reduction in suicidal behaviour has not transpired. There is ongoing uncertainty regarding the long-term impact of the COVID-19 pandemic on adolescent mental health (Panchal et al., 2021). In the first year of the pandemic there was a 25% increase in the prevalence of anxiety and depression, with younger generations being disproportionately affected, and at increased risk of self-injurious and suicidal behaviour (WHO, 2022). A comparison study identified neurobiological changes associated with trauma and chronic stress for adolescents between pre- and post-pandemic timepoints (Gotlib et al., 2023). Subsequently, better understanding of how suicide risk can be reduced is crucial at this time.

Risk vs. protective factors

Recent reviews by Riera-Serra et al. (2024) and Varella et al. (2024) have identified key risk factors for suicide, including prior suicide attempts, mental health disorders, hopelessness, sleep disturbances, delayed remission, substance use, economic hardship and social isolation. While understanding risk is essential for identifying individuals at heightened vulnerability, it is equally important to recognise that protective factors are not simply the absence of risk. As Shaffer and Yates (2010) emphasise, protective factors actively buffer or mitigate risk and may promote resilience even in the presence of adversity.

To date, reviews have begun to explore protective factors across age groups, which include social and family connectedness, a sense of purpose, employment, access to mental health care, physical activity, effective coping skills and spiritual engagement (Ki et al., 2024; Lester, 2006; McLean et al., 2008; van der Feltz-Cornelis et al., 2022). However, much of this literature remains descriptive and generalised, often treating protective factors as static or isolated variables. There is limited exploration of how these factors function in real-world contexts, particularly in rural settings where structural and cultural dynamics may shape their impact. There is also a lack of youth-centred perspectives in the literature, with limited qualitative insight into how young people themselves understand and experience protection and resilience. This gap is critical, as it constrains the development of nuanced, strengths-based suicide prevention strategies that are contextually and culturally relevant.

Protective factors for young people

The literature identifies several factors that contribute to a reduced risk of suicide or are considered protective, many of which reflect findings from adult populations. Social support, particularly from family and peers, is one of the most consistently recognised protective factors (Arat, 2017; Eisenberg & Resnick, 2006; Graves et al., 2020; Kuper et al., 2018; Lew et al., 2019; Mustanski & Liu, 2013). In addition, a positive school environment,

sense of belonging, physical activity, positive self-perception, community-based emotional support and access to healthcare are associated with lower rates of suicidality (Bakken et al., 2025; Richardson et al., 2024a; Whitlock et al., 2014). Engagement in 'positive diversion' activities such as reading or watching films has also been linked to a reduced risk of suicide (M.-H. Kim et al., 2019). Furthermore, earlier studies suggest that young people who are religious or part of faith-based communities may experience lower suicide risk (Molock et al., 2008; Powell et al., 2016).

While these protective or risk-reducing factors provide valuable insights, evidence suggests that suicide rates vary between geographical regions (Gartner et al., 2011; Mohatt et al., 2021). As Lester (2006) argues, suicide, including protective factors, must be understood within its cultural and social context, indicating that protective factors may also differ accordingly. This review responds to that gap by focusing on the interplay between identity, connection and community in shaping resilience among young people in rural settings.

Adolescent suicide in rural communities

Mental health research has traditionally focused on populations from Western, Educated, Industrialised, Rich and Democratic (WEIRD) countries (Henrich, 2020). However, this focus often masks the diversity that exists within these nations, particularly the differences between urban and rural communities. Rural populations face unique environmental, cultural and systemic challenges that shape mental health outcomes in distinct ways (Sharma & Chaturvedi, 2020).

Access to mental health services is typically concentrated to urban centres, leaving rural adolescents with fewer resources, limited facilities and transportation options (Monteith et al., 2021; UK Parliament., 2021). These barriers may significantly hinder help-seeking, which in turn, may contribute to worsening mental health and increased suicide risk (McLoughlin et al., 2015). Additionally, community-based stigma or the perception of stigma

held in the community toward young people experiencing mental ill-health is often more pronounced in rural areas, which has a further negative impact on help-seeking (Schroeder et al., 2020). Thus, both community-level beliefs as well as practical restraints may reduce help-seeking behaviour for rural settlers.

Alarmingly, adolescent suicide rates in rural areas are nearly double those in urban settings, even after accounting for sociodemographic factors (Fontanella et al., 2015). While the causes are complex; access to lethal means, especially firearms, has been identified as a major contributor (Hoffmann et al., 2021), with rural adolescents reporting high rates of self-inflicted gunshot injuries (Murphy, 2014). Other contributing factors include elevated substance use (Dumas et al., 2020; Lambert et al., 2008) and increased exposure to bullying (Bhatta et al., 2014), both of which are linked to suicidality.

Given these distinct risk profiles, it is essential to explore whether protective factors also differ between urban and rural populations. Importantly, protective factors are not simply the absence of risk factors and must be examined independently. A shift in focus towards understanding the protective influences of community connectedness and cultural identity could be key to developing targeted, culturally appropriate suicide prevention strategies (Dorol--Beauroy-Eustache & Mishara, 2021).

Suicide prevention approaches are beginning to emerge. Efforts to improve access to mental health care in rural areas have arisen as a crucial strategy for identifying and addressing suicide risk among adolescents (Weissman et al., 2024). However, these interventions have had limited success. The COVID-19 pandemic further intensified mental health challenges in isolated communities, compounding existing barriers by disrupting already scarce in-person services. While the expansion of telehealth and online support during the pandemic may have offered some benefits to rural populations (Avena et al., 2021) , evidence suggests these alternatives have not significantly improved engagement with

mental health care. In particular, telephone-based support services have struggled to bridge the gap in access and utilisation, these have been unfavourable for this population (Weissman et al., 2024; Thompson et al., 2018). A notable gap in the literature regarding protective factors that may buffer against suicide in these communities remains. Identifying and understanding these protective factors could be key to developing more culturally sensitive and contextually appropriate interventions, ultimately improving engagement with services and/or reducing suicide risk.

Social Identity Theory

Henri Tajfel originally formulated Social Identity Theory to understand the roots of prejudice, discrimination and intergroup conflict in society (Hogg, 2016). A person's social identity is formed through a sense of belonging to a group, which they perceive as emotionally and morally significant. This identity helps define shared values and norms within the group (the "in-group") and distinguishes it from other groups (the "out-groups"). The theory suggests that a strong sense of group belonging may enhance psychological well-being by fostering emotional support and shared purpose. In rural communities, where suicide rates are often higher due to factors that may include geographic and social isolation. This theory proposes that a sense of rural identity may serve as a protective factor against suicide by reinforcing social cohesion and reducing stigma around mental health in the community (Hirsch, 2006; Hirsch & Cukrowicz, 2014; Hogg, 2016). Community-based interventions that strengthen local identity and peer support networks may therefore be particularly effective in mitigating suicide risk in rural settings (Hirsch, 2006).

Rationale and Aims

This review focuses on WEIRD countries as mental health experiences and help-seeking behaviours can be shaped by cultural norms, socio-political landscapes and healthcare systems, which differ widely across global contexts (Al-Krenawi, 2019; Rice &

Liamputtong, 2023). By taking a focused approach, the review aims to produce findings that are more comparable and relevant to policy and practice within these settings.

The age classification in this review aligns with suicide statistics: 10–14 and 15–24 years (CDC, 2024; ONS, 2024). Moreover, including individuals up to age 25 also reflects current social trends, with more young people remaining in full-time education or vocational training beyond adolescence. Since adult protective factors, such as stable employment (Ki et al., 2024) and risk factors like financial hardship (Riera-Serra et al., 2024) are broadly less applicable to this age group, individuals under 25 may be more appropriately studied within youth-focused mental health research.

The aim of this systematic review was to better understand factors that have been found to protect young people from suicide in rural areas. Specifically, what actively reduces the risk of suicidality in people under the age of 25, residing in rural settlements in 'WEIRD' countries.

Method

Given the complexity of suicide prevention among rural youth, where several nuanced factors were anticipated to arise, a flexible and integrative approach to synthesis was required. Thus, a narrative synthesis approach was decided upon.

Narrative synthesis is a systematic review method that primarily uses descriptive text to summarise and interpret findings across diverse study designs, including qualitative, quantitative, and mixed methods (Barnett-Page & Thomas, 2009). This approach is particularly valuable as it supports a deeper exploration of not only what protective factors exist, but how, and why they function. Narrative synthesis enhances transparency and reproducibility by adhering to structured processes and allows for the exploration of relationships within and between studies and assessing the robustness of the findings (Cochrane Consumers and Communication Review Group, 2013; Lucas et al., 2007). This

makes it especially well-suited to the current review, which aims to generate clear, evidence-based guidance on protective factors in youth mental health.

This narrative synthesis adhered to the updated guidelines of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement (Shamseer et al., 2015; Page et al., 2021). This review's protocol was pre-registered with the International Prospective Register of Systematic Reviews (PROSPERO) in October 2023 (registration number: CRD42023464049).

Literature search

The search terms encompassed four major areas: 1) Protective factors, 2) Suicidality, 3) Adolescents, and 4) Rural communities (see *S.I.1* for details). The comprehensive search was conducted in January and February 2025 across PubMed, PsycINFO, Scopus, EMBASE, CINAHL and Medline. Additionally, hand-searching methods were employed to review the reference lists of papers identified during the full-text screening stage. Backward and forward reference searching was also performed for papers that met the eligibility criteria in the initial searches. There were no date limits or restrictions, nor were filters applied to the search, to allow for a comprehensive search.

Eligibility criteria

A study was included if it met the following criteria:

1) Protective factors were measured in relation to suicidality, either as district constructs or as components within broader scales

2) Provided specific outcome data that differentiated outcomes for rural communities

3) Originated from 'WEIRD' countries

4) Participants were under the age of 25

5) Peer-reviewed and empirical studies

6) Published in English.

The inclusion of English-language only papers and studies from WEIRD countries ensures the relevance and applicability of the findings to similar socio-cultural contexts. This approach addresses practical constraints such as translation costs and limited access to multilingual expertise, while maintaining consistency in quality and relevance. Additionally, including qualitative, quantitative and mixed methods studies in a narrative synthesis allows for a more comprehensive understanding of complex issues by integrating statistical trends with contextual insights. This approach also aims to enhance the depth, validity and applicability of findings (McBeath & Bager-Charleson, 2020).

Exclusion criteria included:

1. Non-empirical / peer-reviewed papers e.g., theoretical articles or theses
2. Systematic reviews or Meta-analyses

Screening

At initial screening, 2,456 papers were identified and screened against inclusion and exclusion criteria. Rayyan software was utilised to support the systematic nature of our review, facilitating the organisation of papers, enabling independent, blind screening by the second rater (RQ), and maintaining comprehensive tracking of all included studies. Notably, no AI features of the software were employed.

Data extraction

Data extraction forms were developed and included the following sub-headings to draw

Relevant information: (1) sample size (2) description of participants (i.e., age and any other defining characteristics, (3) country (4) study design and methods (5) study aim or objective (6) outcome measure(s) and (7) main findings relative to the review's research question. Data extraction was led by CE, who carried out data extraction for all papers. The second rater

(RQ) completed data extraction on a random sample (30%) to check accuracy between the reviewers. Any discrepancies were discussed with a third member of the research team (MK).

Quality Assessment

The Mixed Methods Appraisal Tool (MMAT) by Hong et al. (2018) was employed due to the significant heterogeneity of the studies. This tool enables the assessment of five study categories: qualitative, randomised controlled trials, non-randomised studies, quantitative descriptive studies and mixed methods studies. The MMAT is also recognised for its strong psychometric properties, with intra-class correlations ranging from 0.7 to 0.9, indicating moderate to perfect agreement among reviewers (Pace et al., 2012). Lead researcher (CE) conducted the quality assessment for all included studies, while the second reviewer (RQ) evaluated 50% (n = 6) of the studies. Any discrepancies between the reviewers were discussed and resolved. The MMAT is not intended to provide a quality score; instead, a descriptive appraisal was chosen for the synthesis and is reflected in the results as relevant (Hong et al., 2018).

Data synthesis

The data was analysed using narrative synthesis following Economic and Social Research Council) (ESRC) guidelines (Popay et al., 2006). The data synthesis commenced by formulating a theoretical framework to guide the synthesis, identifying broad concepts such as personal protective factors, social support factors and cultural and community protective factors. Brief textual summaries for each study were created to allow familiarisation with the content. Studies were organised into tables based on several criteria, including methodology, study objectives, participant characteristics and main findings, with emphasis on protective factors. This facilitated systematic categorisation and identification of common themes.

Relationships within and between studies were explored by comparing findings within groups addressing similar research questions, such as the impact of self-esteem on suicidal ideation. Relationships between studies with different methodologies or conducted in different contexts, such as rural versus urban settings, were also examined. A brief subgroup analysis was conducted based on country and community type (e.g., Aboriginal, Alaskan Tulip, general rural) and found no observable variations in the results. This exploration helped identify patterns and variability in outcomes, designs, and populations.

To assess the robustness of the synthesis, the quality of the paper was evaluated using the MMAT, ensuring that the studies were methodologically sound with clear research questions and appropriate data collection methods. Limitations in robustness are noted in the results, but no studies were removed due to quality. Sensitivity analyses were conducted by considering the impact of study quality on the conclusions, enhancing the reliability of the findings.

By following Popay et al. (2006), the data synthesis process systematically synthesised the data, explored relationships within and between studies and assessed the robustness of the findings. This approach ensured a comprehensive and reliable synthesis of the protective factors against suicidality amongst youth.

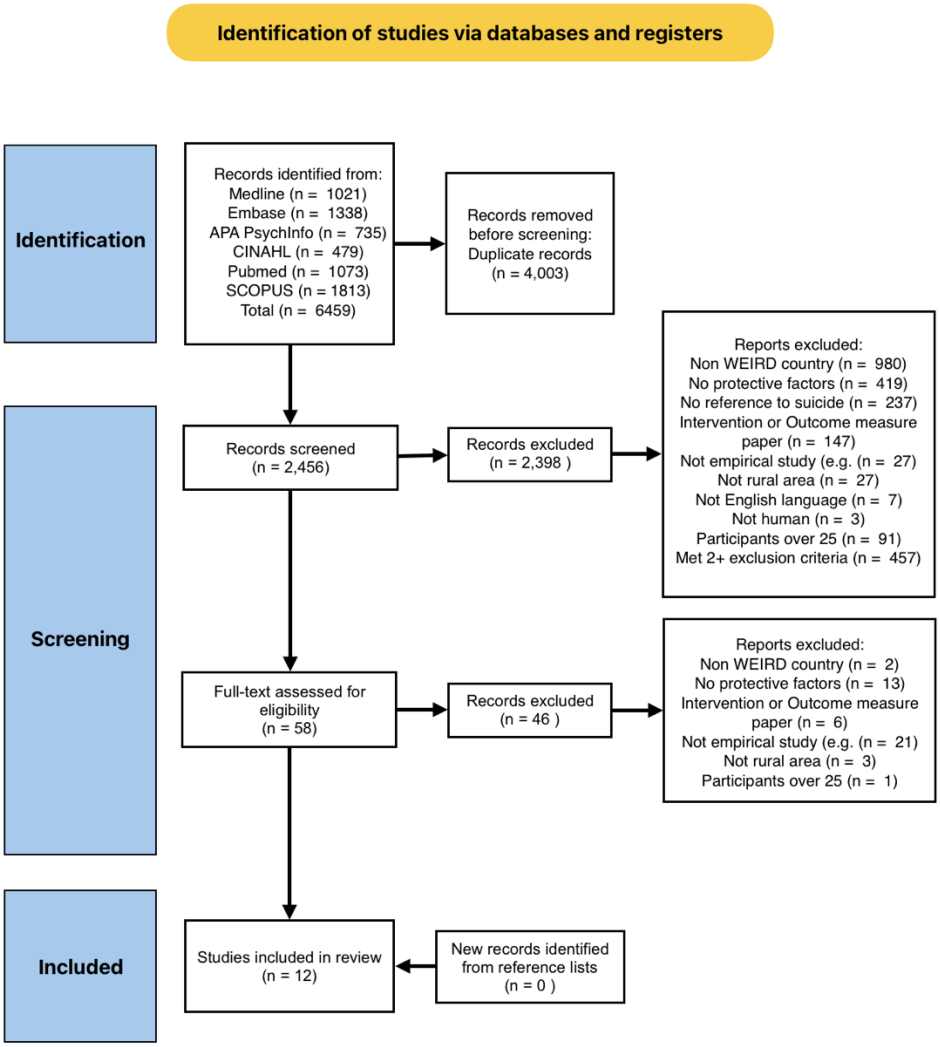
Results

Study Selection

A total of 6,459 papers were identified from the chosen databases. After removing duplicates, 2,456 titles and abstracts, and 58 full texts were screened. Twelve studies met the inclusion criteria for this review. There were several papers that initially seemed to meet criteria but did not share our agreed definition of ‘protective factor’. Thus, papers were excluded if they reported the absence of a risk factor, deeming it a protective factor. The primary author (CE) led the study selection process, screening all abstracts and full texts.

Additionally, a second rater (RQ) independently screened a proportion of records (20% of abstracts and 30% of full texts). The agreement rate between reviewers on each stage, from screening to data extraction and appraisal was very high ($\kappa > .81$). The complete study selection process is illustrated in the PRISMA flowchart (Figure 1).

Figure 1.
PRISMA flowchart of study selection process.



Study Description

A total of 12 studies were included in this review, comprising both qualitative (n = 2) and quantitative (n = 10) research designs (see *Table 1 for* Study Characteristics). Studies spanned a range of geographical locations, predominantly Australia and North America and focused on various protective factors that mitigate suicide risk among adolescents in rural communities. The outcomes and main findings are outlined in *Table 2.* A narrative synthesis was used to identify and group protective factors under three overarching domains: individual-level factors, relational and social support factors and cultural and community-level factors.

The methodological quality of the included studies was assessed using the Mixed Methods Appraisal Tool (Hong et al., 2018). In accordance with guidance, individual items were evaluated and reported without assigning a composite score. This approach enabled a transparent appraisal of methodological strengths and limitations for each study type (qualitative, quantitative, and mixed methods). The results of this assessment are detailed in *Table 3* and were considered in the interpretation and synthesis of findings, particularly when comparing the robustness of evidence across studies.

Data synthesis

The data was analysed using narrative synthesis following Economic and Social Research Council) (ESRC) guidelines (Popay et al., 2006). The data synthesis commenced by formulating a theoretical framework to guide the synthesis, identifying broad concepts such as personal protective factors, social support factors and cultural and community protective factors. Brief textual summaries for each study were created to allow familiarisation with the content. Studies were organised into tables based on several criteria, including methodology, study objectives, participant characteristics and main findings, with emphasis on protective factors. This facilitated systematic categorisation and identification of common themes.

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By following Popay et al. (2006), the data synthesis process systematically synthesised the data, explored relationships within and between studies and assessed the robustness of the findings. This approach ensured a comprehensive and reliable synthesis of the protective factors against suicidality amongst youth.

Table 1.

Study Characteristics and Baseline Participant Demographics

	Article	Year	Sample Size	Description of Participants *Age range in years & additional information*	Country	Study Design
Qualitative	Rasmus et al.	2014	25	11 - 18	Alaska, USA	Qualitative interviews: Grounded theory
	Marlin et al.	2023	11	19 - 30 *LGBTQIA+*	Rural Australia	Qualitative interviews: Thematic analysis
Quantitative	Armstrong & Manion	2006	242	13 -19	Eastern Ontario, USA	Cross-sectional, observational study
	Armstrong & Manion	2014	813 *(459 rural / 354 urban)*	13-19 *Rural and urban youth*	Ontario, Canada	Cross-sectional
	Armstrong & Manion	2015	813	11 - 18 (high school age) *Urban & rural secondary schools*	Eastern Ontario, Canada	Cross-sectional, structural modelling

Connor et al	2006	451	12 - 13 *Parent-child relationship*	Iowa, USA	Longitudinal, observational and self-report
Forrest	1990	191	14 - 18	Western Colorado, Canada	Descriptive, correlational
Gibson et al.	2021	*231*	15 - 24 *Aboriginal & Torres Strait Islander*	Queensland, Australia	Quantitative, observational design with ecological analysis
Islam et al.	2022	365	13.5 - 15 *Indigenous adolescents*	Northen & Eastern Australia	Longitudinal
Miotto et al.	2008	950	15 -19	Northeast Italy	Cross-sectional
Philip et al.	2016	57	12-19 *Yup'ik Alaska Native community*	Alaska, USA	Pre-intervention study
Pisani et al.	2013	7,978	11 - 18 *High school students*	Upstate NY & North Dakota, USA	Cross-sectional

Table 2.
Main findings of included papers.

	Article	Year	Research Aim/Objective	Outcome Measure	Main Findings
Qualitative	Rasmus et al.	2014	Present a picture of Yup'ik youth stressors and resilience strategies	Qualitative interviews	The paper outlined, cultural beliefs, practices and community involvement provided a sense of identity, purpose and strong sense of belonging as primary outcomes. These communities valued supporting the psychological and physical resilience, including the development of individual coping, for their young people which reduced the risk of suicide among Yup'ik youth.
	Marlin et al.	2023	Explore how queer emerging adults experience belonging in rural Australia	Qualitative interviews	Key themes include belonging, social acceptance, rural community attitudes, identity exploration and seeking alternative communities. Queer emerging adults in rural areas often experienced belonging through increased visibility and social support. However, rural settings frequently lacked these supports compared to metropolitan areas, leading to identity concealment. When belonging and support were present, they helped mitigate psychological distress and foster resilience against suicide.
Quantitative	Armstrong & Manion	2006	Investigate distance from school and youth engagement on suicidal ideation	**Outcomes Measured:** Suicidal ideation, depressive symptoms, distance from school, youth engagement, social support. **Measures Used:** Suicidal Ideation Questionnaire (SIQ),	Primary outcomes noted that higher youth engagement was significantly associated with lower suicidal ideation in adolescent males (medium effect). A higher level of social support from peers was associated with lower levels of suicidal ideation (small effect).

Article	Year	Research Aim/Objective	Outcome Measure	Main Findings
			Beck Depression Inventory-II (BDI-II), Centre of Excellence for Youth Engagement (CEYE) Engagement Matrix, Social Support Questionnaire (SSQ).	
Armstrong & Manion	2014	Investigate protective factors against suicidal ideation in rural and urban youth	**Outcomes Measured:** Suicidal ideation, depressive symptoms, youth engagement, risk behaviours, self-esteem and social support. **Measures Used:** Suicidal Ideation Questionnaire (SIQ), Beck Depression Inventory-II (BDI-II), Centre of Excellence for Youth Engagement (CEYE) Engagement Matrix, Checklist of Risk Behaviours for Youth (CORBY), Rosenberg Self-Esteem Scale (RSES), Social Support Questionnaire (SSQ).	Key findings outlined that high self-esteem, strong social support and meaningful activity engagement all reduced suicidal ideation, with small to medium protective effects. Supportive relationships, especially satisfaction with support and having multiple supportive people was key. For rural adolescents, being meaningfully involved in activities was particularly beneficial. A wide range of activities also built skills and social connections, further strengthening protection against suicide.
Armstrong & Manion	2015	Investigate predictors of suicidal ideation by gender	**Outcomes Measured:** Suicidal ideation, depressive symptoms, risk behaviours, self-esteem, perceived social support. **Measures Used:** Suicidal Ideation Questionnaire (SIQ), Beck Depression Inventory-II	Main outcomes outlined that self-esteem and social support reduced suicidal ideation and lower depression (large negative effect) especially among females. For rural males, self-esteem reduced depression, which in turn lowers suicidal ideation (large effect).

Article	Year	Research Aim/Objective	Outcome Measure	Main Findings
			(BDI-II), Checklist of Risk Behaviours for Youth (CORBY), Rosenberg Self-Esteem Scale (RSES), Social Support Questionnaire (SSQ).	
Connor et al.	2006	Investigate parent-child relationships and adolescent suicidality	**Outcomes Measured:** Adolescent suicidality, parental warmth, parental hostility, emotional distress. **Measures Used:** Iowa Family Interaction Rating Scales, Symptom Checklist–90 – Revised (SCL-90-R), Youth Risk Behaviour Survey.	The paper noted that paternal warmth indirectly reduced adolescent suicidality by mitigating emotional distress (small to medium effect). Maternal warmth directly reduced suicidality (small to medium effect).
Forrest	1990	Examine social support, self-esteem, depression, and suicidal ideation	**Outcomes Measured:** Suicidal ideation, self-esteem, depression, social support. **Measures Used:** Suicidal Ideation Questionnaire (SIQ), Dimensions of Depression Profile for Children and Adolescents, Social Support Scale.	Key findings included: higher self-esteem, better mood, and greater energy levels. These strongly linked to lower suicidal ideation, with large to medium effects. Support from parents and classmates also reduced suicidal thoughts (medium effect), while support from teachers (especially for older teens), close friends and higher socioeconomic status show smaller protective effects in reducing suicidality.
Gibson et al.	2021	Examine cultural connectedness and area disadvantage on suicide rates	**Outcomes Measured:** Suicide rates, cultural connectedness indicators (cultural social capital, community language use), discrimination, low	Main outcomes noted that communities with higher levels of social capital were associated with significantly lower suicide rates, and greater use of Indigenous languages was also linked to reduced incidences of suicide. Both present even whilst risk factors such as geographic isolation, access to services,

Article	Year	Research Aim/Objective	Outcome Measure	Main Findings
			socioeconomic resources, remoteness. **Measures Used:** The study used data from the Queensland Suicide Register (QSR), the Australian Standard Geographical Classification - Remoteness Areas (ASGC-RA), the Index of Relative Socioeconomic Advantage and Disadvantage (IRSAD), and synthetic estimates from the Australian Urban Research Infrastructure Network (AURIN) system.	discrimination and low socioeconomic status were problematic. Greater engagement in cultural events and community activities were also associated with a 37% reduction in suicide rates.
Islam et al.	2022	Analyse protective factors against self-harm and suicidality	**Outcomes Measured:** Self-harm, suicidality, family cohesion, Indigenous identity, making friends, self-efficacy, SDQ prosocial subscale scores. **Measures Used:** Strengths and Difficulties Questionnaire (SDQ), Indigenous Relative Socioeconomic Outcomes (IRSEO) index.	Key findings included: strong family cohesion was highly protective against suicidality, having low total SDQ score (generally suggests fewer emotional and behavioural difficulties) and being male was associated with lower suicidality (large effect). Strong cultural identity was not found to be a protective factor against suicidality in this sample.
Miotto et al.	2008	Examine social desirability and suicidal ideation	**Outcomes Measured:** Suicidal ideation, psychiatric symptoms, social desirability.	High denial scores on the MC-SDS are associated with lower suicidal ideation, showing medium to large protective effects across age and socioeconomic groups. While age and socioeconomic status influence

Article	Year	Research Aim/Objective	Outcome Measure	Main Findings
			Measures Used: Symptom Checklist 90R (SCL-90R), Marlowe-Crowne Social Desirability Scale (MC-SDS).	suicide risk, their direct protective effects are modest. Instead, denial appears to mediate this relationship, playing a more substantial role in reducing risk.
Philip et al.	2016	Examine social network and protective factors against suicide	**Outcomes Measured:** Social network factors, family protective factors, community protective factors. **Measures Used:** Brief Family Relationship Scale, Multicultural Mastery Scale, Youth Community Protective Factors Scale, ego-centred approach.	The paper outlined that strong connections to adults were highly protective against suicidality (large effect). Higher network density was protective against suicidality, particularly in family contexts (medium effect). Connections to elders might have had a protective effect against suicidality (small effect). Network size alone did not have a significant protective effect against suicidality.
Pisani et al.	2013	Investigate emotion regulation, youth-adult relationships, and suicide attempts	**Outcomes Measured:** Suicide attempts, risk factors, emotion regulation, youth-adult relationships, depressive symptoms. **Measures Used:** The study used data from the Youth Risk Behaviour Survey (YRBS), the Difficulties in Emotion Regulation Scale (DERS), the Youth-Parent Communication Scale, and the Short Mood and Feelings Questionnaire (SMFQ).	Key findings were that a positive relationship with parents and strong family connections were linked to up to a 39% reduction in suicide attempts, even after accounting for depression, emotion regulation and demographics. Trusted adult relatives helped buffer the impact of emotion regulation difficulties, while trusted school adults also reduced suicide risk but did not moderate this link. Although these findings were statistically significant, the effect sizes were small.

Table 3.
Quality Appraisal

		Screening questions		Qualitative questions					Quantitative descriptive				
Authors	Year	Are there clear research questions?	Do the collected data allow to address the research questions?	Is the qualitative approach appropriate to answer the research question?	Are the qualitative data collection methods adequate to address the research question?	Are the findings adequately derived from the data?	Is the interpretation of results sufficiently substantiated by data?	Is there coherence between qualitative data sources, collection, analysis and interpretation?	Is the sampling strategy relevant to address the research question?	Is the sample representative of the target population?	Are the measurements appropriate?	Is the risk of nonresponse bias low?	Is the statistical analysis appropriate to answer the research question?
Marlin et al.	2023	Yes	Yes	Yes	Yes	Can’t tell	Can't tell	Yes					
Rasmus et al.	2014	Yes	Yes	Yes	Yes	Yes	Yes	Yes					
Gibson et al.	2021	Yes	Yes						Yes	Yes	Yes	Yes	Yes
Pisani et al.	2013	Yes	Yes						Yes	Yes	Yes	Yes	Yes

Connor et al.	2006	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Forrest	1990	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Armstrong & Manion	2015	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Islam et al.	2022	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Philip et al.	2016	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Armstrong & Manion	2006	Yes	Yes	Yes	No	Yes	Yes	Yes
Miotto et al.	2008	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Armstrong & Manion	2014	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Identifying Themes

Three overarching themes emerged across the included studies:

(1) Cultural and community-level protective factors

(2) Relational and social support factors

(3) Individual-level factors

These themes reflect a multi-faceted understanding of protective influences, beginning with the role of broader societal values and community practices. Thus, followed by the quality of interpersonal relationships with peers, parents and other significant adults, and finally, individual psychological attributes such as self-concept, emotional regulation and psychological resilience. These levels are not mutually exclusive. Several studies highlighted the interaction between them. For example, how self-esteem may impact one's perception of social support or reduce depressive symptoms, resulting in subsequent reduced suicidality. Thus, suggesting that individual and relational factors often work in tandem.

Themes were developed through a systematic process of mapping the results of each paper to potential thematic categories. Studies were then grouped based on the presence of these themes, allowing for a visual representation of thematic overlap and divergence *(see S.I.2*). This matrix approach helped ensure that the thematic structure was grounded in the data and that the synthesis captured the full range of protective factors identified across the included literature.

To maintain inclusivity and avoid missing critical insights, all studies were included in the synthesis regardless of their quality appraisal outcomes. This decision was particularly important given the value of diverse methodological contributions and data outputs. While limitations were acknowledged, convergence across sources enhanced the reliability and depth of the findings.

1. Cultural and Community-Level Protective Factors

Cultural identity and engagement played critical roles in suicide prevention for rurally based young people; seven of the twelve papers discussed community and/or cultural factors. Gibson et al. (2021) reported that higher cultural social capital, including indigenous language use and participation in cultural events, was associated with significantly lower suicide rates. Rasmus et al. (2014) similarly noted that cultural practices and community involvement among Yup'ik youth provided a positive sense of cultural identity and purpose, both buffered against suicide risk. Conversely, Islam and colleagues (2022) did not find that having a strong cultural identity was protective against suicide. Both insights are helpful, but the latter paper did not measure identity directly, whereas Rasmus and colleagues (2014) explored this in some depth.

Moreover, higher network density is indicative of a reduction in suicidality according to Rasmus et al. (2014), whereas Philip and colleagues (2016) note that the size of one's network alone did not have a significant positive effect on mitigating against suicide risk. This suggests that the size of one's community is not the key component, rather the quality and sense of belonging and connection to a community. These studies met all qualitative appraisal criteria, including coherence between data sources, collection, analysis and interpretation.

Marlin and colleagues' (2023) paper lacked methodological rigour and precision in reporting, as reflected in *Table 3.* Nonetheless, given that this was a qualitative paper, quotes alone helpfully illustrated the impact of the multi-faceted benefits of cultural connectedness that are in line with other papers in the review. Moreover, it highlighted that rurality could mean less support was available than in urban areas for queer youth, which is discussed in the context of identity concealment. However, feeling connected to an online community and

feeling supported in this format, protected against risk factors such as discrimination, psychological distress or lack of acceptance. This suggests that the role of perceived belonging and acceptance, online or otherwise, in rural areas as a crucial element of psychological wellbeing and suicide prevention.

Finally, youth engagement in structured activities was associated with lower levels of suicidal ideation, particularly among rural males (Armstrong & Manion, 2014; Armstrong & Manion, 2006). While this finding highlights the potential of structured activities as a protective factor, the study's sampling limitations specifically the underrepresentation of Grade 9 students, raises questions about the reliability of this conclusion across all adolescent age groups. According to MMAT criteria, such sampling bias can compromise the internal validity of the study, suggesting that the observed protective effect may not be equally applicable to younger adolescents. Nonetheless, the broader evidence base supports the conclusions i.e., the value of structured, community-based engagement in fostering connection, purpose and belonging factors that are especially critical in rural contexts where opportunities for social integration may be limited. Thus, this limitation does not have a substantial impact on interpreting the combined findings of these collective studies.

2. **Relational and Social Support Protective Factors**

This theme was the most prevalent among included papers, with eleven of the twelve eluding to the protective nature of social and/or relational support. Trusted relationships with adults, particularly parents, teachers and community members, were consistently identified as protective against suicidality. Peer and teacher support correlated with reduced suicidal ideation, generally with medium to large effect sizes (Forrest, 1990; Armstrong & Manion, 2015). Moreover, youth with strong connections to adults and elders in the community had significantly lower rates of suicidality (Marlin et al., 2023). The methodological rigour of these papers was satisfactory to support the conclusions that trusted adults, including teachers

as well as peers actively mitigate suicide risk. Marlin and colleagues' (2023) show how qualitative analysis not only highlights how relationships and social support may feed into a sense of belonging to a community, but also how the sense of active support, encouragement and acceptance from others promotes resilience against suicide.

The most prominent protective factor within this theme was the role of parents; and the pivotal role they play in reducing suicide risk. All of these studies that discussed the parental role met quality appraisal standards. Effective communication with parents, particularly, strong family cohesion and the active provision of emotional support was associated with up to a 54% decrease in risk (Pisani et al., 2013; Islam et al., 2022). Positive relationships with parents, specifically outwards parental warmth was associated with lower emotional distress and associated suicidality (Connor et al., 2006). On a more practical level, higher family socio-economic status was correlated with reduced suicide risk (Forrest, 1990; Miotto et al., 2008). This finding is included under the theme of relational support, as socio-economic status can significantly shape the relational environment in which young people develop. Given that adolescents and young adults are typically still financially dependent on their families, the material resources available within the household can influence access to mental health care, educational opportunities and overall stability. These factors, in turn, affect the quality and availability of emotional and practical support within the family unit. Thus, socio-economic status is not only a structural factor but also a relational one, shaping the context in which protective family dynamics and support systems operate.

3. **Individual-Level Protective Factors**

Eight of the included papers explored individual-level protective factors. However, the concept of 'individual' was often nuanced. For instance, some studies identified a sense of belonging or community identity as protective, which, while experienced personally, was

deeply rooted in social and communal contexts. This highlights the interconnection between individual and relational factors. Still, some clearly personal attributes emerged from the data as protective factors. For example, Armstrong and Manion (2014, 2015) identified self-esteem as a key protective factor, reporting large negative effect sizes for suicidal ideation among both rural females and males.

Self-esteem, broadly defined as an individual's overall sense of self-worth or personal value, plays a critical role in how young people perceive themselves, their sense of identity and their ability to cope with challenges. In rural contexts, where access to mental health resource is limited and social isolation more common, high self-esteem can serve as a psychological buffer, fostering resilience, agency and a sense of control. The strength of the association in these studies suggests that interventions aimed at enhancing self-esteem could be particularly impactful in reducing suicide risk among rural youth. These papers scored positively on the MMAT. Although, self-esteem was not measured individually in Forrest's (1990) paper, rather measured self-esteem as part of a depression scale, and concluded that it was a protective factor by association with a better perception of social support and subsequent reduction in suicidal behaviour.

Strong emotion regulation skills were found to reduce depressive symptoms and suicidal thoughts among adolescents (Pisani et al., 2013). Similarly, lower levels of emotional and behavioural difficulties, as measured by the Strengths and Difficulties Questionnaire (SDQ), were associated with reduced suicidality (Islam et al., 2022). Broader psychological resilience also emerged as a noteworthy individual-level protective factor in Rasmus et al.'s (2014) high-quality qualitative study, which highlighted how community-level influences, particularly kinship ties, play a crucial role in fostering individual resilience. According to the MMAT, these studies were methodologically robust, with clearly defined research questions,

appropriate data collection methods, and minimal risk of bias, enhancing the credibility of their findings.

Finally, higher denial scores on the Marlowe-Crowne Social Desirability Scale (MC-SDS), which measures individuals' tendency to present themselves in socially acceptable ways, were also associated with lower levels of suicidal ideation (Miotto et al., 2008). This suggests that, in some cases, the inclination to deny distress or conform to social norms may function as a short-term protective factor, potentially by reinforcing internalised expectations of resilience or emotional control. Thus, presenting with the widely accepted social identity. This suggests that individuals who are more likely to deny socially undesirable thoughts or behaviours, possibly as a coping mechanism or due to a strong desire to conform to social norms, may report fewer suicidal thoughts. While this could reflect genuine resilience in some cases, it may also indicate underreporting due to stigma or self-presentation bias. However, the role of stigma, identity and self-presentation are not addressed in the included papers. These findings highlight the complex role of social desirability in mental health assessments and the need for careful interpretation when evaluating self-reported data.

Summary

These themes reflect a multi-layered model of protection, from societal and cultural influences to interpersonal relationships and individual psychological traits. The most prominent theme was relational and social support, discussed in eleven of the twelve studies. Parental support as well as trusted relationships with parents, teachers and community members consistently emerged as strong protective factors. Individual-level factors were also addressed in eight of the studies and included self-esteem, emotion regulation and psychological resilience; these traits often interacted with relational and community factors. Cultural and community-level factors were reported in seven studies emphasising the

importance of cultural identity, community engagement and belonging. Notably, the quality of community connection, rather than its size, was key to its protective effect.

Overall, the findings underscore the importance of multi-level protective factors and their interactions. Even studies with some methodological limitations contributed valuable insights, reinforcing the need for inclusive, context-sensitive approaches to suicide prevention in rural youth populations.

Discussion

This narrative synthesis presents a multidimensional framework of protective factors that reduce suicide risk among young people in rural communities. These protective factors operate across individual, relational and cultural domains, with identity emerging as a consistent, unifying theme. This review offers a unique perspective outlining how protective factors manifest uniquely within rural populations. Whilst many protective factors such as self-esteem, emotion regulation and social support are relevant across contexts, their expression and accessibility in rural settings are shaped by the integration of distinct structural and cultural dynamics. For example, community connectedness emerged as a particularly salient protective factor in rural areas that influences individual and relational factors. Tight-knit social networks shared cultural practices and a strong sense of interdependence can foster individual factors such as belonging and resilience. The identified factors are supported by literature e.g., Ackerman & Horowitz, (2022) and Weatherly et al., and colleagues (2025).

Relational factors such as parental involvement consistently surfaced as a key protective influence, highlighting the importance of supportive and engaged caregiving. Cultural connectedness and participation in structured, meaningful activities, particularly those that foster belonging, were also associated with enhanced psychological resilience, positive identity and a stronger sense of purpose. At the individual level, traits such as

positive mental health, self-esteem and emotion regulation were identified as protective factors. Across these domains, the findings underscore that identity is not a fixed attribute but a dynamic construct shaped by interactions within and across ecological levels.

These insights align with Bronfenbrenner's Ecological Systems Theory (Shaffer & Yates, 2010) which emphasises the interplay between individuals and their surrounding environments. The protective factors identified; family support, cultural engagement and community involvement, reflect the influence of the microsystem and mesosystem in shaping youth mental health. Meanwhile, individual traits such as self-esteem and emotional regulation represent personal characteristics within the microsystem. Together, these elements illustrate how identity formation and resilience are co-constructed through nested systems of influence, offering a nuanced understanding of suicide prevention in rural youth.

The findings also resonate with a broader literature base that highlights the protective role of social support, cultural identity and positive self-perception in mitigating adolescent suicidality. Consistent with Shaffer and Yates (2010), this review reinforces that protective factors are not simply the absence of risk, but distinct a notion that actively promote wellbeing and reduce risk. Cultural engagement and community involvement further strengthened protective outcomes, aligning with research by Gibson et al. (2021) and the CDC (2024), which underscore the resilience-enhancing effects of cultural identity. However, this relationship is not universally protective; Islam et al. (2022) found that cultural identity alone did not confer protection among indigenous adolescents, suggesting that the quality and context of cultural engagement may be more critical than its mere presence.

Family and peer support emerged as particularly influential, echoing earlier findings by Arat (2017), Eisenberg and Resnick (2006) and Kuper et al. (2018). Similarly, positive school environments and a sense of belonging highlighted by Whitlock et al. (2014) were reflected in studies linking positive, supportive interpersonal relationships with both teachers

and classmates to reduced suicidal ideation. A recent umbrella review by Richardson and colleagues (2024), which synthesised findings across all geographical contexts, highlights a notable gap in the literature regarding community-level and relational protective mechanisms. While the review identified school connectedness as a protective factor, cultural identity was not explicitly addressed, likely reflecting the urban-centric focus of existing studies and possibly being a less dominant protective factor for such populations. In contrast, the present review, which focuses on rural youth, found that cultural connectedness and community belonging are not only present but appear vital protective factors in rural contexts.

In rural settings, cultural factors may be more salient or amplified due to the centrality of community life and the limited availability of formal mental health services. This is supported by Weatherly et al. (2025), who note that rural communities often possess strong social ties, interdependence and cultural cohesion, which can be leveraged in suicide prevention efforts. Their review of community-based interventions in rural U.S. settings particularly among Indigenous youth demonstrates how culturally grounded programs, such as Qungasvik and PC CARES, foster protective factors by embedding suicide prevention within local traditions, values and relational networks. These findings suggest that while cultural connectedness may be broadly beneficial across geographical locations, its protective effects are amplified in rural settings where community identity is often more tightly woven into daily life and where formal mental health services are less accessible. Thus, supporting the outcomes of the present review in noting that cultural connectedness may be a central protective factor for young people residing in rural settlements.

Moreover, rural youth face unique barriers to accessing mental health services, including geographic isolation, transportation challenges and a shortage of providers. These conditions amplify the importance of informal support systems, such as trusted adults and community programs, which may serve as primary sources of protection in the absence of

formal services as noted by Ackerman and Horowitz (2022). This perspective is largely absent from existing systematic reviews and meta-analyses, which tend to prioritise individual or school-based variables without accounting for the relational and cultural dynamics that are often more pronounced in rural environments.

At the individual level, self-esteem and emotion regulation were consistently associated with lower suicidality. These findings align with Rogier and colleagues' (2024) meta-analysis, which identified adaptive emotion regulation strategies as protective across age groups. Similarly, Bakken et al. (2025) found that positive self-perception and school connectedness significantly reduced suicidal ideation and attempts over time. Harris and Orth (2020) further demonstrated a reciprocal relationship between self-esteem and social relationships, suggesting a reinforcing cycle of resilience during adolescence.

Social Identity Theory (Tajfel & Turner, 1979) provides a useful lens for interpreting the present findings. It posits that individuals derive self-worth and meaning through group membership, which may buffer against psychological distress. This is particularly relevant in rural contexts, where cultural practices and community ties can foster a strong social identity and sense of belonging (Gibson et al., 2021; Rasmus et al., 2014). Not only does a sense of collective identity have positive impacts on psychological wellbeing; the Social Identity Model of Collective Action (SIMCA) (van Zomeren et al., 2008) suggests that shared identity may motivate collective responses to social issues. The MATES in Construction program (Gullestrup et al., 2011, 2024) exemplifies this dynamic: by fostering a shared community identity, the intervention transformed individual distress into collective action, promoting solidarity, hope and peer-led suicide prevention. These findings highlight the potential of identity-based, community-driven approaches to achieve sustainable impact particularly important given the challenges of maintaining long-term suicide prevention efforts (Kim et

al., 2024). Thus, strong social identity within communities could facilitate and sustain potential intervention efforts within rural areas.

Digital environments also emerged as potential sources of protection; Marlin et al. (2023) highlighted how online communities can offer a sense of belonging and support for queer youth in rural areas, particularly where local support is limited. Emerging evidence suggests that social media may offer benefits for adolescents who struggle with a sense of belonging (Massing-Schaffer et al., 2022). While these digital spaces may offer emotional support and connection, their protective value appears to depend on the nature of the content and the adolescent's existing vulnerabilities or strengths (Prinstein et al., 2020). Future research should explore how online and offline forms of community belonging compare in their impact on adolescent mental health and suicidality.

Despite the valuable insights provided by this synthesis, several limitations must be acknowledged. The studies included varied significantly in sample size, participant demographics and geographical locations, which may affect the generalisability of the findings. None of the included papers are UK-based papers, and despite international parallels in rural culture, variability in sociopolitical contexts impact how we can generalise and apply these findings to the UK. Additionally, some studies had unclear aspects regarding the derivation of findings from the data and coherence between data sources, collection, analysis and interpretation. Although the search strategy was carefully considered, it is possible that some relevant papers were missed and subsequently not included in this review. The reliance on self-report measures in several studies may also introduce bias and affect the accuracy of the reported outcomes.

Future research should aim to address these limitations by conducting more rigorous and standardised studies with larger and more diverse samples. A UK study looking at protective factors against suicide would help us understand any differences and support the

development of UK specific understandings and intervention. Similarly, a comparison study to establish to what extent the identified factors in this review are unique to rural communities is warranted. Longitudinal studies that track changes in protective factors and mental health outcomes over time would provide valuable insights into the long-term effectiveness of these factors. Finally, research should explore the impact of strengths-based approaches that honour, compliment and augment the existing strengths and abilities within rural communities. By leveraging these inherent strengths, intervention may be more culturally relevant and sustainable, especially when we implement SIMCA ideas for ensuring lasting impact of community-led intervention.

The findings of this synthesis have important implications for the development of targeted suicide prevention strategies for young people in rural communities. Interventions should focus on enhancing self-esteem, emotion regulation skills and social support networks. Programs that promote cultural engagement and community involvement may also play a crucial role in fostering resilience. Policymakers and practitioners should consider the unique challenges faced by rural adolescents, such as limited access to mental health services, and work to improve service availability and accessibility. By addressing these factors, it is possible to reduce suicidality and improve the overall mental health and well-being of youth in rural communities.

Conclusion

This narrative synthesis emphasises the multifaceted nature of protective factors, identity-centred approach to suicide prevention among rural youth. Protective factors operate not in isolation but through dynamic interactions across individual, relational and cultural domains, reinforcing the value of ecological and social identity frameworks. Central to these protective processes are affirming relationships, cultural belonging and opportunities for meaningful engagement, all of which contribute to a resilient and coherent sense of self.

Despite recognised limitations, the synthesis provides valuable insights for developing targeted suicide prevention strategies. Future research should focus on interventions that harness community strengths, foster collective identity and promote youth agency, both offline and online, and offer promising pathways for sustainable impact. Future efforts must prioritise culturally responsive, community-driven strategies that recognise identity not only as a protective factor but as a foundation for empowerment and connection.

Contributions

The research question for the review was developed by CE and MK. CE, MK and support from OH library team developed search terms. CE conducted searches, all title/abstract, full text screening, data extraction and quality assessment. RQ was the second reviewer for each stage of the review. MK provided input and oversaw each stage, supporting with any discrepancies.

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Supplementary Information (S.I)

Supplementary Information 1 (S.I.1): Search Terms

Table 1.

Search terms.

Protective factors	Age	Suicidality	Rural area
Protective factors	Youth	Suicid*	Rural
Protect*	Teen*	Suicidal Behavio*r	Rural health
Coping	Young adult	Suicidal ideation	Rural population
Cope	Young people	Suicide risk	Rural community
Positive resources	Young		Farm*
Protective influence	Child*		Island
	Adolescen*		Remote
	P*ediatric		Coast*
	CAHMS		Countryside
	CYP		Village
			Agricultur*
			Desert
			Outback
			Isolated community

Supplementary information 2 (S.I.2): Division of themes across included studies

Table 1.

Division of themes across included research studies.

	Theme 1: Individual-level factors	**Theme 2: Relational & Social support factors**	**Theme 3: Cultural & Community-level factors**
Marlin et al.		■	■
Rasmus et al.	■	■	■
Gibson et al.			■
Pisani et al.	■	■	
Connor et al.	■	■	
Forrest	■	■	
Armstrong et al.	■	■	
Islam et al.	■	■	■
Philip et al.		■	■
Armstrong and Manion		■	■
Miotto et al.	■	■	
Armstrong	■	■	■

Service Improvement Project

Psychologists' perception of systems, power, therapeutic engagement, and hope in Forensic Services.

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Date of submission to the course: June 2024

Proposed Journal: The **Journal of Forensic Psychiatry & Psychology.**

This peer reviewed journal was chosen given the relevance to the chosen topic area. Additionally, it is a multidisciplinary journal that reaches various professionals far beyond psychology which would broaden the scope of results dissemination and hopes to inspire similar projects with other professions (See Appendix C for submission guidelines).

Conflicts of interest: The authors have no declarations.

Data Availability Statement: The data that support the findings of this study are not publicly available due participant information compromising their privacy and anonymity. The data can be made available on request from the corresponding author (CE).

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Abstract

Background: Psychologists working in forensic settings navigate complex power dynamics shaped by systemic, professional and socio-political pressures. These dynamics can heighten feelings of powerlessness among Forensic Service Users (FSUs), impacting therapeutic engagement and recovery. Understanding the role of power and hope is critical for improving mental health support within these settings.

Design: This qualitative study explored psychologists' perceptions of systemic power in Thames Valley Forensic Services. Six one-to-one interviews were conducted and analysed using inductive thematic analysis.

Analysis and Results: Five main themes and fourteen subthemes were identified: *Systemic Power*, *Negative Impact of Power*, *Therapeutic Engagement*, *Mitigation of Power*, and *Perspectives on Empowerment*. Findings illustrate the pervasive impact of power on both patients and staff, potentially contributing to disempowerment, learned helplessness, and moral injury.

Conclusions: The study highlights the importance of recognising and addressing power dynamics to enhance therapeutic engagement and support recovery in forensic services. Recommendations for service improvements and areas for future research are discussed.

Key words: Power; Forensic psychology; Therapeutic Engagement; Hope

Introduction

As defined by the Power-Threat Meaning Framework (PTMF), power is fundamentally about control and influence, (Johnstone et al., 2018). Foucault (1976) further conceptualises power as intertwined with knowledge, where power is enacted through the creation and dissemination of knowledge, reinforcing power structures; ergo, knowledge is a path to power. In forensic settings, clinical psychologists wield significant power due to their specialist knowledge, which not only aids in psychological well-being but also shapes institutional power dynamics (Goodbody & Burns, 2011; Haslam et al., 2020; Jones & Hartley, 2021). With reference to the PTMF's definition highlighting control and influence, the wider system, i.e., National Health Service (NHS), Ministry of Justice (MoJ) and socio-political systems, hold extensive power. The interplay between this overarching power and the power a psychologist has is multifaceted and requires further understanding and investigation.

Chronic austerity measures have severely impacted prison services, leading to diminished healthcare access, poorer living conditions and increased violence within our prisons (Ismail, 2020). These issues may be exacerbated, by what David Smail (2001) terms "distal power" i.e., socio-political power embedded in the NHS and/or MoJ. Between 2010 and 2016, prison funding decreased by 22% in real terms (The Institute for Government, 2017), a reduction that may have indirectly undermined the principles of Article 25 of the Universal Declaration of Human Rights (1948) and NICE Quality Standards (National Institute for Health and Care Excellence (NICE), 2011), by limiting access to adequate healthcare and meaningful activities for prisoners. The current socio-political context may exacerbate the powerlessness of Forensic Service Users (FSUs) as structural inequities, discriminatory policies, and exclusion from decision-making processes perpetuate trauma and limit opportunities to meet basic needs (Burgess et al., 2025; Fiorillo & De Giorgi, 2024; Hassan et al., 2023; Tomlin et al., 2024). There is a high prevalence of mental health issues in prison populations; 70% meet

criteria for multiple diagnoses (Fazel & Danesh, 2002; Nordentoft et al., 2013), subsequently many of whom are transferred to mental health institutions (NHS England, 2017).

The sense of powerlessness may be heightened due to restrictive conditions and legal repercussions (Askew et al., 2020). Clinical psychologists have a crucial role in addressing these power dynamics to enhance the psychological well-being of FSUs, while balancing risk and public safety. The combined influence of systemic priorities and psychologists', sometimes contrasting, priorities in line with professional values present significant challenges. Thus, a psychologist aims to improve psychological wellbeing in a setting that perpetuates mental health problems.

Power and therapy

Therapists are powerful, especially in forensic settings (Boyd, 1996; Warr, 2020). Other factors widen the power gap i.e., race, gender and socioeconomic status (De Varis, 1994; Linden & Schermuly-Haupt, 2014; Parry et al., 2016). Whereas FSUs feel powerless due to pressures to "use therapy properly," time constraints and recalling traumatic memories (Mc Glanaghy et al., 2022a). FSUs see psychologists as powerful and part of a system that necessitates engagement in therapy and have risk reduction as a ‘goal’ for therapy; making building therapeutic rapport difficult (Shingler et al., 2020; Simms-Sawyers et al., 2020). These feelings are amplified by systemic pressures like limited funding and recruitment challenges (Frost et al., 2017; Mann et al., 2014; JCP-MH, 2013). Subsequently, service user’s views are not always considered, despite recommendations (Frost et al., 2017; JCP-MH, 2013 Mann et al., 2014).

Role of hope

There is evidence to suggest a relationship between power and hope; both a felt sense and neurologically Li et al., 2021; Yang et al., 2022). Building "hope-inspiring" therapeutic relationships is vital for recovery and engagement (Dawson et al., 2014; Elwyn, 2023; Mountain, 2016; Nsamenang & Hirsch, 2015). However, for staff, sustaining hope in forensic settings can be challenging. There are high rates of vicarious trauma, compassion fatigue, and burnout among forensic mental health professionals, these may inhibit the perpetuation of hope in one's work (Pirelli et al., 2020) However, a lack of hope can lead to negative outcomes for FSUs, such as burnout, hopelessness and withdrawal (Figley, 2013).Therefore, holding in mind the role of hope despite the widespread impact of the power structures at play seems essential for fostering empowerment and engagement in forensic settings.

Service Improvement

Psychology team leads in Thames Valley Forensic Services, identified how the role of power may be under-recognised. Similarly, the service's Patient Feedback Survey 2022, addressing various FSUs experiences, from admission to relationships with the team to care planning also highlighted potential examples of FSU powerlessness. The survey was completed by 70 service users and emphasised a lack of collaboration on care planning and risk assessment, unsatisfactory care plans for their needs, lack of information and lack of empowerment to discuss challenges. Consequently, questions were raised amongst the team, querying whether disempowerment was impacting engagement with psychology.

The recognition within the service, alongside a literature review brought to light a lack of research in the area, specifically the insight into the impact of power a psychologist holds. Both being a part of an incredibly powerful system whilst navigating a powerful therapeutic role.

This study aimed to understand these power dynamics from a psychologist's perspective. By addressing this gap in the literature and examining how systemic powers affect therapeutic engagement and therapists' hope. Aims are concurrent with the NHS quality improvement 'Plan, Do, Study, Act' framework (Healthcare Quality Improvement Partnership, 2015); an evaluation method allowing services to explore the impact of new initiatives whilst learning from experiences and improving approaches. The results of the study were shared with the team in the form of a reflective discussion to support understanding of power and hope. The long-term aim is to improve therapeutic engagement and access to psychology; in line with NHS Long term Plan objectives to increase access to treatment.

Methods

Design

Semi-structured interviews were conducted as part of a Doctorate in Clinical Psychology Service Improvement Project. Thus, grounded in a phenomenological approach that acknowledges the socially constructed nature of power while taking a realist stance to interpret participants' responses as true experiences.

Each study component, including interviews, was approved by both a subcommittee of the University of Oxford Doctor of Clinical Psychology Research Team and the trust Forensic Service Clinical Governance Committee *(Appendix D).* Interviews explored psychologists' awareness of power, the role of power with FSUs, therapeutic engagement and relationships, adapting approaches and holding hope.

Following the interviews, a reflective feedback session was held with therapy staff across the service. This session aimed to share findings, stimulate critical reflection and explore the implications of systemic and therapeutic power dynamics. This informal evaluation aimed to explore whether engaging in a reflective process would enhance participants' confidence and understanding in navigating power within their clinical roles.

The expectation of change following the session was grounded in principles of reflective practice and adult learning theory (Mukhalalati & Taylor, 2019; Schön, 1983), which suggest that structured reflection can enhance professional insight and confidence. Specifically, it was hypothesised that engaging with the research findings in a collaborative and reflective environment would increase psychologists' awareness of power dynamics and their confidence in addressing these within their clinical work. This expectation was also informed by the NHS's 'Plan, Do, Study, Act' (PDSA) framework, which supports iterative learning and improvement through feedback and reflection.

Participants

Participants were qualified psychologists working within Thames Valley Forensic Services. Every psychologist in the service between December 2023 and March 2024 were invited to participate voluntarily; contacted via email and during a psychology meeting. The purpose of the study was to explore a unique power a psychologist holds; it was decided that only qualified staff would be included. Assistant psychologists, support workers etc. were excluded. Both verbal and written informed consent were obtained; all agreed to anonymised data being used for research.

Data collection

Interviews were conducted and recorded using Microsoft Teams by lead researcher (CE) who was external to the service. To ensure objectivity in meeting the research aims, the interview protocol was developed by an expert-panel *(S.I.2).* This included four qualified psychologists and two trainees with experience in forensic settings. The protocol was used as a guide, whilst the semi-structured nature allowed for prompts and flexibility.

A combination of online and physical questionnaires was used to collect quantitative pre-post data. To evaluate the impact of the reflective session, a pre-post questionnaire was developed by the researcher and supervisor. The questionnaire included Likert-scale items (0–

100) assessing self-rated confidence and insight across domains such as recognising systemic power, incorporating power into formulations, advocating for FSUs and maintaining hope. The tool, while unvalidated, was designed to pragmatically assess immediate changes in perceived competence, inform future training needs and the feasibility of ongoing reflective sessions in the team.

Analysis

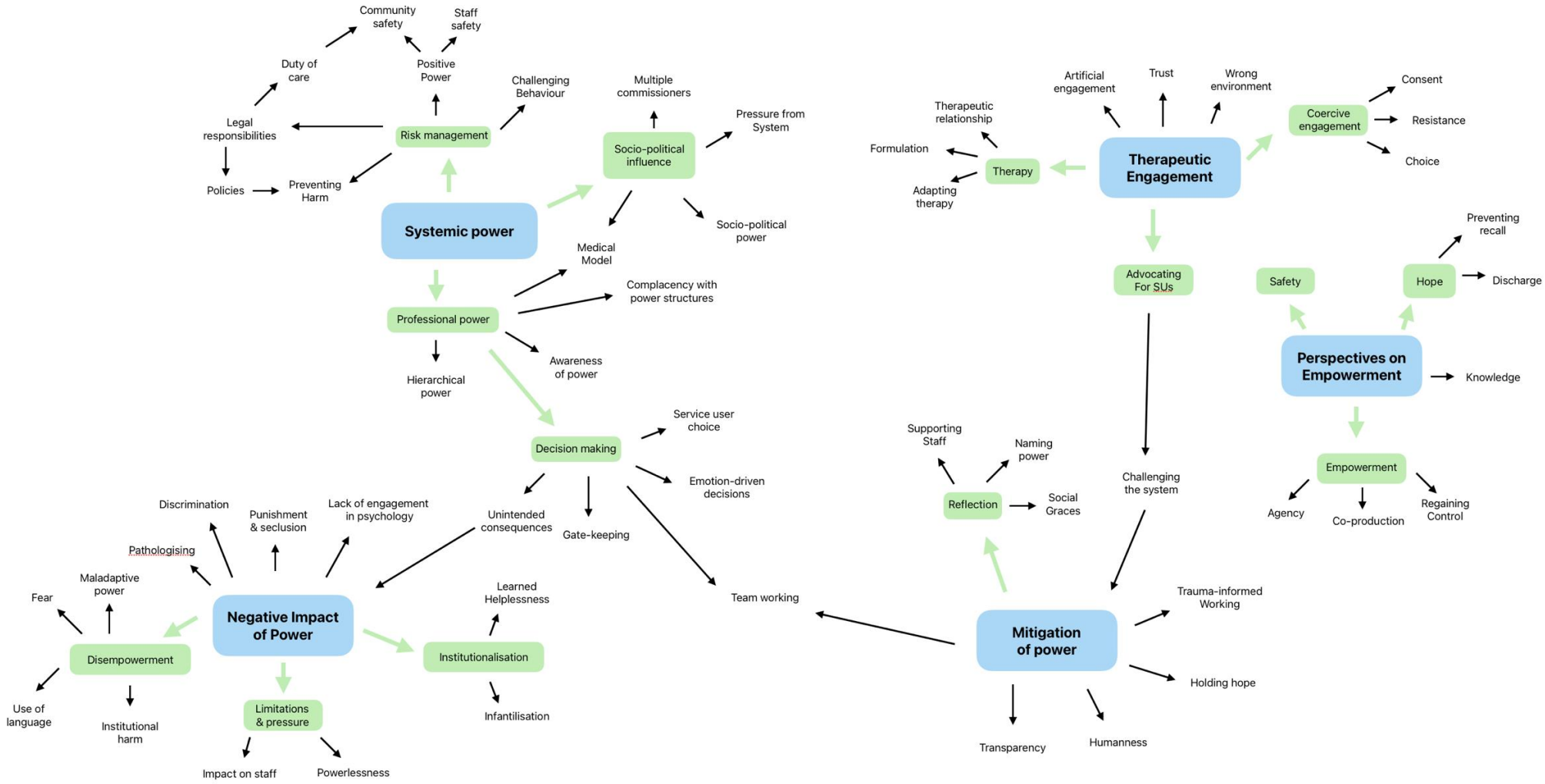
Interviews were transcribed intelligent verbatim by the lead researcher, then uploaded to NVivo 12. Analysis was guided by Braun and Clarke's (2021) outline for conducting high-quality, rigorous and reflexive thematic analysis (TA). An inductive method for data interpretation was adopted, enabling the emergence of themes and the exploration of underlying assumptions meanings, and semantic information, rather than conforming to a pre-existing framework. See *S.I.1* for exploration of analysis self-reflexivity in the lead researcher's Position Statement.

Descriptive statistics were used to demonstrate change between pre- and post- reflection questionnaires. Each question reflects a specific statement assessed on a scale of 0-100 before and after the feedback session.

Results

Of the nine psychologists approached, six completed interviews, two did not respond and one was on sickness absence. Five themes and fourteen subthemes were identified to illustrate the key characteristics of the research questions and aims. Themes were mapped out in multiple ways, re-phrased and discussed with the research team before final themes were decided upon. It was felt that these best captured and conceptualised most of the data; allowing the formulation of a narrative that best brought together the accounts of all participants to answer the research question. The five overarching themes were: Systemic Power, Negative Impact of Power, Therapeutic Engagement, Mitigation of Power and Perspectives on Empowerment (*See Figure 1 for final mapping).*

Figure 1: Thematic map



Systemic Power

All six participants expressed concern regarding the system's treatment of individuals, noting examples of disempowerment from the wider system. Three psychologists noticed how the probation service overtly wields power; *"if this person doesn't turn up to their weekly appointments, this person doesn't comply with their licence conditions, then they'll be arrested and sent back to prison. That's an immense wield of power, and that's explicit"* (P4). This acknowledgment emphasises the challenging context in which these psychologists work within, observing the significant consequences individuals face for non-compliance underscoring the power differentials at play.

Moreover, four participants recognised the role of language and branding in perpetuating power differentials, one noted, *"language is an important part of that and the naming and the branding of different elements of our service and how that implicitly communicates differences in power"* (P1). This notes the subtle ways in which power differentials are reinforced through institutional practices. Two participants named their role in perpetuating that, by in this instance being complicit with using *'offender personality disorder pathway'* how that might perpetuate viewing somebody always as an offender rather than somebody who's moving away from that. This recognition of complicity underscores the difficulty psychologists have with the convolution of systemic power dynamics within forensic settings in the context of mental health.

Given the focus of study being how psychologists navigate the complexity of wider systemic power, sub-themes 'Socio-political influence' and 'Risk' will be explored in detail to illustrate the interplay of systemic influences.

Socio-political Influence

Many examples of the influence of institutionalised socio-political structures were discussed. For example, resource limitations *"lack of resources and funding and not having the capacity to have so much flexibility that we could really offer"* (P6). The challenges faced by professionals striving to deliver holistic, person-centred care within constrained environments was stressed throughout.

Three participants critiqued the tendency within the health system to prioritise symptom reduction which might *"take years to do [we] rob people of the life skills that are needed to live out in the community" (P3).* This evaluation underlines the importance of considering the broader implications of the overshadowing nature of the medical model and the impact it has on people's lives long term.

Four participants reflected on the impact of representation and diversity within organisational structures. Four participants raised concerns about the predominance of white men in management positions, stating, *"organisationally, I'm just trying to think about like [the] management structure though, at the moment we have dominantly white men*…and *for example some of our assessment tools, they're based on research that are done with white men"* (P1). This acknowledges the need for critical reflection on the cultural and demographic biases embedded within forensic psychological practices.

Risk

All six participants noted the instrumentalisation of risk assessment within the system, noting its role in decision-making processes. Participants recognised the inherent power dynamics within risk assessment, *"I think that there needs to be aspects of power within a judicial system, otherwise you can't uphold the law. But…I guess psychologists are very much a part of that. Like we do risk assess…they're making a psychologically informed decision about whether this person is deemed manageable in the community. That's very much a part*

that's a powerful position we hold" (P5). This emphasises the significant influence psychologists wield in determining individuals' trajectories within the legal system, more so than other services. Most participants spoke to this powerful position and the negative impact it had on engagement with psychology.

Negative Impact of Power

All participants explored the profound disempowerment experienced by patients; "*the clients we work with accept a sense of learned helplessness"* (P5). Such experiences are often pathologized, rather than recognised as responses to systemic power dynamics and were described as effective means of coping for FSUs, at least in the short-term. Thus, considered by two participants as a factor that likely reduces engagement with psychology.

The negative impacts of power extend beyond the confines of the forensic setting, reverberating through families and society at large. Most FSUs were said to have already been let down by the wider system. Thus, perpetuating cycles of trauma and re-traumatisation during their time in forensic settings, further marginalising and disempowering vulnerable populations: *"People who might be retraumatised, people who've had situations in their personal life where their sense of agency and control has been violated and we're re-enacting that as a service" (P6).*

Interviews indicated that institutionalisation, inherent in forensic settings, likely causes dependency and impedes individuals' autonomy. FSUs often exhibit learned behaviours reflective of their institutional experiences, further entrenching their sense of helplessness and dependence; *"if they wanna have a shave, they've gotta go knock on the door for somebody to give them their razor…and ask permission from somebody else. It's quite infantilising"* (P3); *"we're then scratching our heads…because they've probably been institutionalised for 15 years that hasn't allowed or hasn't promoted those skills"* (P6). This dynamic not only hampers patients' rehabilitation but also poses challenges for staff members striving to support their

recovery. Three of six participants shared the personal impact of this *"I was just experiencing so much moral injury"* (P1).

The impact of power differentials extends staff feeling physically threatened to their safety and well-being; *"you can be assaulted. You can be hurt" (P2)*. All participants recount instances of assault and racial abuse contributing to a pervasive sense of fear and sense of powerlessness. Although not directly discussed, may impact how one holds hope. As one staff member reflects, *"that probably comes from my own feelings of disempowerment because of the experience of me as a representation in their own minds as being intimidating or frightening or something that they need to influence or have some sense of dominance over"* (P4). These experiences of staff powerlessness can erode morale and exacerbate feelings of hopelessness, ultimately impeding their ability to provide effective care and adding complexity to developing therapeutic relationships.

Therapeutic Engagement

All participants illuminated the intricate balance between coercion from the wider-system and genuine rapport-building. Critiquing the conditional nature of therapeutic progress, *"this person can't have unescorted leave until they've 'done' psychology…Like what we do is a pill that people can take and it's over and done with. So we work in a coercive environment"* (P3). This recognition of coercion notes the intricacies of engaging individuals in psychology. Specifically, the juxtaposition between service provision, constraints and power, as well as a desire to create therapeutic safety, trust, to empower, to give a sense of choice and autonomy to FSUs.

Moreover, participants articulated the transactional nature of therapeutic relationships within forensic contexts, noting some instances of 'artificial engagement' "*it's not a real relationship they want with the psychologist, it's getting out"* (P2). This observation suggests the instumentalisation of the therapeutic relationship, where individuals seek psychological

support to navigate bureaucratic requirements challenging traditional understandings of a genuine and trusting reciprocal relationship. This was referred to by some participants as a way in which FSUs attempted to regain a sense of power.

Three psychologists discussed their responsibility to model and engage in healthy relationships "*if you're thinking about the therapeutic process and relationship as modelling an appropriate human connection you have responsibility to be able to help the person to build a safe relationship with you so that they can take that attachment elsewhere"* (P5). This highlights the pivotal role psychologists play in navigating the delicate balance between systemic pressures and genuine therapeutic rapport, fostering healing, resilience and autonomy for FSUs.

Conversely, multiple participants addressed their desire to support, drawing parallels between therapeutic advocacy and parental support, emphasising the role of advocacy in empowerment: *"but then if we have a little bit of strength that we can hold on their behalf and that we are able to advocate for them, it makes me think a lot about the child-parent relationship and re-parenting within therapy"* (P6). This view on advocating was widely held among participants to improve engagement, but also to mitigate against power imbalances between psychologist and client.

Mitigation of Power

The importance of advocacy, cultural competence, transparency and collaborative teamwork in promoting client-centred care and fostering equitable therapeutic relationships were common narratives. The idea of 'humanness' was noted by five respondents; refraining from formal titles and engaging in authentic human interactions *"I try and mitigate that by being quite personable…I don't ever introduce myself as doctor".* Alternatively, modulating their attire, *"I don't wear smart clothing to work on purpose…Interestingly, I might do the opposite if I'm working with particular professionals"* (P6). Possibly illustrating the duality of

actively disempowering oneself with a client but emphasising one's professional power to advocate or challenge views within the system; a view held by three psychologists.

There was emphasis on reflective practice; to think together about how power can be a help or hindrance at different times. Four participants considered the role of social graces *"my social graces symbolise hat I have a huge amount of resources or power"* (P3). The discussed graces were education, class, race, age and gender, the most common by far being education. Participants also talked about naming power explicitly and consider how it transpires in therapy and relationships. *"Feeling able to name and talk about power imbalances and social graces and bringing that into the conversation, that feels actually progressive"* (P1). Accentuating the importance of acknowledging power differentials to promote collaborative decision-making.

Two participants were in support of co-production, being able to have "*paid service user involvement roles"* (P6) highlighting the value of incorporating lived experiences into service delivery.

Shared staff responsibility was also mentioned *"we are in the team, you might have different opinions, but then the decision comes as a team…the way to avoid the sense of power or minimise as much as possible. Maybe that is the right term minimise"* (P2). This emphasises the value of collective responsibility in mitigating against individual power imbalances within forensic settings. Nonetheless, an idea that the MDT "gang up" on FSUs was also acknowledged.

Perspectives on Empowerment

Participants offered diverse perspectives, emphasising the importance of leveraging institutional power, amplifying client voices, fostering institutional and individual empowerment whilst recognising the limitations within systemic constraints. The significance of providing individuals with a platform to voice their concerns was shared by three participants: *"people want to be heard. They want to have their story heard and nobody else is*

going to ask him the question that psychology will…I want to help people recognise the power that they do have" (P3) suggesting a psychologists' role in facilitating clients' self-awareness and empowerment by noticing their power.

The intersecting aims of different systems was noted, recognising opportunities for collaboration and mutual empowerment: *"the overlap between these two systems where…supporting people to come out of custody safely and hopefully preventing recall, our aims might be the same"* (P1). This suggests the potential for shared goals and collaborative efforts in promoting empowerment. Two participants proposed *"thinking a lot about trauma-informed care and how we can kind of give some level of choice and empowerment to the [people] that we work with"* (P5) shedding light on the importance of creating safe environments that prioritise clients' growth and recovery, as opposed to feeding into the re-traumatisation seen in prisons.

Hope

Despite the challenges discussed, all participants were able to exhibit a positive outlook, emphasising their belief in the possibility of making a meaningful difference. *"No, it's not easy. Wow, but I wouldn't work here if I didn't think it possible to make a difference"* (P2). This widely held perspective highlights an optimism and determination to effect change within the system. Moreover, amidst changes within the system, psychologists' express gratitude for progress and anticipate positive shifts, *"decisions that are being made at the top. Again, I know that the system is changing. I'm like, thank goodness"* (P5). This attitude reflects their hopeful outlook for the future trajectory of the system. Psychologists drew strength from their belief in the impact of their work, maintaining faith in the systems and processes they engage with.

The narratives of FSUs represent ongoing journeys filled with potential for growth and improvement; *"I've always been interested in, is stories, I think that probably what makes me a psychologist, because I'm interested in people's stories and stories are often never*

finished…that's where the hope comes from and knowing that their story isn't complete. So, there's more to do, and in that there's always a possibility of things being better" (P3). Psychologists noted endless possibilities for positive change and transformation. There was a clear sense of responsibility to hold hope, especially when FSUs are not able. Viewing themselves as catalysts for hope, actively cultivating optimism and belief in the potential for improvement.

Reflective feedback session

Of the 30 people who attended the reflective session 22 completed pre and post measures. The group primarily comprised of clinical psychologists, assistant psychologists and psychotherapists. The feedback session (S.I.3) revealed improvements in mean scores across all eight questionnaire items. Descriptive analysis showed the largest increases in confidence related to mitigating power (Pre: M = 62.05, Post: M = 76.75) and incorporating systemic power into formulations (Pre: M = 64.55, Post: M = 77.75). The smallest change was observed in maintaining hope (Pre: M = 72.90, Post: M = 74.00). These findings suggest the reflective session was effective in enhancing awareness and confidence in navigating power dynamics within the team.

Discussion

The service improvement project explored psychologists' perspectives of the impact of systemic power on their therapeutic work. It addressed an underexplored phenomenon; the unique power psychologists wield in forensic settings and its influence on therapeutic engagement. The findings outline the intricate relationship between systemic power and the hope for organisational change. Psychologists navigate both amid challenges that may hinder genuine therapeutic engagement, whilst hope persists.

Systemic Power and Negative Impact of Power

Participants' responses resonated with the concept of power as the ability to control or influence, in line with the definition from the PTMF (Johnstone et al., 2018)(Johnstone et al., 2018). When discussing systemic power and its impacts, participants seemed to display a sense of detachment from it. Psychologists held an understanding regarding the wider system and viewed themselves as powerless, relative to the system. Socio-political factors like austerity measures and reduced prison funding were highlighted as significant influences. The disempowering effects of systemic power on FSUs align with existing literature, reflecting the restrictive environment and legal consequences they face (Askew et al., 2020)Askew et al., 2020)Ismail, 2020; Kerfoot et al., 2012; The Institute for Government, 2017)Ismail, 2020; Kerfoot et al., 2012; The Institute for Government, 2017) Additionally, the idea that the prison service is re-traumatising people (Browne et al., 2015; Fazel & Danesh, 2002; Nordentoft et al., 2013)(Browne et al., 2015; Fazel & Danesh, 2002; Nordentoft et al., 2013) was considered by participants in the broader context of how power presents and negatively impacts FSUs. Participants also identified institutionalisation and learned helplessness as ways in which the system de-skills FSUs and perpetuates mental health conditions (Song & Vilares, 2021) David Smail's (2005) Impress of Power Model addresses many commonalities with the results. Notably, the role of distal and proximal factors (i.e., politics, social relations, economics and social graces), also addressing beliefs and interests of the person. Future research could explore how these personal factors moderate psychologists' perceptions of power.

Therapeutic Engagement

In the realm of therapeutic relationships, psychologists acknowledged the vast power they hold, particularly through the lens of the 'social GGRRAAACCEEESSS' (Burnham, 2021)(Burnham, 2021)(Burnham, 2021) Previous literature has suggested that significant differences across social graces between therapist and service user can negatively impact

therapeutic engagement or even cause adverse effects (De Varis, 1994; Linden & Schermuly-Haupt, 2014; Parry et al., 2016). Participants seemed most comfortable identifying their education as the social grace that 'grabbed' them the most (Totsuka, 2014). Questions may be raised regarding why this was most prominent may reflect an area of self-reflexivity that psychologists could consider, paying utmost attention to unvoiced graces. This may be done using the exercise from Totsuka's (2014) paper.

Previous literature by McGlanaghy and colleagues (2022) noted that therapeutic engagement can be difficult when FSUs feel powerless. This could be due to a pressure to 'use therapy properly' or give 'the right answer' and feel an obligation to recall bad memories; however, this was not directly addressed when exploring psychologists' perception of power in forensic settings. Nonetheless, a related area that all interviews addressed was the role of 'coercive engagement'. Thus, considered to be because of systemic powers encouraging FSUs to 'do psychology' before they could be considered for leave, or FSUs perceived completing psychology to get out quicker. With reference to McGlanaghy et al., (2022), this may be an example of FSUs feeling powerless and coerced into therapy, or conversely them trying to regain a sense of control to 'get out'.

In addition to the power psychologists hold, results align with psychological knowledge indicating a sense of power that psychologists have within the MDT, thus echoing findings from wider literature (Goodbody & Burns, 2011; Haslam et al., 2020; Jones & Hartley, 2021). Moreover, participants noted the importance of advocating for FSUs in the wider system, both to build and maintain therapeutic relationships. Thus, consistent with findings from a qualitative paper by Kozan & Blustein (2018). In these results, advocacy was also considered to mitigate against power between psychologist and service user.

Mitigating against Power and Empowerment

Participants proposed various strategies to mitigate power imbalances, including emphasising 'humanness' and breaking down professional barriers, consistent with existing literature (Audet & Everall, 2010; Jolley, 2019). A common suggestion was emphasising a sense of 'humanness', whether that be the way they introduce themselves to FSUs, self-disclosure, how they dress or non-therapy conversations. These factors were also discussed in the context of improving therapeutic engagement.

Co-production was also considered a helpful method of reducing power imbalances. Specifically, in terms of paid roles and input on service development was suggested, thus in line with benefits noted in the literature (e.g., (Bostock et al., 2009; McFadden et al., 2022; Moffatt et al., 2014)). Under the broader theme of alternative perspectives, shared decision making was also discussed in light of reducing power. Though this was not a universal belief, this could be considered to reduce the power of an individual staff member but unlikely to mitigate against systemic power for FSUs; rather increase the sense of us and them. Present research explores power imbalances within the MDT (Rogers et al., 2023, 2024), but is limited in terms of MDT decision making and mitigating against power between FSUs and MDT.

Hope and empowerment were discussed interchangeably, generally in the context of power being used positively to support FSUs to reclaim power, skills, autonomy over decisions and hope for the future. Therapist hope has been associated with recovery and positive outcomes (Dawson et al., 2014; Elwyn, 2023; Nsamenang & Hirsch, 2015), which was mostly consistent with the perceptions of psychologists. Participants reflected on the importance of hope, equally how frequently hope can wane, often due to systems making things difficult. For example, psychologists practicing in ways beyond their personal and professional values. Thus, raising questions regarding the possibility of moral injury and to what extent this may impede a sense of hope. Moreover, for staff participating in the reflective feedback session, data from

the questionnaire indicated that the item on maintaining a sense of hope that the work psychologists do in forensic settings is meaningful, displayed the least amount of change.

Limitations

A significant limitation of the project was the difficulty in defining power, as participants had varying definitions and understandings, particularly within forensic settings. This inconsistency may have affected question interpretation and response unity. The challenging nature of the interview questions might have limited openness and honesty. There was a risk of the Hawthorne effect, where participants alter behaviour due to observation. The small sample size, typical of qualitative research, and the specificity of service context limit generalisability. However, this study could inform larger research. Additionally, the pre- and post-reflection session measure, developed by the researcher and supervisor, is unvalidated, so conclusions should be drawn cautiously. Finally, collecting demographic information would have been helpful but compromised participant anonymity.

Conclusion

Outcomes suggest that systemic power dynamics in forensic settings disempower FSUs, fostering learned helplessness through some restrictive and infantilising practices. Both patients and staff are affected by these dynamics. FSUs responses to power are often pathologised instead of being understood as coping mechanisms. This environment not only challenges FSUs autonomy, but also negatively impacts staff who experience moral injury and disillusionment. The ethical dilemmas faced by psychologists in forensic settings, including the need to balance their therapeutic role with advocating for patients, highlight the complexity of maintaining therapeutic integrity amidst systemic constraints. Ultimately, these findings underscore the need for systemic changes to empower both patients and practitioners within forensic contexts.

Recommendations

With the view of Thames Valley Forensic Services improving therapeutic engagement, reduce power imbalances and foster a more empowering and hopeful environment for both psychologists and FSUs. Recommendations were developed based on the results of this project and a discussion with the service lead. The recommendations cover four areas: (1) training and reflective practice, (2) co-production and shared decision making, (3) organisational change, and (4) research and evaluation.

Recommendations aimed to address power imbalances and enhance therapeutic engagement within Thames Valley Forensic Services. Training should focus on systemic power dynamics and include reflective exercises to build confidence and awareness. Co-production must be strengthened by involving current FSUs in service development and decision-making, especially in meetings. Organisational change is needed to reduce systemic harm, with policies that support both FSUs and staff and provide psychologists with supervision and peer support. Finally, further research is recommended to explore power dynamics in psychological practice and evaluate the long-term impact of interventions across services to ensure broader applicability and effectiveness; see *Table 1* for specific information.

Table 1.
Recommendations for Service Improvement

1. Training & Reflective practice*:*	*Rationale* *There was a sense of discomfort during the feedback session discussing power dynamics and the impact of these on therapeutic engagement and relationships and on service user disempowerment. The pre- and post- questionnaire identified a lack of confidence in discussing such issues, but the increase in confidence post reflection suggests its utility. Additionally, there were mixed views on advocating for service users.* *Recommendation* *Develop and implement a training program focused on systemic and therapeutic power dynamics unique to psychologists. Training should include practical exercises, such as those suggested by Totsuka (2014), to help psychologists reflect on their social graces, especially unvoiced graces, and power dynamics within therapy. Moreover, consider how psychologists distinguish their role as therapist from that of being an advocate.*
2. Co-production and Shared Decision-Making*:*	Rationale Interview data highlighted a lack of service user voice in service development, risk assessments and decision making. Psychologists observed how CPA meetings may perpetuate power imbalances, FSUs are subjugated to many professionals having a conversation around them, with little say. Possibly reenacting child protection meetings etc. from their early life. Recommendation Foster co-production initiatives where FSUs are actively involved in service development and decision-making processes. The organisation could look at improving meetings that involve service users e.g., adapting structure to allow FSU voice to be heard. Additionally, current FSUs to be involved in service meetings as opposed to only previous FSUs (Peer Support Workers).

3. Organisation level:	Rationale Both the reflective feedback session and interview data highlighted the negative impact organisational power has on both FSUs and staff e.g., institutionalisation, learned helplessness, moral injury and burnout. If this is the case for psychologists, it is likely that many other professionals are experiencing similar. Recommendation Institutions must be better aware of the harm they are causing through the recommended practices. Conversations should be had at higher levels to consider how systemic power imbalances could be reduced. Advocate for policies that address the root causes of systemic disempowerment, such as funding cuts and restrictive legal frameworks. Policies should aim to create more supportive and empowering environments for both FSUs and psychologists. Secondly, the institution should provide better support to psychologists to mitigate the effects of moral injury and burnout. This could include regular supervision, peer support groups, and opportunities for professional development focused on maintaining hope and resilience.
4. Research and Evaluation:	Rationale There is limited literature highlighting the unique interaction of power that psychologists navigate within the systems they work and therapeutic relationships. This interplay is under-explored and relatively novel, thus requires a richer understanding. Recommendation Conduct further research beyond that of one service to improve generalisability. Explore the effectiveness of different strategies for mitigating power imbalances and enhancing therapeutic engagement. This should include longitudinal studies to assess the long-term impact of training and systemic changes.

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Supplementary Information (S.I)

S.I.1: Position Statement

I am a white British, middle-class 27-year-old woman. I have not been closely involved in the justice system, nor have anyone in my family or close circle. Prior to my doctoral training in clinical psychology at Oxford, I had not been closely involved in forensic psychology settings, nor worked directly with this population. My pervious academic experiences must also be considered in this reflective space. I am presently completing my doctoral training in clinical psychology. Prior to this, I achieved a BSc in Psychology and an MSc in Mental Health Studies. During both degrees I conducted qualitative research, suggesting a level of familiarity with the premise of thematic analysis. These may have influenced my adoption of a realist and social constructionist epistemological stance.

Whilst conducting the research, I kept a reflective diary, this supported my ability to keep track of how the project was shaped by my personal and professional experiences whilst navigating training. Reflecting on my experience analysing the data, I found myself becoming acutely aware of my own views and values around political systems, societal perceptions of prisons and social graces, namely gender and socioeconomic status. These personal perspectives seemed to surface and I noticed where this may have been taking influence of my interpretation of the data. This recognition of my biases was something I took caution to navigate carefully to maintain objectivity.

Given the emotive nature of some of the conversations and a personal passion for understanding these complex ideas, during the analysis, I felt a strong response to certain aspects of the data. This emotional engagement was a double-edged sword; while it made me deeply connected to the material, it also posed a risk of colouring my interpretations with my subjective viewpoints. It was a challenging process to step back and ensure that my personal

beliefs did not unduly influence the outcomes of the analysis. It made me think about Jonathan Haidt's Moral Foundations Theory suggests that our moral reasoning is often guided by intuitive values shaped by cultural and personal experiences.

To ensure objectivity in my analysis I took these reflections to both of my supervisors individually at multiple time points, recognising the necessity of external perspectives to maintain objectivity. Discussing my emotional and cognitive responses with them helped me untangle my personal biases from the analytical process. This supervisory support was invaluable, providing a space to explore and validate my reflections while ensuring the integrity of my research.

In the end, this journey of reflection and supervision was not just about ensuring the accuracy of my analysis, but also about personal growth. It deepened my understanding of how my personal values shape my professional work and highlighted the importance of self-awareness in research. This experience, I hope, has enriched my approach to qualitative analysis, reinforcing the need for a reflective, narrative, and explorative lens in my work.

S.I.2 Interview Protocol

- **What is your awareness of the role of power within the service?**
    - What are the systems of power that you're aware of?
    - How is power experienced?
    - How does the organisation signal power?
    - How does it manifest / where does it come up?
- **Within your service, how aware are you of power?**
- **What role does power play in your relationship with FSUs?**
    - How does it affect FSUs?
    - How does it affect the therapeutic relationship?
    - How easy do you find it to talk about power and its role in your therapy?
- **Does power affect therapeutic engagement?**
    - Do you think power impacts a service user's relationship to help?
- **Do you adapt your therapeutic approach / style to account for the power of the wider system? If so, how?**
- **How do you carry / hold hope for the people you're working with despite the system?**

Additional questions added after Interview 1-3:

- **Do you see a positive influence of power within the service, if so, could you explain?**
- **How do you as a psychologist mitigate against power?**
    - Does this have an impact on service user engagement?
- **How much influence / power do FSUs have over their care pathway?**
    - Is it a psychologist's role to support FSUs to understand and better use their power?

S.I.3: Outcomes for reflective feedback session

Question	*Pre*	*Post*	*Mean difference*	*Std. Deviation*
I feel confident talking to service users about power in sessions (0 – 100)	71.25	79.9	-8.65	23.5
How important is the issue of power within your therapeutic relationships (0 – 100).	78.5	88.25	-9.75	18.25
I understand the impact of the power I hold as a psychologist in forensic services (0 – 100).	79.45	86.75	-7.3	17.92
I have a strong understanding of how the influential power from the wider system (NHS, MOJ and Socio-political power) impacts therapeutic engagement (0-100)	80.1	85.25	-5.15	17.75
I feel confident including the impact of systemic power, institutionalisation and institutional harm in my formulations (0-100)	64.55	77.75	-13.2	27.46
I have a good understanding of how to mitigate against power in my work (0 – 100).	62.05	76.75	-14.7	24.36
I feel confident in formulating issues of power within the therapeutic relationship (0 – 100).	67.95	81	-13.05	21.84
I find it easy to hold hope that the work I do is having a positive impact (0 – 100).	72.9	74	-1.1	17.23

S.I.4: Table of Themes, Sub-themes and Quotes

Theme	Sub-theme	*Quote*
Systemic power	Socio-political influence	*"I feel like a lot of its geared around what's gonna get the vote rather than what's gonna be beneficial for society as a whole" (P1)* *"I think it's more just because of lack of resources and funding and not having the capacity to have so much flexibility that we could really offer…a truly person-centred service and be responsive to the different needs." (P1)* *"Organisationally, I'm just trying to think about like [the] management structure though, now we have predominantly white men, and in a lot of our kind of research and evidence base" (P6)* *"Particularly in the forensic work world, like our risk assessments for example and some of our assessment tools, they're based on research that are done with white men." (P5)* *"You know it's against the Geneva Convention to tell her somebody in custody that they must do therapy to be released. It is specifically in the Geneva Convention." (P3)*
	Risk Management	*"In the same way that medication is done to them. It might be that there's [an] unwritten rule that if you want to get out, you gotta talk about your risk assessment" (P4).* *"There is kind of like an elephant in the room sometimes that if they're real kind of like risk issues that come up within our sessions and I talked about like we have that duty to be able to pass that on and that... is organisational element of power. But it's also like a professional power, and we've got a duty to protect other people" (P2)* *"But I think that there needs to be aspects of power within a judicial system, otherwise you can't uphold the law. But…I guess psychologists are very much a part of that. Like we do risk assess…they're*

	making a psychologically informed decision about whether this person is deemed manageable in the community. That's very much a part that's a powerful position we hold." (P4) *"it's not about the health needs, it's about public protection and managing risk." (P6)*
Professional power	*"If you think about the probation service. If this person doesn't turn up to their weekly appointments, this person doesn't comply with their licence conditions, then they'll be arrested and sent back to prison. You know that that's an immense wield of power, and that's explicit" (P6)* *"And because our service is a part of that system, I guess we're kind of complicit within the way that power operates in" (P1)* *"So many different elements as our role as a psychologist, where power comes in both usefully and sometimes unhelpfully." (P6)* *"There needs to be aspects of power within a judicial system, otherwise you can't uphold the law… But I guess psychologists are very much a part of that." (P5)*
Decision making	*"My role is integral within the session, supporting somebody to think about the decisions that they are making. What may be some of the obstacles? What's the power that's operating within that? We might not be able to change it, like for example, the probation systems, I can't change that." (P1)* *"And we hold a lot of power in relation to being able to understand our service users and making decisions about whether we share that understanding with others" (P6)* *think at times of how our organizational power runs on a day-to-day basis, I think it's more decision making around how our service is set up and it is impacting those decisions (P1)* *I will emphasise choice with people, and particularly the people who are more anti-authoritarian or more suspicious about power." (P3)*

		I think that is the reason why there is a team around you, because if you work only on your own, you might be led by your emotions, your own emotions and that is wrong. The team around you help you to be impartial and fair" (P2) *So, I think if you're able to be thoughtful from a relational perspective, you can give people power and choice on like a one-to-one level. So, like our service is voluntary. So, in a system where actually things are mandated, we try and say look, you don't have to come and meet with us if you don't want to, it's your choice to be able to do that. I think inevitably, there's unspoken, unintentional coercion. (P5)*
Negative Impact of Power	Disempowerment	*"We disempower them, we distil them and then we kick them out the door and hope they're gonna just pick that back up again… all we are doing that's taking away from them" (P3).*
	Institutionalisation	*"I saw it much too. I think to other people's annoyance in my risk assessment I started to add in a bit about institutional harm and I'm finding that people don't like it. Because they don't want to think that the effort and sacrifice that they're making to work in these quite difficult places. You know, that's not always resulting in a good outcome." (P3)* *"They've had a childhood that's been peppered with feeling powerless and confused and unable to kind of have any say over their own life or kind of experience abuse of power from people who should have cared for them, whether that be institutions or family members. I think some of the learned helplessness and that sense that I either don't deserve to have an opinion or view, or 'I'm bad' in some way, or even if I did, people won't listen or they will abuse it." (P5)* *"Umm, anytime you rip somebody from society and stick them in a custodial system and treat them like a child for years Yeah, it's gonna have an impact on them. It's gonna have an impact on society. It's gonna have an impact on their families." (P6)* *So, I have started to do that and I think that I might explore that more. I think we need to keep this up to think about the kind of risk of institutionalization with patients and what those factors are." (P3)*

		"So, I think it becomes learned from quite a young age and is in some ways a relatively. I don't want to say healthy. I don't think that's right, but it but a relatively. Useful coping strategy that actually if I have to spend 10 years of me life fighting against a system that I am objectively unable to get out of. I'm going to that's going to be awful. And so, it's emotionally and psychologically safer for me to take a position of accepting my powerlessness than that I can't do anything. Because what's the point? So, I think that it is a coping mechanism really that keeps people safe from psychological harm over long periods of time." (P5)
	Limitations & Pressure	*"as much as you try you are, you still remain a human being and you make mistake." (P2)* *"And it's sort of leaked through and it'll be a policy or procedure or a new thing that we've got to do that has, you know, quite significant effects in people need to understand why we doing that, why have we got change our practice around this?" (P3)* *"That also I think goes for the staff as well feeling in a very under resourced stretch system where they are working with like 130% plus caseloads and not being able to respond to the need there and feeling quite powerless, particularly with working with quite risky guys. And having to hold that and feeling quite powerless to be able to do their job well or be able to evoke any change in the system that they're in." (P5)* *"If you say to their staff or why didn't you feel more compassionate about this person? The staff will turn around and say, well, I don't feel safe either. And so you end up in a position where you you're trying to put forward, the staff point of view doesn't have integrity." (P3)* *"All of that's really important and I found our patients get let down quite a lot. You know they'll, you know, they're often in the position where their needs. They're not needs that they couldn't meet for themselves, but because they're in a custodial environment," (P1)*
Therapeutic engagement	Therapy	*"People want to be heard. They want to have their story heard and nobody else is going to ask him the question that psychology will." (P5)* *"But I think with therapy, psychologists are often in the position where they do hear about people's experiences of being stuck in that system and their experiences are how they deal with the power of*

	that. So, we do have a kind of observer witness role in all of that, which can be therapeutic, of course." (P3) *"You are in a in a powerful position compared to where patients are and you need to be extremely careful how you use this position because the risk is that you hurt your patients if you're not careful with that." (P2)* *"I wouldn't want any patient that I'm in sort of a therapeutic relationship to, to feel that I had more power than them or more powerful than them and whether that be academically or whether that be sort of, you know, socioeconomically or whether that be you know sort of white privilege or whatever that might be." (P4)* *"What are you going to do with my emotion if I bring it? Does it feel safe on a human relational level to bring it? And also, does it feel safe in terms of are you going to go record it on some probation service and it come back and bite me in terms of my report writing." (P5)*
Coercive Engagement	*"I think of coercion within and supporting people on probation to come to our service and which leads to really kind of murky waters" (P5).* *"People come to me as I will work with you but that's because I'm gonna help them to go out." (P2)* *"They probably associate being vulnerable with abuse of some sort or pain, and so a huge percentage of us* *time probably becomes about engagement. We call it engagement, but we could also call it coercion." (P3)*
Advocating for service users	*"[feel] safe or empowered…there is someone who can advocate for them. So, the sense was that we didn't have any power, which we don't. We've got a little bit more than them" (P5).* *"To try and advocate for the client and shift the power, so I guess it depends where I am in the system." (P1)*

"But then if we have a little bit of strength that we can hold on to on their behalf and that we are able to advocate for them, it makes me think a lot about the child parent relationship and kind of re-parenting within therapy and that in the journey to independence and being able to take control over your own life as children, you want your parents to be able to advocate you for you and be strong enough to hold stuff for you and have conversations on your behalf" (P6)

Mitigation of power	Reflection	*"I'm very aware of just the power in terms of class and education level" (P4).* *"Yeah, parts of me and the other person might be hugely different, whether that's directly linked to a sense of power, I think for some people it probably is felt like that, my social graces symbolises that I have a huge number of resources or power" (P4)* *"If I work with somebody who's had particular racial experiences and or they've got like cultural beliefs or backgrounds and maybe it's something that's not known to me because my religious beliefs or cultural backgrounds very different, it enables me to go and read up on that and go and have a think about it and educate myself aroundit and have discussions with them" (P1)* *"I try and mitigate that by being quite personable and I don't ever really say, I say I'm a psychologist I don't ever introduce myself as doctor or anything like that…I think quite carefully about self-disclosure when it's appropriate to do that, just that I can be a little bit human. I pay attention a lot to that. That journey from the reception through to the room and have quite just a normal human conversation. So, like that I think I do quite intentionally, that I let people see my humanity." (P6)* *"I think it can also maybe act as a barrier or cause us to act in ways that were not necessarily consciously aware of at all times and all that were maybe not actively kind of speaking enough about, or asking enough questions around." (P1)* *"We are in the team, you might have different opinions, but then the decision comes as a team. So, by working together, that is the way to avoid the sense of power or minimize as much as possible. Maybe that is the right term minimize." (P2)* *"Being able to have like paid service user involvement roles" (P1)*

Perspectives on empowerment	Empowerment	*"I think by empowering the institution, I think we are properly using the power we have been given" (P2)* *"I want to help people recognize the power that they do have." (P3)* *"Explore how that might feel for them and explore a little bit around what power they do have within these constraints and restrictions of decisions that they make and what they can kind of have element of control over." (P1)* *"Whether it's true giving power to the to the client. I think it's limited based on the context that we're in, but you can only work with what you have" (P5)* *"I think that offers a level of empowerment to people on probation to think about whether they want to take part in our service or not." (P6)*
	Hope	*"You have to have a belief in the system and the process and that despite all of the empirical evidence that what you're doing has some meaningful impact" (P4).* *"Decisions that are being made at the top. Again, I know that the system is changing. I'm like, thank goodness."* *"I think naming and noticing. Highlighting when they're making very, very, very small steps and incremental steps towards those goals or if you see a little shifts in their behaviour holding that in mind, being able to celebrate that with your immediate or wider team" (P5).* *"Just in terms of encouraging them of progress and kind of making that explicit with them, that actually when they've handled things well, so that there is hope that they can, that things could be different. Like if there if there's this glimmer of hope there or I see it in them, I'll make sure we name it to try and hope that that doesn't get pushed over" (P5).*

	"I think I am in a position as a professional I need to be capable to all the hope for both patient and for three of us, myself, patient and an institution." (P4) *"I really care about it. I'm not doing a service only to my patients and doing the service for the Community too. So, I think I think we need to preserve this institution, make it better but preserve it." (P2)* *"You must have a belief in the system and the process and that despite all of the empirical evidence that what you're doing actually has some meaningful impact" (P4)*
Safety	*"There is a reason why we do that is to prevent them to harm themself, a member of the Community and I strongly believe in it." (P2)* *"And it's not about the health needs, it's about public protection and managing risk. So, there are there are differences in sort of felt power there. The other interesting thing that I kind of notice, certainly within this service." (P4)*

Theory-Driven Research Project

Coping with Stoicism: Understanding Mental Health in Rural Communities

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Date of submission to the course: February 2025

Proposed Journal: The **British Journal of Clinical Psychology** has been selected as it is an internationally recognised journal of research in clinical psychology. The journal's scope includes descriptive comparisons and studies on the assessment, aetiology and treatment of psychological problems across diverse populations and settings. Given the paper's exploration of mental health challenges, coping strategies and stoic beliefs among rural communities, it aligns well with the journal's emphasis on psychological interventions and treatments. In addition, the journal has a relatively high impact factor and is popular with practitioners and academics. Author guidelines are available in Appendix E.

Abstract

Objectives: Mental health challenges are disproportionately prevalent among UK farmers, yet the psychological mechanisms driving this disparity remain poorly understood. Rural areas face unique challenges compared to urban communities: limited access to services, inadequate transportation, social isolation and cultural beliefs inhibiting help-seeking.

Design & Method: This mixed-methods, cross-sectional study explored the role of stoic beliefs and coping styles in shaping mental health outcomes within rural populations, using the Transactional Model of Stress and Coping as a theoretical framework.

Analysis and Results: Data were collected from two occupational groups (farmers and teachers) via an online survey. There were no significant differences in mental health scores between the groups; therefore, data were combined for the main analyses. Hierarchical regression analysis showed that higher stoicism and greater use of avoidant coping were significantly associated with poorer mental health, with medium and large effect sizes, respectively. Mediation analysis indicated that avoidant coping may account for the relationship between stoicism and mental health. The mediation model explained over 50% of the variance in mental health scores, representing a large effect size. These findings highlight the potential role of avoidant coping as a mechanism through which stoic beliefs are linked to mental health outcomes.

Conclusions: Findings emphasise the importance of addressing avoidant-coping strategies in interventions targeting mental health in rural populations. They also highlight a need for context-sensitive mental health interventions focusing on adaptive coping to improve rural populations' wellbeing.

Practitioner Points:

- The study highlighted the importance of understanding cultural nuances in mental health research and service development, whilst providing valuable insights for developing tailored support services for rural communities.
- The findings suggest the need for context-sensitive mental health interventions, particularly for agriculture communities who notably struggle to access support. Intervention needs to account for a tendency for avoidant-coping and stoic beliefs, both of which may inhibit engagement with services.
- Addressing avoidant-coping strategies e.g., overworking, substance use, not sharing difficulties and promoting adaptive coping mechanisms, could improve mental health outcomes for farmers and rural populations.

Key words: Rural Mental Health; Transactional Model of Stress and Coping; Stoicism, Agriculture.

Introduction

Our understanding of mental health and healthcare in the UK has primarily focused on urban populations, leaving a gap in knowledge about how rural communities experience mental health (Murray et al., 2024). While the literature on mental health outcomes in rural areas is mixed, there is some agreement that people in rural regions tend to report poorer health and wellbeing, and increased mental health challenges (Garrett et al., 2019; Geiger et al., 2023; Wheeler et al., 2012, 2015). However, rurality alone does not seem to create these disparities. Instead, factors such as limited access to services, socio-economic disadvantage, cultural practices, lifestyle and hazardous environmental and occupational conditions may contribute to the divide (Murray et al., 2024; Smith et al., 2008). Disparities are often compounded by barriers to accessing mental health care, including attitudes and beliefs about mental distress and help-seeking (Boyd et al., 2008; Laird et al., 2014; Murray et al., 2008).

As compared to the general population, a rural group that is known to face increased mental health challenges are farmers (Hounsome et al., 2012; Sturgeon & Morrissette, 2010). Farmers face daily stressors such as economic challenges, policy changes, poor weather, animal health issues and interpersonal conflicts (Daghagh Yazd et al., 2019; Hovey & Seligman, n.d.; Lunner Kolstrup et al., 2013; Proctor & Hopkins, 2023). These stressors contribute to poor physical, and mental health, including anxiety, depression, substance abuse, and suicide (Lobley et al., 2018; Lunner Kolstrup et al., 2013; McShane et al., 2016). Recent reviews indicate that the ongoing impact of COVID-19 has further worsened UK farmers' mental health, with long-lasting consequences expected (Rose et al., 2023). A national survey by the Farm Safety Foundation (FSF., 2023) revealed that 94% of farmers under 40 view poor mental health as the biggest hidden problem in the industry. Despite this, there is a lack of research into the psychological mechanisms behind farmers' emotional distress and strategies for promoting their wellbeing.

A Transactional Model of Stress and Coping

Coping styles significantly influence an individual's psychological and physical responses to stress and its effective management (Shikai et al., 2007). Lazarus and Folkman (1984) described coping as cognitive and behavioural responses used to handle internal and external stressors perceived to exceed personal resources, that subsequently impact one's mental health (Carver & Connor-Smith, 2010; Echemendia et al., 2019).

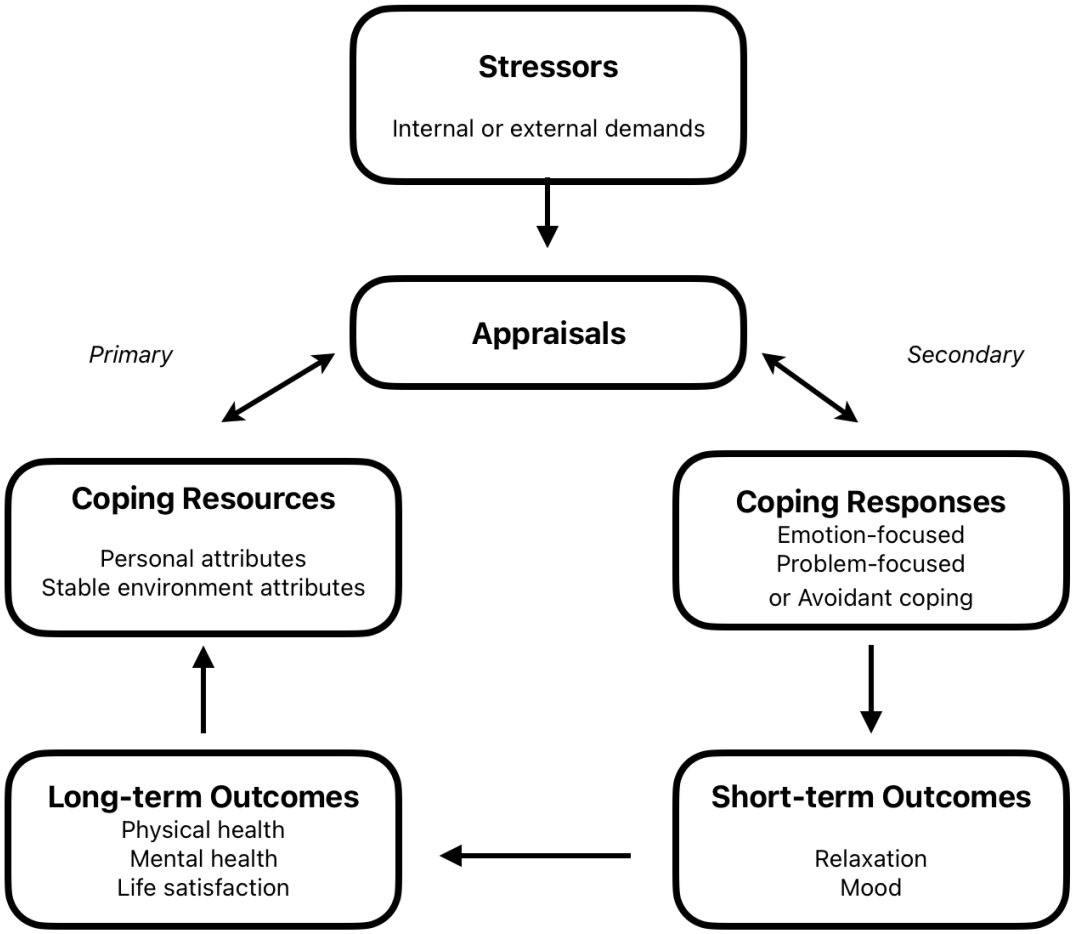
The Transactional Model of Stress and Coping (Lazarus & Folkman, 1984) *(Figure 1)* offers an understanding of how people navigate stressors. The model outlines how one may respond to stressors with cognitive appraisal. A primary appraisal involves the initial assessment of whether a situation poses a threat or not, whilst a secondary appraisal evaluates one's personal resources and coping abilities in response to a stressor. The employable coping strategies fall into two categories: problem-focused coping and emotion-focused coping.

Problem-focused strategies include taking control of the stress through problem-solving e.g., eliminating the source, seeking assistance to manage the situation or removing oneself from the stressor. Whereas, emotion-focused coping managing the psychological response and the associated emotions, as opposed to altering the situation itself. Emotion-focused coping is often used when the stressor is beyond one's control (Carroll, 2020). A third coping style was later introduced; thus, avoiding and/or ignoring the stressor and successive emotional response, termed avoidant-focused coping (Carver, 1997). The model in *Figure 1* has been adapted to include avoidant-focused coping.

Present literature outlines that problem-focused coping is more efficacious in reducing the impact of stressors than emotion-focused or avoidant-focused (Ben-Zur, 2009). Moreover, there is a positive relationship between problem- and emotion-focused coping and

wellbeing, whereas avoidance has been found to often have the opposite effect (MacIntyre et al., 2020).

Figure 1.
Adapted: Transactional Model of Stress and Coping (Carver, 1997; Lazarus & Folkman, 1984).



Stoicism

Stoicism, originating as a Hellenistic philosophy, emphasises control, acceptance and the cultivation of virtues, such as wisdom, courage and temperance (Murray et al., 2008). Over time, its conceptualisation has shifted from philosophical to psychological, manifesting as emotional restraint, endurance and avoidance of help-seeking behaviours (Moore et al., 2013; Wagstaff & Rowledge, 1995). In rural farming communities, particularly among men, stoicism is deeply ingrained, potentially influencing a reluctance to

seek mental health support and contributes to higher suicide rates compared to urban counterparts (Caldwell et al., 2004; Judd et al., 2006). Stoic beliefs may also hinder the recognition of mental health symptoms, preventing help-seeking altogether (Judd et al., 2006; Pinnock et al., 1998).

Farmers are at heightened risk of psycho-social difficulties due to limited social support (Wessel et al., 2020). The solitary nature of farming, especially in older generations, emphasises stoic ideals of self-reliance, further inhibiting help-seeking behaviour (Judd et al., 2006; Moore et al., 2013). While social support is broadly protective (McLaren & Challis, 2009), the interplay of farmers' individual coping mechanisms and their views on self-reliance in relation to social support remains underexplored (Roy et al., 2017). Social norms in tight-knit farming communities often discourage expressions of distress, reinforcing stoic attitudes and avoidant coping (Judd et al., 2006).

Despite potential negative impacts on wellbeing, stoicism fosters positive resilience, dignity and social identity, with psychological benefits such as self-sufficiency and assertiveness (Fuller et al., 2000; Spiers, 2006). Understanding the role of stoic beliefs in mental health could improve our understanding of coping for farming communities. Stoic beliefs may influence coping strategies that are often more action-oriented than communicative (Robertson, 2007), with a preference for problem-focused coping over emotion-focused strategies. In line with the Transactional Model of Stress and Coping (Lazarus & Folkman, 1984(Lazarus & Folkman, 1984), stoicism can promote positive coping when it facilitates appraisals of challenges as manageable, leading to constructive stress responses (Folkman, 2008). However, the high prevalence of avoidant coping and poor mental health in farmers suggests stoic beliefs may also contribute to maladaptive coping, such as substance abuse and social isolation (Alston, 2012; Sturgeon & Morrissette, 2010).

Research on stoicism and coping in agriculture has often conflated stoic beliefs with behaviours that reflect avoidant coping (Murray et al., 2008). Thus, it is pivotal to differentiate between stoic beliefs and coping strategies to better understand their effects on mental health. Much of the existing literature focuses on international samples, and research specifically exploring the impact of stoic beliefs on UK farmers is limited. Farmers in the UK experience distinct stressors e.g., post-Brexit changes to policy and subsidies impacting financial viabilities (Ojo et al., 2021; Rose et al., 2023). Subsequently understanding the relationship between stoic beliefs, avoidant coping and mental health seems key, with careful consideration of gender and age factors.

Social Support

Social support is acknowledged within Transactional Model of Stress and Coping (Lazarus & Folkman, 1984), as a critical external resource assessed during secondary appraisal, influencing how individuals perceive and respond to stress. It can buffer the psychological impact of stressors by enhancing perceived coping capacity and reducing emotional distress (Biggs et al., 2017). This buffering effect is particularly relevant in rural contexts, where isolation and cultural norms around self-reliance may limit access to emotional support. Empirical extensions of the model further emphasise the moderating role of social resources in shaping coping outcomes and adaptation (Wethington et al., 2015). For farmers, social support, particularly from family and friends, is known to mitigate and prevent depressive symptoms (Bjornestad et al., 2019). Thus, the inclusion of social support in the present study allows for a more nuanced exploration of how interpersonal factors interact with stoic beliefs and coping styles to influence mental health in rural populations when considering isolation.

Aims

This study aims to explore how stoicism and coping strategies influence mental health outcomes in rural populations. It remains unclear whether the mental health challenges faced by farmers are specific to the occupation or represent broader cultural phenomena within rural communities.

The study compares mental health, stoic beliefs and coping styles between farmers and teachers. Teachers are another occupational group facing similar stressors beyond their control. Like farmers, teachers face stressors from frequent policy changes (Harding et al., 2019; Kidger et al., 2016) and are at increased risk of poor mental health, with the COVID-19 pandemic further exacerbating these challenges (Jerrim et al., 2021; Kim & Asbury, 2020). Teachers in rural communities were chosen as a comparison group to account for shared environmental factors, such as isolation, access to services and cultural norms (Batterham et al., 2022; McLoughlin et al., 2015). Research suggests teachers utilise both emotion- and problem-focused coping, with social support playing a key role in mental health, while avoidant coping is associated with negative outcomes (Austin et al., 2005; Kim & Asbury, 2020).

The study investigates whether mental health differs between farmers and teachers, and how stoicism and coping strategies, particularly avoidant coping, affect mental health outcomes in both groups. The hypotheses were as follows:

Primary hypotheses:

a) Higher levels of stoicism and greater use of avoidant coping strategies will be associated with more severe mental health symptoms.

b) Higher levels of social support will mitigate the negative impact of stoicism and avoidant coping on mental health outcomes.

Secondary hypotheses:

H2:

Farmers will demonstrate significantly lower mental health scores compared to rural teachers.

H3:

Farmers will exhibit a higher level of stoicism compared to rural teachers.

H4:

Avoidant coping strategies will mediate the relationship between stoicism and mental health, such that higher stoicism will be associated with greater use of avoidant coping, which in turn will be associated with poorer mental health outcomes.

Exploratory:

The strength of these effects will vary between farmers and teachers. Farmers will show stronger associations between stoicism, avoidant coping and mental health, whilst the association will be less prominent for teachers.

Methods

Design:

A cross-sectional within and between-groups design, utilising a mixed methods online survey.

Participants:

Participants self-identified their occupational group. For the farmer group, participants were engaged in professional farming activities i.e., a person working full or part time on a farm, working in the agricultural industry, identifies as a farmer and lives in a rural area. The comparison group were teachers (i.e., full or part time qualified teachers) living in a rural area. Rurality was operationalised using the UK Government's Rural Urban Classification, which defines rural areas as settlements with fewer than 10,000 residents,

based on Census Output Areas (Department for Environment, 2021). Participants were over 18 years old, computer literate, able to read and understand English and residing in the UK.

A G*Power analysis revealed a total sample size of 68 participants for the hierarchical regression, 77 for the mediation analysis and 128 for the t-test, based on the assumption of a medium effect size related to stoicism and coping and 80% power. There is no published research indicating the effect size in studies of stoicism, coping and mental health; therefore, a medium effect size was used. 105 participants were recruited in total (Farmers: 49 vs. Teachers 56).

Recruitment:

Participants were recruited via voluntary response sampling, approached through social media (Instagram & Facebook), charities and third sector organisations (Young Farmer's organisations, mental health charities and agricultural organisations). Snowball sampling was also adopted; information sharing was widely encouraged to reach isolated participants. No compensation was offered for participation.

Procedure and measures:

The survey included several psychometric measures, all of which are detailed in *Table 2*, alongside a qualitative element comprised of open-ended questions for the farmers group to explore nuances not captured by questionnaires. The design and materials were reviewed by three experts-by-experience from the agricultural and education sectors. Feedback was positive and involved additional ideas for recruitment, including targeted Facebook groups and organisations to contact. Ethical approval was gained from the Central University of Oxford Research Ethics Committee (R93567/RE001) (*Appendix D*).

Materials were distributed online and via posters utilising a QR code and link. Following confirmation of eligibility and informed consent, participants completed the survey via Qualtrics, beginning with a demographics form, then questionnaires and

qualitative questions in the order shown in *Table 1*, ending with a debrief. Qualitative questions are outlined in *S.I.1*. Signposting to support was available throughout the survey.

Table 1.
Measures Used in the Study

Measure	Purpose	Scoring method	Validity
Demographics	Collects participant information: age, gender, ethnicity, relationship status, education, additional employment, socioeconomic status (approximate annual income), and role (principal farmer/business manager or head/deputy head teacher).	Not applicable.	Not applicable.
Pathak-Wieten Stoicism Ideology Scale (PWSIS)	Assesses stoic beliefs across four components: Endurance, Taciturnity, Serenity, and Death acceptance.	Each of the 12 items is rated on a Likert scale; higher scores indicate stronger endorsement of stoic beliefs. A total score for stoicism is generated from summed scores, high score suggests high endorsement of stoic ideology.	The PWSIS has shown acceptable reliability and validity in predicting wellbeing outcomes with α ranging from 0.55 to 0.90 (Karl et al., 2022).(Karl et al., 2022).
Depression Anxiety Stress Scales (DASS-21)	Measures the severity of depression, anxiety, and stress symptoms.	Consists of 21 items each rated on a 4-point scale. Scores for each subscale (Depression, Anxiety, Stress) are summed to provide a total mental health score, higher scores indicate poorer mental health.	The DASS is a valid tool that provides a comprehensive measure of mental health symptom severity (Akin & Çetin, 2007) and shows adequate internal consistency reliability (Shea et al., 2009).
Brief COPE	Evaluates coping strategies across problem-focused,	Contains 28 items, each rated on a 4-point scale. Scores are	This brief COPE draws upon the Stress and Coping model (Lazarus

Measure	Purpose	Scoring method	Validity
	emotion-focused, and avoidant coping styles.	averaged for each of the 3 subscales, reflecting the extent of use of specific coping strategies.	& Folkman, 1984), and is a widely recognised and extensively validated measure (García et al., 2018).
Short Lubben Social Network Scale (LSNS-6)	Measures social engagement with family and friends to assess social isolation.	Comprises 6 items, each scored from 0 to 5. The total score ranges from 0 to 30; higher scores indicate greater social engagement.	The LSNS-6 is a valid and reliable scale, it has been shown to have good internal consistency intergenerationally (Lubben et al., 2006; Villas-Boas et al., 2018)
Open-ended Qualitative Questions	Explores subjective experiences of stress management and mental health (for farmers only).	Responses are analysed qualitatively.	Not applicable.

Analysis:

Statistical analysis was conducted using SPSS version 29. Initial t-tests compared groups on mental health, stoicism, and social support. A four-block hierarchical regression analysis was performed to examine associations between demographic, psychological, and social variables and mental health scores. To examine the associations between psychological and demographic variables and mental health symptom severity, a four-block hierarchical regression was conducted. Each block introduced variables in a theoretically driven sequence to assess their incremental contribution to the variance in mental health scores:

- Block 1: Demographic Variables

  This block included age, gender, and occupational group (farmer vs. teacher). These were entered first to account for basic individual differences and assess whether demographic factors were associated with mental health outcomes.

- Block 2: Stoicism (PWSIS Total Score)

  The second block added the total score from the Pathak-Wieten Stoicism Ideology Scale to explore whether stoic beliefs were associated with mental health symptoms beyond demographic factors.

- Block 3: Coping Styles (Brief COPE Subscales)

  This block introduced three coping styles: problem-focused, emotion-focused, and avoidant coping to assess their associations with mental health and whether they accounted for additional variance beyond stoicism.

- Block 4: Social Support (LSNS-6 Score)

  The final block added social support scores to explore whether perceived social engagement was associated with mental health outcomes and whether it contributed additional explanatory value.

Mediation analysis was used to assess whether coping styles mediated the relationship between stoicism and mental health. Additionally, an exploratory moderation analysis was conducted to evaluate whether the mediation effects varied between occupational groups. To explore whether the indirect effect of stoicism on mental health via avoidant coping differed between occupational groups (farmers vs. teachers), a moderated mediation analysis was conducted using Hayes' PROCESS macro for SPSS (Model 7). This model allows for the testing of conditional indirect effects, where the strength of the mediation pathway is moderated by a categorical variable. Bootstrapping with 5,000 samples was used to generate bias-corrected confidence intervals for the indirect effects. The index of moderated mediation was examined to determine whether the mediation effect significantly varied between groups.

For the qualitative data, a content analysis was performed to identify key ideas from optional contributions made by farmers (Neuendorf, 2016). Due to the limited volume of

qualitative responses, the data was insufficient for a full thematic analysis. Instead, content analysis served as a supplementary exploratory approach to complement the quantitative findings.

Results

Brief descriptive statistics were performed on the demographics (*Table 2*), as described above.

Table 2.
Table of participant demographics (N = 105)

Demographic	Total sample	Farmer (46%, n=49)	Teacher (54%, n=58)
Age	18 – 70 (mean age 39.5, SD = 13.1)	18-70 (mean age 39, SD = 15)	22-62 (mean age 40, SD = 11.24)
Gender	Male 36% (n=38) Female 63% (n=68) Prefer not to say 1% (n=1)	Male 47% (n=23) Female 53% (n=26) Prefer not to say 0% (n=0)	Male 26% (n=15) Female 72% (n=42) Prefer not to say 2% (n=1)
Additional employment	Yes 32% (n=34) No 68% (n=73)	Yes 47% (n= 23) No 53% (n=26)	Yes 19% (n=11) No 81% (n=47)
Educational attainment	Secondary school 8% (n=9) College 20% (n=21) Undergraduate 43% (n=46) Post-graduate 29% (n=31)	Secondary school 18% (n=9) College 39% (n=19) Undergraduate 37% (n=18) Post-graduate 6% (n=3)	Secondary school 0% (n=0) College 3% (n=2) Undergraduate 48% (n=28) Post-graduate 48% (n=28)
Civic status	Married 53% (n=57) Living as a couple 21.5% (n=23)	Married 53% (n=26) Living as a couple 16% (n=8)	Married 53% (n=31) Living as a couple 25% (n=15)

Demographic	Total sample	Farmer (46%, n=49)	Teacher (54%, n=58)
	Divorced / Separated 4% (n=4) Single 20% (n=21) Widowed 1% (n=1) Other 1%(n=1)	Divorced / Separated 4% (n=2) Single 22% (n=11) Widowed 2% (n=1) Other 2% (n=1)	Divorced / Separated 3% (n=2) Single 17% (n=10) Widowed 0% (n=0) Other 0% (n=0)
Currently taking medication for MH	Yes 10% (n=11) No 90% (n=96)	Yes 6% (n=3) No 94% (n=46)	Yes 14% (n=8) No 86% (n=50)
Past professional support for MH	Yes 34% (n=36) No 66% (n=71)	Yes 31% (n=15) No 69% (n=34)	Yes 36% (n=21) No 64% (n=37)
Currently receive professional support for MH	Yes 6% (n=6) No 94% (n=101)	Yes 2% (n=1) No 98% (n=48)	Yes 9% (n=5) 91% (n=53)

Primary Hypothesis

A 4-block hierarchical multiple regression was conducted to evaluate whether the inclusion of demographic factors, coping strategies, stoicism, and social support significantly enhanced their association with mental health symptom severity (See *Table 3*). Prior to running the regression, tests for normality alongside other assumption-based tests were checked, all assumptions were satisfied.

In Block 1, the demographic factors (occupation, age, and gender) were not significantly associated with mental health scores, F (3,110) =0.896, p=.446, R^2= .024. None of the individual variables were significantly associated with DASS scores.

The addition of PWSIS total score to Block 2 led to a statistically significant increase in the variance F (1,109) =15.511 p<.001, R^2 of 0.145 (adjusted R^2 = 0.114), with levels of Stoicism accounting for 15.5% of the variance of the model.

The inclusion of coping styles in Block 3 significantly improved the model, F (3,106) =28.367 p<.001, R2=.526 (adjusted R2 = 0.495). Coping styles collectively explained an additional 52.6% of the variance in mental health, representing a large effect size. Specifically, avoidant coping (β=0.455, t (106) =5.571 p<.001) and emotion-focused coping (β=0.383, t (106) =3.990, p<.001) had significant positive effects, while problem-focused coping had a significant negative effect on DASS scores (β=−0.221, t(106) =−2.590, p=.011). Although stoicism initially remained significantly associated with mental health outcomes in Block 3 (β=0.240, t=0.159, p=.031), its effect became reduced when accounting for all other variables. This suggests that stoicism was less significantly associated with mental health once coping styles were included in the model, indicating that coping styles may account for part of the relationship between stoicism and mental health outcomes. A formal mediation analysis would be required to explore this further. The final addition of social support in Block 4 resulted in a minor increment which was not statistically significant, F (1,105) =1.407, p=.238, R2= .532. Social support was not significantly associated (β=−0.088, t (105) =−1.186). In Block 4, stoicism's effect became non-significant (β=0.132, p=.085) when social support is added, indicating additional shared variance between stoicism, coping styles and social support.

Table 3.

Hierarchical Regression Results for Mental Health (DASS scores) (N = 105).

Variable	B	95% CI		SE	β	R^2	Δ R^2
		LL	UL				
Block 1							
Constant	15.36	3.61	27.1	5.93		0.24	
Age	-0.01	-0.19	0.17	0.92	-0.10		
Gender	3.8	-0.97	8.56	2.4	0.15		
Profession	0.1	-3.73	3.93	1.93	0.01		
Block 2							
Constant	-7.25	-23.11	8.61	8		0.15	0.12
Age	0.02	-0.153	0.19	0.1	0.19		
Gender	3.98	-0.504	8.46	2.26	0.16		
Profession	1.45	-2.21	5.12	1.85	0.73		
Stoicism (PWSIS)	**0.539**	0.27	0.81	0.124	**0.36**		
Block 3							
Constant	-27.5	-41.54	-13.44	7.1		0.53	0.38
Age	0.06	-0.08	0.19	0.05	0.06		
Gender	2.17	-1.25	5.6	1.73	0.09		
Profession	1.5	-1.4	4.32	1.44	0.07		
Stoicism (PWSIS)	**0.24**	0.02	0.46	0.11	**0.16**		
Problem-focused coping	**-3.99**	-7.04	-0.94	1.54	**-0.22**		
Emotion-focused coping	**9.85**	4.95	14.74	2.47	**0.38**		
Avoidant coping	**11.97**	7.71	16.23	2.15	**0.46**		
Block 4							
Constant	-19.22	-38.92	-.48	9.934		0.53	0.01
Age	0.053	-0.08	0.19	0.068	0.054		
Gender	1.992	-1.44	5.42	1.728	0.080		
Profession	1.382	-1.48	4.24	1.441	0.069		
Stoicism (PWSIS)	0.200	0.03	0.43	0.115	0.132		

Variable	B	95% CI		SE	β	R^2	Δ R^2
Problem-focused coping	**-3.943**	-6.99	-0.9	1.536	**-0.219**		
Emotion-focused coping	**10.037**	5.14	14.93	2.468	**0.390**		
Avoidant coping	**11.331**	6.95	15.71	2.210	**0.430**		
Social support (LSNS-6 score)	-0.120	-0.32	0.08	0.101	-0.088		

Moreover, a minimally adjusted linear regression was conducted to examine the relationship between social support and mental health, controlling for age, gender, and profession. Social support was significantly associated with lower DASS scores (B = −0.341, p = .012, 95% CI [−0.607, −0.076]), indicating that greater social support is linked to better mental health outcomes. None of the covariates were significant (See Table 4).

Table 4.
Minimally adjusted Hierarchical Regression Results for Mental Health (DASS scores) (N = 105).

Variable	B	95% CI		SE	β	R^2	Δ R^2
		LL	UL				
Block 1							
Constant	29.011	11.77	46.25	8.69		0.08	0.04
Social Support	**-0.34**	-0.61	-0.08	0.13	**-0.26**		
Age	0.054	-0.19	0.17	0.09	0.06		
Gender	2.48	-2.71	7.66	2.61	0.1		
Profession	1.85	-3.17	6.86	2.52	0.01		

Therefore, part a) of the primary hypothesis can be accepted. The analysis revealed that while stoicism was initially associated with poorer mental health outcomes, its effect was less significant once coping styles were accounted for, suggesting a mediating role of coping. Social support did not significantly mitigate the negative impact of stoicism and avoidant coping in the full model, and thus part b) of the primary hypothesis was not supported.

However, a minimally adjusted model indicated that social support may still play a protective role, warranting further investigation.

Secondary hypotheses: H2 and H3

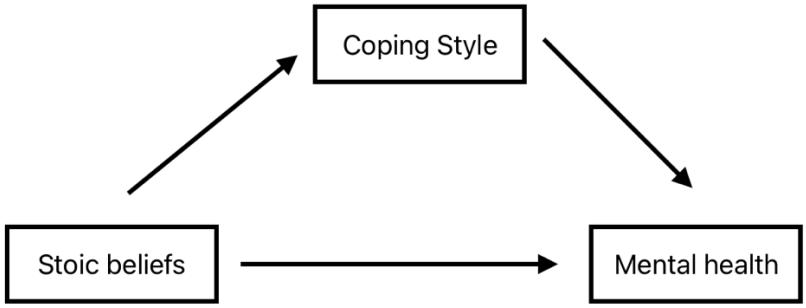
An independent t-test revealed no significant differences in mental health scores between farmers and teachers, $t(103) = -0.620$, $p = .54$. Farmers had a mean DASSTotal score of 20.55 ($SD = 13.58$), while teachers had a mean of 22.16 ($SD = 13.01$). Although this difference was not statistically significant, the medium effect size (*Cohen's d* = −0.12) suggests a potentially meaningful difference that may have been obscured by limited statistical power. Notably, over 60% of participants scored above the clinical threshold for mental health difficulties, with 34% falling in the severe to extremely severe range.

In contrast, a significant difference was found in stoicism scores, $t(105) = 3.191$, $p < .001$. Farmers had a mean stoicism score of 37.90 ($SD = 8.62$), while teachers had a mean of 32.67 ($SD = 8.29$). This difference was supported by a very large effect size (*Cohen's d* = 1.59), indicating a substantial divergence in stoic beliefs between the two groups.H2 was not accepted, mental health scores do not differ significantly between groups. Conversely, H3 was accepted, farmers exhibit significantly higher levels of stoicism as compared to rural teachers.

Hypothesis 4:

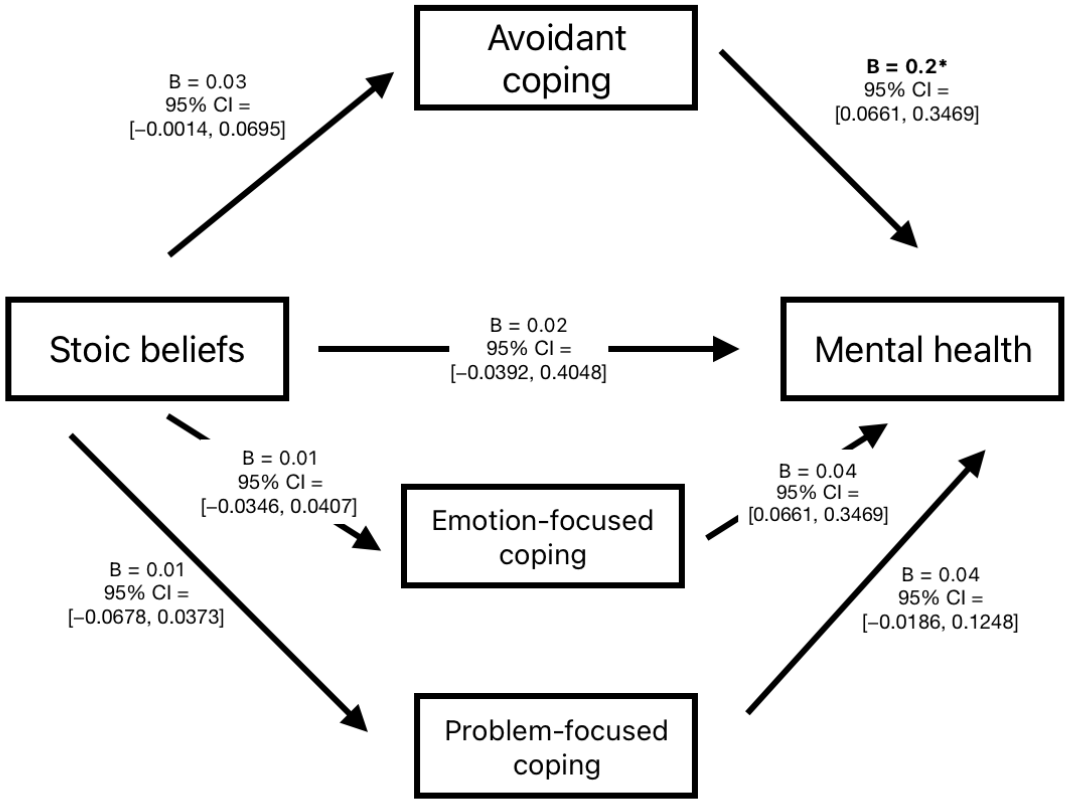
A mediation analysis was conducted to explore whether avoidant coping, emotion-focused coping and problem-focused coping mediated the relationship between stoicism and mental health (See *Figure 2).* With the addition of the exploratory hypothesis considering whether the strengths of these effects differ between groups.

Figure 2.
Mediation Model.



The total effect of stoicism on mental health was significant, B = 0.4899, SE = 0.1325, p =.0003, 95% CI [0.2274, 0.7524]. The bootstrap analysis was based on 5,000 samples, ensuring robust estimates of the indirect effects. When the mediators (avoidant coping, emotion-focused coping, and problem-focused coping) were included in the mediation model, the direct effect of stoicism on mental health was became less significant, B = 0.2013, SE = 0.1073, p = .0632, 95% CI [−0.0113, 0.4139]. Avoidant coping significantly mediated the relationship, B = 0.2025, BootSE = 0.0718, 95% CI [0.0661, 0.3469], while emotion-focused coping (B = 0.0433, BootSE = 0.0591, 95% CI [−0.0759, 0.1628]) and problem-focused coping (B = 0.0428, BootSE = 0.0363, 95% CI [−0.0186, 0.1248]) did not significantly mediate the relationship (See Figure 3).

Figure 3.
Multiple mediation models. Mediation coefficient effect scores are outlined per model (N = 105).



The model explained 50.42% of the variance in mental health, $R^2 = .5042$, $F(4, 112) = 28.48$, $p < .001$. These results suggest that avoidant coping mediates the effect of stoicism on mental health. However, the absence of significant mediation effects for emotion-focused and problem-focused coping suggests that avoidant coping is the primary mechanism through which stoicism influences mental health.

Given the statistically significant difference in stoicism between farmers vs. rural teachers, an exploratory moderated mediation analysis was conducted to explore whether the mediation differs between groups. The analysis followed Hayes' (2018) Model 7 using the

PROCESS macro for SPSS. The overall model examining associations with mental health was statistically significant (R^2 = .5145, $F(4, 100) = 26.50$, $p < .05$). Stoicism was indirectly associated with mental health through avoidant coping, suggesting a potential mediating pathway. The indirect effect of stoicism on mental health via avoidant coping was significant for the farmer group (β =.2781, 95%CI [0.0529,0.4902]) but not for teachers (β =.1332, 95%CI [−0.0294,0.3302]). The index of moderated mediation was −0.1448 with a 95% confidence interval of [−0.3893,0.1385]. Since the confidence interval includes zero, the result is not statistically significant, suggesting that the difference in the indirect effect across vocational groups is not statistically meaningful. Nonetheless, both H4 and the exploratory hypothesis were accepted. Avoidant coping mediated the relationship between stoicism and mental health. Higher stoicism is associated with avoidant coping and poorer mental health. Finally, the strength of this effect did vary between farmers and teachers, the relationship was less significant for teachers.

Content Analysis

Qualitative questions were optional for the farmer group; on average, 53.3% of farmers completed qualitative questions. *Table 5* demonstrates the common categories and sub-categories, in addition to frequency of emergence from participant responses.

Responses echo some of the quantitative findings; examples of avoidant coping and stoic attitudes are widely discussed. Despite some responses suggesting the functionality of avoidance and the association between stoicism and essential resilience, there is an acknowledgement that avoiding problems is not always adaptive beyond the short-term relief they provide. Stigma was not directly measured in the study but emerged in the open-text questions as seen in Table 5. Social support is considered an important factor for wellbeing and more opportunities for socialising is suggested as something that would benefit the community moving forwards. Moreover, improved government and financial support were

noted, in addition to tailored mental health resources e.g., better access to rural mental health professionals and improving GP services with mental health units would also improve rural mental health.

Table 5.
Content Analysis, including emergence and frequencies of responses and supporting quotes from participants (N = 49 farmers; 53.3% responded to qualitative questions).

Categories	Sub-categories	Total responses	Quote
Stigma	Silence; Weakness; Inhibits talking about emotions	5	*It's like the men will explain the issue and brush it off almost immediately and change the subject, but you can see its still on their mind but too embarrassed to admit they have an issue, let alone it affecting their mental health.* *mental health and emotional distress is seen as a weakness*
Avoidance	Maladaptive coping; Overworking; Alcohol use; Not talking	15	*I feel that many farmers (especially older men) will turn to alcohol and occasionally turn against those closest to them in an effort to shield these people from the pain they are feeling.*
Mixed views on stoicism	Conditional benefits; Cultural reflection; Challenge severity; Uncertainty	16	*no matter the challenges or difficulties ahead within agriculture you've got to get on with it…Is it always helpful I'm unsure as it then builds up a lot of possibly negative emotions within you.*
Resilience	Positive impact of stoic beliefs; Keep going; Facilitates good work ethic	13	*It's better than sitting round crying. We can't take time off so just have to get on with it*

Categories	Sub-categories	Total responses	Quote
Age	Generational differences; Openness	2	*The young are more open than the older people*
Awareness	Support charities; Raising awareness	5	*Charities like DPJ and Tir Dewi are doing great work in raising awareness.*
Social support	Communication; Listening and sharing; Community engagement; Openness	12	*Often, communicating about one's mental health will generally have the best outcomes in the long term.* *It would be great to have a social club similar to YFC but for older people*
External / specialist support	Government financial support; Tailored mental health support; Specialist resources	7	*I believe that rural GPs need to be equipped with better mental health support units and resources so that farmers do not have to go as far and wait as long* *limited access to rural therapists, etc. Which many older farmers would probably perceive as some sort of witchcraft. Stopping declining rural populations would benefit many I feel.* *Sort the government out to support us and not try to get rid of British Ag.*

Discussion

The findings provide a nuanced perspective on the role of stoicism and coping strategies on mental health in a rural context. Thus, countering existing frameworks such as the Transactional Model of Stress and Coping (Lazarus & Folkman, 1984). Both occupational groups demonstrated heightened mental health scores, with over half being above clinical threshold. This may be representative of the significant psychological

challenges rural areas experience. While demographic factors (age, gender and profession) were not significantly associated with mental health difficulties; stoicism explained part of the variance in mental health scores, indicating its meaningful influence on psychological well-being for this population. The most substantial contribution came from coping strategies, which accounted for over half the variance. Avoidant and emotion-focused coping were significantly positively associated with mental health difficulties, while problem-focused coping had a significant negative effect, emphasising the critical role of stress management strategies.

While emotion-focused coping is often considered adaptive when stressors are uncontrollable, for these groups it was positively associated with the presence of mental health difficulties. This unexpected and counterintuitive finding may reflect the contextual limitations of such strategies in rural environments. In communities where stoicism and self-reliance are culturally reinforced, emotional expression may be discouraged or stigmatised, reducing the effectiveness of emotion-focused coping (Hays, 2001; Heppner et al., 2014). Individuals who attempt to engage in these strategies may experience frustration or isolation, particularly if their efforts are met with silence or disapproval.

Mediation analysis revealed that stoicism was significantly associated with avoidant coping, which in turn was also associated with a presence of mental health symptoms, suggesting coping as a mediating variable in the relationship between stoicism and mental health. People who are stoic are more likely to cope with stress by avoiding their problems. This relationship is significant in the farmer group but not for teachers, highlighting potential occupational differences. Nonetheless, occupation did not significantly moderate the overall mediated relationship between stoicism, avoidant coping and mental health. In contrast, stoicism was not associated with emotion-focused or problem-focused coping, nor were these styles significant mediators. Social support, while included in the model, did not significantly

enhance the association of mental health outcomes. Nonetheless, while the primary hypothesis was not supported in the fully adjusted model, the minimally adjusted analysis revealed a significant association between social support and mental health. This suggests that social support may play a protective role, and its effect may have been obscured by overfitting in the full model. Future research should consider model parsimony to better isolate the effects of key variables.

Findings regarding the high levels of stoicism in the farming community are in line with existing literature (Hull et al., 2017; Vayro et al., 2020) and its association with poor mental health, substance abuse and suicidal tendencies (Alston, 2012; Garnham & Bryant, 2014; Cambell et al., 2006; Hawton et al., 1998; Sturgeon & Morrissette, 2010; Wessel et al., 2020). Results outline the associative impact of avoidant and emotion-focused coping is also representative of previous literature. Moreover, the findings echo literature suggesting that problem-focused coping predicts wellbeing; thus problem-focused coping was associated with better mental health scores (Ben-Zur, 2009; MacIntyre et al., 2020). Qualitative responses suggest some positive impacts of stoicism, such as resilience and self-reliance reiterating early findings by Fuller et al (2000) and Gerrard et al (2004).

The significant mediation effect of avoidant coping in the relationship between stoicism and mental health denotes how stoicism, when leading to disengagement from stressors, can exacerbate mental health symptoms. The Transactional Model emphasises that adopting a challenge appraisal and engaging in problem-focused coping, can lead to positive outcomes by leveraging controllable factors and resources (Folkman, 2008; Ohayon & Flanagan, 2019). The findings are consistent with the model in terms of problem-focused coping being positively associated with mental health, though avoidant coping emerged as the dominant strategy in this rural context. This discrepancy suggests that for this community, structural or cultural barriers may reinforce avoidance, contributing to poor mental health

outcomes. These findings challenge the assumption that stoicism universally promotes adaptive coping and highlights the importance of addressing the broader environmental and social factors that shape coping strategies in rural populations.

Similarly, whilst the quantitative results do not totally emulate previous findings that social support mitigate against poor mental health and stress, qualitative responses highlight its vital role (McLaren & Challis, 2009; Roy et al., 2017) as represented in the minimally adjusted analysis. Thus, there may be nuance in how the social support is important. Judd and colleagues (2006) noted that maintaining a stoic attitude is expected in social interaction among farmers, suggesting that socialising within their communities could have adverse effects if they are unable to openly share the challenges they face. The LSNS-6 explores the amount of social engagement with friends and family, as opposed to the nature and openness of the discussions, which might be an important area to focus future research.

Although the primary focus of this study was on farmers, the findings revealed that rural teachers also reported elevated mental health symptoms, with over half scoring above the clinical threshold on the DASS. This suggests that poor mental health outcomes may not be exclusive to agricultural occupations but could reflect broader challenges faced by rural professionals. Teachers in rural areas may experience similar stressors, such as isolation, limited access to services, and policy-driven pressures, which may contribute to emotional distress. Despite lower stoicism scores compared to farmers, the high levels of distress among teachers indicate that other mechanisms such as occupational burnout, systemic pressures or lack of tailored support may be at play. Future research should explore these factors in more depth to better understand and address the mental health needs of rural educators.

Limitations

Firstly, the use of self-report measures may introduce response bias. The sample, recruited primarily via social media, may not be representative of the broader rural

population, potentially favouring more digitally literate or help-seeking individuals. The study was underpowered for some analyses, particularly group comparisons, which limits the confidence in non-significant findings.

Measurement limitations include the use of the LSNS-6, which may not fully capture the emotional quality or openness of social support, and the Brief COPE, which does not account for the interaction of multiple coping styles. Similarly, the inclusion of multiple covariates may have led to overfitting; a simpler model showed that social support was significantly associated with mental health when adjusting only for age, gender, and profession. Additionally, the internal reliability of the stoicism scale (PWSIS) was not assessed in this sample. Finally, the cross-sectional design precludes causal inference, limiting conclusions about the directionality of observed relationships.

Future directions

Future research should employ longitudinal designs to examine how stoicism and coping strategies influence mental health over time, particularly in rural populations. This would help clarify the directionality of effects observed in this study. Given the unforeseen finding that emotion-focused coping was linked to greater distress, future work should explore how cultural norms, stigma and the quality of social support moderate the effectiveness of different coping styles in rural contexts. Additionally, while stoicism emerged as a key factor among farmers, it was less relevant for teachers, despite similarly high levels of distress. This suggests that other mechanisms may be at play in rural teachers' mental health, warranting further investigation into alternative psychological or occupational stressors. Finally, future studies should refine the measurement of social support to better capture its emotional quality and openness, particularly in communities where stoicism may inhibit help-seeking. These insights could inform the development of culturally sensitive

interventions that promote adaptive coping and reduce reliance on avoidance in rural mental health care.

Conclusions

This study enhances understanding of rural mental health by examining how stoicism and coping styles influence the mental health of farmers and teachers. While stoicism was not directly associated with mental health outcomes, it was associated with greater use of avoidant coping, which in turn was associated with higher distress. This mediating relationship was consistent across both groups, despite farmers reporting significantly higher stoicism. The unexpected link between emotion-focused coping and poorer mental health suggests that such strategies may be less effective in rural contexts where emotional expression is culturally constrained. These findings highlight the need for culturally sensitive interventions that promote adaptive coping and reduce reliance on avoidance. Future research should explore these dynamics longitudinally and investigate alternative mechanisms of distress, particularly among rural teachers.

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Supplementary Information (S.I)

S.I.1: Qualitative questions

1. What ideas or beliefs do you perceive the farming community to hold regarding mental health and emotional distress?

2. What do you believe to be the most common strategies you or others use to cope with the pressures and stressors of farming life?

3. Do you perceive any of the above to have a helpful or unhelpful impact on mental health over time?

4. *Stoicism is the practice of maintaining emotional control, facing challenges without complaint, and facing adversity with a quiet strength and lack of outward emotional expression.*
Do you think this is a helpful or unhelpful way of approaching challenges within the farming community, and why?

5. Would your beliefs about the helpfulness of stoicism change depending on the circumstances or situation? If yes, how?

6. What recommendations do you have for improving mental health support within the agricultural sector?

S.I.2: **Multicollinearity Check**

To assess multicollinearity among variables in the regression model, a Pearson correlation matrix was examined. All inter-variable correlations were below .80, with the highest being .591 between problem-focused and emotion-focused coping. This suggests that multicollinearity was not a significant concern in the model. Therefore, the inclusion of multiple covariates did not distort the regression estimates.

S.I.3 Correlation table

Variable	*DASSTotal*	*How old are you?*	*Gender*	*What is your primary profession?*	*StoicismTotal*	*Problem*	*Emotion*	*Avoidant*	*Social support*
DASSTotal	1.000	-0.007 (p = 0.470)	0.154 (p = 0.051)	0.041 (p = 0.334)	0.331 (p = 0.000)	0.094 (p = 0.159)	0.496 (p = 0.000)	0.634 (p = 0.000)	-0.313 (p = 0.000)
How old are you?	-0.007 (p = 0.470)	1.000	0.017 (p = 0.431)	-0.009 (p = 0.462)	-0.079 (p = 0.202)	-0.177 (p = 0.030)	-0.207 (p = 0.014)	-0.033 (p = 0.364)	-0.050 (p = 0.299)
Gender	0.154 (p = 0.051)	0.017 (p = 0.431)	1.000	0.233 (p = 0.006)	-0.066 (p = 0.244)	0.135 (p = 0.076)	0.148 (p = 0.058)	0.071 (p = 0.227)	-0.076 (p = 0.210)
What is your primary profession?	0.041 (p = 0.334)	-0.009 (p = 0.462)	0.233 (p = 0.006)	1.000	-0.194 (p = 0.019)	0.153 (p = 0.053)	0.171 (p = 0.035)	-0.117 (p = 0.108)	0.046 (p = 0.314)
StoicismTotal	0.331 (p = 0.000)	-0.079 (p = 0.202)	-0.066 (p = 0.244)	-0.194 (p = 0.019)	1.000	-0.123 (p = 0.095)	0.086 (p = 0.180)	0.299 (p = 0.001)	-0.361 (p = 0.000)
Problem	0.094 (p = 0.159)	-0.177 (p = 0.030)	0.135 (p = 0.076)	0.153 (p = 0.053)	-0.123 (p = 0.095)	1.000	0.591 (p = 0.000)	0.212 (p = 0.012)	0.048 (p = 0.305)
Emotion	0.496 (p = 0.000)	-0.207 (p = 0.014)	0.148 (p = 0.058)	0.171 (p = 0.035)	0.086 (p = 0.180)	0.591 (p = 0.000)	1.000	0.478 (p = 0.000)	-0.064 (p = 0.249)

Avoidant	0.634 (p = 0.000)	-0.033 (p = 0.364)	0.071 (p = 0.227)	-0.117 (p = 0.108)	0.299 (p = 0.001)	0.212 (p = 0.012)	0.478 (p = 0.000)	1.000	-0.316 (p = 0.000)
Social support	-0.313 (p = 0.000)	-0.050 (p = 0.299)	-0.076 (p = 0.210)	0.046 (p = 0.314)	-0.361 (p = 0.000)	0.048 (p = 0.305)	-0.064 (p = 0.249)	-0.316 (p = 0.000)	1.000

Executive Summary of TDRP

Coping with Stoicism: Understanding Mental Health in Rural Communities

Why is this research important?

Mental health research has predominantly focused on urban populations, leaving rural communities underrepresented. Rural residents, especially farmers, experience higher rates of mental health difficulties, namely depression, anxiety and substance abuse. High suicide rates are also a pressing issue; rural communities are at significantly higher risk compared to urban counterparts. There is an awareness of some of the unique challenges faced by rural populations, including geographic isolation, limited access to mental health services and cultural norms and beliefs that discourage help-seeking behaviours. However, there is little evidence exploring possible individual factors and/or psychological conceptualisation for the increased mental health problems we are beginning to understand. There is an urgent need for a better understanding of the mechanism driving such mental health disparities across geographical locations.

Using the Transactional Model of Stress and Coping as a theoretical framework, the study sought to understand what factors influence mental health outcomes in two rural occupations, focusing on the role of stoic beliefs, coping styles and social support's impact on mental health.

Aims:

1. **Explore the relationship between stoicism and mental health:** Determine how stoic beliefs impact mental health among farmers compared to rural teachers.
2. **Identify coping strategies:** Examine the role of coping styles employed by farmers and teachers and their effects on mental health.

3. **Assess the role of social support**: Investigate whether social support mitigates the impact of stoicism and avoidant coping on mental health.

What did we do?

The study employed a mixed-method cross-sectional design, collecting data from farmers and teachers via online surveys. 105 participants between 18 – 70 (mean age 39.5) were recruited through social media, charities and agricultural organisations. The survey included psychometric measures such as the Pathak-Wieten Stoicism Ideology Scale (PWSIS), Depression Anxiety Stress Scales (DASS21), Brief COPE and Short Lubben Social Network Scale (LSNS6) alongside qualitative questions. Hierarchical regression and mediation analyses were conducted to identify predictors of mental health and explore the mediating role of coping styles, whilst a content analysis on qualitative responses sought to illuminate nuances.

What did we learn?

1. **Mental Health Scores**: No significant differences in mental health scores between farmers and teachers were found, although both groups exhibited high, clinically significant levels of mental health challenges.
2. **Stoicism**: Farmers demonstrated significantly higher levels of stoicism compared to teachers.
3. **Coping Styles**: Avoidant coping and emotion-focused coping were significant predictors of poorer mental health, while problem-focused coping predicted better mental health outcomes.
4. **Mediation Analysis**: Avoidant coping mediated the relationship between stoicism and mental health, suggesting that stoic beliefs lead to avoidant coping, which in turn affects mental health negatively.

5. **Social Support**: While not a strong predictor in the full model, qualitative responses and a simpler, minimally adjusted analysis highlighted its protective role.

How is this relevant?

The findings underscore the need for context-sensitive mental health interventions in rural communities. Addressing avoidant coping strategies and promoting adaptive coping mechanisms can improve mental health outcomes for farmers and rural populations. The study highlights the importance of understanding cultural nuances in mental health research and service provision and provides valuable insights for developing tailored support services for rural communities.

Connecting Narrative

Throughout my research journey, my commitment has been to understand and improve engagement with mental health support for underrepresented and often overlooked populations. Across three projects, each situated in different contexts I aimed to explore how cultural, systemic and relational barriers limit or improve access to meaningful mental health care or community support. All three projects play a role in illuminating and addressing some of the factors that impact poor mental health, impact therapeutic engagement and aim to contribute to the development of equitable, responsive interventions.

SRL

Growing up in a rural, agricultural part of Wales, mental health discussions felt actively avoided, despite suicide becoming a tragically familiar occurrence in the local area. While internationally there is significant understanding of suicide risk factors, reflected in models like Joiner's Interpersonal-Psychological Theory of Suicide, protective factors have often been overlooked, especially in rural contexts.

Through in-depth discussions with my primary supervisor - whose extensive experience in risk-based research has spanned both clinical and academic settings it became clear that much of the literature focused heavily on identifying risks. What often remained overlooked was the role of protective factors, and the potential impact of interventions grounded in strengths-based approaches rather than those that solely aim to mitigate or reduce risk. What seemed to be missing was a coherent understanding of existing protective factors, especially for young people, particularly within rural contexts. While there were references to protective factors for rural youth across various studies, there was no systematic effort to bring these insights together to provide a coherent understanding of protective factors against suicide in rural communities. It became clear that a systematic review was needed to collate, synthesise and make sense of this fragmented knowledge.

Conducting my first systematic review was both challenging and rewarding. Developing search strategies for complex definitions, refining inclusion criteria and selecting quality appraisal tools required extensive collaboration with supervisors, library staff and my second rater.

Exploring the evidence-base for underrepresented groups and preventative mental health work, aided my understanding of the role of existing strengths and protective factors not just risks, but the crucial protective elements that could inform future interventions. By highlighting these key areas, I hope that they can be incorporated in suicide prevention efforts for young people growing up in rural communities.

SIP

Continuing the overarching theme of improving access and engagement for marginalised groups, my SIP project extended this focus into a forensic context. This project explored how systemic power dynamics shape psychologists' perceptions and impact therapeutic engagement within forensic settings.

The service had identified a need to better understand systemic power, given their unique position working across the powers of the NHS and the Ministry of Justice. Through discussions with three highly experienced psychologists, I gained deeper insight into the complexities psychologists must navigate: inconsistent guidance, competing policies, the dominance of the medical model and overarching legal frameworks, all of which shape therapeutic possibilities before direct client contact even begins.

A qualitative design felt the natural fit to explore these nuanced experiences. Drawing on my previous qualitative research experience, and maintaining a reflective journal guided by the Social GGRRAAACCEESS framework, I remained mindful of my own biases throughout data collection and analysis. Support from my supervisors was invaluable during

the lengthy thematic analysis process, allowing us to develop codes and themes that captured the intricate ways in which systemic power affected therapeutic engagement.

This project underscored how relational barriers are deeply embedded within institutional systems and mirrored themes from my rural-focused work: that structural forces, whether cultural norms like stoicism or systemic constraints like legal governance, can powerfully limit meaningful mental health support.

TDRP

Mirroring the origins of my SRL, rural areas once again stood out in my TDRP. Within my community, mental health problems were often seen as flaws within the individual, rather than as outcomes influenced by cultural, systemic or environmental factors. As I progressed through my education, I encountered alternative conceptualisations of mental illness, ones that acknowledged suffering rather than brushing it aside. This experience led me to a critical question: why was there such a disparity in how agricultural communities viewed and prioritised mental health needs? Over time, I have become deeply passionate about rural mental health and feel immense gratitude for the opportunity to illuminate the unique challenges faced by this often-overlooked group.

The idea for my TDRP emerged from recognising a significant gap in the evidence base, particularly in UK-specific rural mental health research. Finding supervisors with expertise in this area proved challenging, further highlighting the neglect this topic has faced. Through collaboration with supervisors and public and patient involvement (PPI), several hypothesised influential factors were identified, including stoicism, avoidance, social support and substance use. The Transactional Model of Stress and Coping was selected as a framework to explore emotional distress within farming communities.

To examine whether these challenges were unique to farmers, we included a comparison group of teachers, chosen for their shared experiences of government influencing on professional practice. Recruitment efforts were strongly supported by charities, organisations, schools and community members. This positive response illuminated how communities also desired an understanding and hope for change. Analysing the findings revealed the impact of stoic beliefs and avoidant coping strategies on mental health outcomes. I hope these insights contribute to the development of interventions tailored to the specific needs of rural communities, whose voices and struggles have for too long gone unheard.

Conclusion

Across projects, an overarching idea that effective mental health support for underrepresented populations requires a deep understanding of cultural, systemic and relational barriers. By exploring these factors across different populations and contexts, my work seeks to amplify the voices of marginalised groups and to advocate for tailored, culturally competent and systemically aware approaches to mental health provision. Together, these projects demonstrate that engagement is not solely a matter of individual willingness but is deeply intertwined with the structures and narratives that shape people's lives.

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I'm teulu a ffrindiau agos, fasen ni byth wedi cyrraedd Rhydychen hebddoch chi. Does dim dîm ar y diolch y gallaf cyfleu.

Appendices

Appendix A: The Journal of Adolescent Health: Guidelines for Authors
Guide for authors

The following list will be useful during the final checking of an article prior to sending it to the *Journal of Adolescent Health* for review. Please consult this Guide for Authors for further details of any item. Ensure that the following items are present:

Cover letter

Disclosure of any prior publications or submissions with any overlapping information

A statement that the work is not posted under consideration elsewhere

Disclosure of any potential conflict of interest, real and perceived, for all named authors

Names and contact information for 5 potential reviewers

Statements of Authorship

Please submit a separate statement for each named author

Title page

Article title

Full names, academic degrees (master's level and above), and affiliations of all authors

Name, address, e-mail address, telephone and fax number of the corresponding author

Sources of funding and acknowledgments of support and assistance

Disclosure of potential conflicts, real and perceived, for all named authors

Clinical trials registry site and number

List of abbreviations

Manuscript

Please double-space

Abstract in the appropriate format: Original Articles and Briefs require structured abstracts; Review Articles and Clinical Observations require unstructured abstracts

List of keywords

Implications and Contributions statement

Institutional Review Board (IRB) Research Ethics Board (REB) statement in the Methods section- or consent statement for Clinical Observations (Case reports)— in the Methods section

References should be formatted according to the *AMA Manual of Style*, 11th edition; all references mentioned in the Reference list are cited in the text, and vice versa

Figure titles should be on a separate page

Manuscript has been spell-checked and grammar-checked

Page numbering turned on

Tables

Each saved as a separate document, including title and footnotes

Figures

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Types of Articles

The *Journal* publishes the following types of articles. Word count limits apply only to the main body of the manuscript and do not include the title, references, or figure and table captions.

Review Articles

Review Articles provide a high-quality summary of the mature literature in a specific area. Systematic reviews and meta-analyses are preferred, though strong, evidence-based integrative reviews will be considered for publication. Book chapters and dissertations will not be considered. All review articles are subject to a rigorous peer-review process. The format of the review article should include the introduction, review of the relevant literature, discussion, summary and implications section. Each review article must have a 200-word summary abstract. Review articles are limited to 4500 words, 5 tables/figures, and an unlimited number of references. Review articles should include a 50-word Implications and Contribution summary statement.

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Topic/Content. Is the content new, innovative, and/or important to the field of adolescent and young adult health?

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A clean version of the revised manuscript.

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Fast-tracking for critical issues in adolescent and young ad

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It is important that the file be saved in the native format of the word processor used. The text should be in single-column format. Keep the layout of the text as simple as possible. Most formatting codes will be removed and replaced on processing the article. In particular, do not use the word processor's options to justify text or to hyphenate words. However, do use bold face, italics, subscripts, superscripts etc. Turn on page numbering in your manuscript file.

When preparing tables, if you are using a table grid, use only one grid for each individual table and not a grid for each row. If no grid is used, use tabs, not spaces, to align columns. The electronic text should be prepared in a way very similar to that of conventional manuscripts (see also the International Committee of Medical Journal Editors' (ICMJE) Recommendations). Note that source files of figures, tables and text graphics will be required whether or not you embed your figures in the text. Please do not submit PDF documents as source files. See also the section on Electronic artwork. To avoid unnecessary errors, you are strongly advised to use the 'spell-check' and 'grammar-check' functions of your word processor.

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Authors should provide a list of abbreviations on the title page. All acronyms in the text should be expanded at first mention, followed by the abbreviation in parentheses. The acronym may appear in the text thereafter. Do not use abbreviations in the title. Acronyms may be used in the abstract if they occur 3 or more times therein. Generally, abbreviations should be limited to those defined in the *AMA Manual of Style*, 11th edition.

Formatting of funding sources

List funding sources in this standard way to facilitate compliance to funder's requirements:

Funding: This work was supported by the National Institutes of Health [grant numbers xxxx, yyyy]; the Bill & Melinda Gates Foundation, Seattle, WA [grant number zzzz]; and the United States Institutes of Peace [grant number aaaa].

It is not necessary to include detailed descriptions on the program or type of grants and awards. When funding is from a block grant or other resources available to a university, college, or other research institution, submit the name of the institute or organization that provided the funding.

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Appendix B: Confirmation of study approval: Clinical Governance Committee Minutes

NHS Oxford Health NHS Foundation Trust

Forensic Clinical Governance Committee
Minutes

Thursday the 10th of August 2023 – 13:30 – 15:30
Oxford Clinic – Windrush Room

14:30 – Psychologists' perception of systems, power, therapeutic engagement, and hope in inpatient Forensic Services **CE (Carys E)**	**RB** outlined that the following research is being supervised and supported by **JJ, RB** and **CK**. Clinical Governance Presentation - CE 10.0 ***CE shared PowerPoint slides with Committee**** **Aims:** To establish whether psychologists view the power structure within wider system as impacting therapeutic engagement. To understand ow psychologists understand the concept of power and the impact on their work. To identify if and/or how ow psychologists adapt their approach and sustain hope within these conditions. **Rationale:** Clinical psychologists and service leads have identified how power may be hindering access to psychological therapies in the service. The research explores the psychologists' reflections on the role of power in the context of therapeutic engagement adaptations made and the means of sustaining hope despite these conditions. The long-term aim is to improve the therapeutic engagement and access to psychology. The outcomes will be fed back to teams to increase the knowledge and understanding of power and to facilitate consistency of approach and to foster hope. CE stated that the interview will be developed by expert psychologists who are external to the service. **Methodology:** Indictive, semi-structured interviews via Ms Teams and f2f. Further thematic analysis will be carried out. Data will be managed in line with policies and the research doesn't require NHS ethics. Dissemination process will follow once results are collected **(please refer to PowerPoint embedded)** **JD** expressed that the research sounds very interesting, and she is aware of the conceptual nature of the study and difficulty in accurately nailing down the definitions of 'hope' and 'power'. **RB** invited **JD** to attend a meeting regarding the research to explore further. No governance or ethical issues raised. Confirmed the presented project could go ahead.

Appendix C: The Journal of Forensic Psychiatry & Psychology: Guidelines for Authors

Preparing Your Paper

Original manuscripts

Should be written with the following elements in the following order: title page (including Acknowledgements as well as Funding and grant-awarding bodies); abstract; keywords; main text; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figure caption(s) (as a list).

Should be between 3,000 and 4,000 words, excluding abstract, tables, figure captions, footnotes, endnotes.

Should contain an unstructured abstract of 200 words.

Should contain between 3 and 6 **keywords**. Read making your article more discoverable, including information on choosing a title and search engine optimization.

Please include a word count.

Checklist: What to Include

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For multiple agency grants
This work was supported by the [Funding Agency #1] under Grant [number xxxx]; [Funding Agency #2] under Grant [number xxxx]; and [Funding Agency #3] under Grant [number xxxx].

Disclosure statement. This is to acknowledge any financial or non-financial interest that has arisen from the direct applications of your research. If there are no relevant competing interests to declare please state this within the article, for example: *The authors report there are no competing interests to declare.* Further guidance on what is a conflict of interest and how to disclose it.

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.

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.

Supplemental online material. Supplemental material can be a video, dataset, fileset, sound file or anything which supports (and is pertinent to) your paper. We publish supplemental material online via Figshare. Find out more about supplemental material and how to submit it with your article.

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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.

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We are committed to promoting and increasing the visibility of your article. Here are some tips and ideas on how you can work with us to promote your research.

Queries

Should you have any queries, please visit our Author Services website or contact us here.

Appendix D: TDRP Ethical Approval Letter

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

Dr Emily Reeves & Carys Evans
Oxford Institute for Clinical Psychology Training
Isis Education Centre
Warneford Hospital
Oxford

30 May 2024

Dear Dr Reeves and Carys,

Research Ethics Approval - CUREC 1

Ethics Approval Reference: R93567/RE001

Study title: Mental health of Farmers: Unravelling the interplay of psychological appraisals, coping styles and mental health

Short title: Mental health, beliefs and coping in agriculture and rural teaching

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 **30th May 2024** until **29th 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
97146B5D2DC543A...

Mrs Leah Butts
Research Ethics Administrator

for
Dr Helen Barnby-Porritt
Research Ethics Manager

Appendix E: The British Journal of Clinical Psychology: Guidelines for Authors

The British Journal of Clinical Psychology publishes original contributions to scientific knowledge in clinical psychology. This includes descriptive comparisons, as well as studies

of the assessment, aetiology and treatment of people with a wide range of psychological problems in all age groups and settings. The level of analysis of studies ranges from biological influences on individual behaviour through to studies of psychological interventions and treatments on individuals, dyads, families and groups, to investigations of the relationships between explicitly social and psychological levels of analysis.

All papers published in The British Journal of Clinical Psychology are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).
The following types of paper are invited:
• Papers reporting original empirical investigations
• Theoretical papers, provided that these are sufficiently related to the empirical data
• Review articles which need not be exhaustive but which should give an interpretation of the state of the research in a given field and, where appropriate, identify its clinical implications
• Brief reports and comments
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The word limit for papers submitted for consideration to BJCP is 5000 words and any papers that are over this word limit will be returned to the authors. The word limit does not include the abstract, reference list, figures, or tables. Appendices however are included in the word limit. The Editors retain discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length. In such a case, the authors should contact the Editors before submission of the paper.
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• Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
• Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. You may like to use this template. When entering the author names into Editorial Manager, the corresponding author will be asked to provide a CRediT contributor role to classify the role that each author played in creating the manuscript. Please see the Project CRediT website for a list of roles.
• The main document must be anonymous. Please do not mention the authors' names or affiliations (including in the Method section) and refer to any previous work in the third person.
• Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript but they must be mentioned in the text.
• Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi. All figures must be mentioned in the text.

• All papers must include a structured abstract of up to 250 words under the headings: Objectives, Methods, Results, Conclusions. Articles which report original scientific research should also include a heading 'Design' before 'Methods'.
• All Articles must include Practitioner Points – these are 2–4 bullet points to detail the positive clinical implications of the work, with a further 2–4 bullet points outlining cautions or limitations of the study. They should be placed below the abstract, with the heading 'Practitioner Points'.
• For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full and provide DOI numbers where possible for journal articles.
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If you need more information about submitting your manuscript for publication, please email Melanie Seddon, Managing Editor (bjc@wiley.com) or phone +44 (0) 1243 770 108.

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