

**An Exploration into the Role of Educational Psychologists in Supporting
Children and Young People, Parents and Schools to Respond to Self-harm**

Kayleigh Felstead

Registration Number: 100432408

Submitted in part requirement for the Doctorate in Educational Psychology (EdPsyD)

University of East Anglia

May 2026

Word Count (Excluding Contents Pages, Acknowledgements, References and
Appendices): 37,579

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Summary

This thesis consists of three chapters: a narrative literature review, an empirical paper and a reflective chapter.

The narrative literature review summarises the key literature on self-harm, including how it is defined and understood, explanatory models of self-harm and how CYP experience help seeking in relation to self-harm. It then begins to contextualise the current study by considering educational perspectives on self-harm and the EP role in mental health more generally, considering how this is constructed and how the role has changed in line with the changing socio-political landscape.

The empirical chapter outlines an exploratory qualitative study exploring the role of EPs in supporting CYP, parents and schools to respond to self-harm. It considers how well-equipped EPs feel to carry out work in this area, through consideration of the key barriers and facilitators to practice. Data was collected through semi-structured interviews with seven qualified EPs working in the UK and analysed using reflexive thematic analysis, which generated a number of key themes. The chapter concludes by considering the implications of the research for EPs, organisations and training providers, as well as the limitations and directions for future research.

The final chapter provides a reflective account of the researcher's journey. It considers the researcher's positionality, beliefs and thoughts at various points throughout the research journey, considering how these impacted on decision making.

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Key Abbreviations

CAMHS	Child and Adolescent Mental Health Service
CBT	Cognitive Behavioural Therapy
CPD	Continuous Professional Development
CYP	Children and Young People
DfE	Department for Education
DSH	Deliberate Self-harm
DSL	Designated Safeguarding Lead
DSM-5	Diagnostic and Statistical Manual of Mental Illnesses, Fifth Edition
EP	Educational Psychologist
GDPR	General Data Protection Regulation
HCPC	Health and Care Professions Council
IQ	Intelligence Quotient
LD	Learning Disabilities
NICE	National Institute for Health and Care Excellence
NSSI	Non-suicidal Self-injury
RCADS	Revised Child Anxiety and Depression Scale
SEMH	Social, Emotional, Mental Health
SENCo	Special Educational Needs Coordinator
SEND	Special Educational Needs and Disabilities
SH	Self-harm
SRB	Specialist Resource Base
TEP	Trainee Educational Psychologist
UK	United Kingdom

Acknowledgements

Firstly, I would like to thank the Educational Psychologists who took the time to participate in the research study. Your willingness to participate, engage with the more challenging aspects of practice and reflect openly on your experiences are what made this study possible. Thank you to all the young people I have worked with over the years who have trusted me with their stories and to my sister whose own experiences are what inspired my interest in this topic.

I would also like to thank my research supervisor, Dr LeMarra Williamson, for her knowledge, support and guidance throughout this research journey. You have challenged me to think more deeply and trust in myself, and your gentle encouragement is what gave me the confidence to give things a go. I would like to thank the tutors at UEA for the valuable knowledge and experience they have shared throughout the course but especially Dr Chris Clarke, my university tutor. I also want to thank my wonderful UEA cohort; I wouldn't have wanted to share this experience with anyone else. Furthermore, thanks to the Department for Education for providing the funding to allow me to access the doctorate training.

I also want to acknowledge my incredible colleagues and supervisors on placement, who have not only provided invaluable support and guidance throughout this journey, but have given me the time and space to dedicate to this project. A special shout out to my placement supervisors: Dr Susanne Treadwell, Dr Rachel Wade and Dr Kirstie Summers.

Finally, to my family and friends who have stood by me and encouraged me every step of the way, I never would have been able to complete this project without your unwavering love and support. Thanks to my mum for always believing in me and for showing me a true example of hard work, dedication and never giving up on your dreams. Thank you to Michael for standing by me throughout this journey, I wouldn't have made it without all the delicious food and laughs you have provided.

To my grandad, who was always my biggest cheerleader, I hope I have made you proud. This is dedicated to you.

Richard Felstead

23rd June 1951- 16th May 2018

Chapter One: Literature Review

Introduction

The overall objective of this chapter is to synthesise the relevant literature on self-harm, identifying any gaps in the research and laying the foundation for the proposed research study which will consider the role of EPs in this area. The review will begin by defining self-harm and providing an exploration into the models and theories of self-harm. It will then explore real life accounts and experiences of help seeking in relation to self-harm, helping to contextualise the EP role in this area. Building on this, it will then examine the evolution of the EP role in mental health, considering the historical and socio-political context, as well as how the role has been constructed both within and outside the profession. It will then attempt to further understand the EP role in this area by exploring work across different levels, before finally focussing specifically on the EP role in managing self-harm.

Narrative Literature Review

Given the diversity of research on this topic across health, education and psychological disciplines, a narrative literature review was chosen to provide a comprehensive summary of research in this area. This allowed the researcher to thoughtfully synthesise the relevant research, deepening understanding of the topic area and identifying any gaps (Sukhera, 2022).

A systematic review was not chosen within this context due to its emphasis on rigorous, pre-defined methods, specific research questions and rigid inclusion criteria (Greenhalgh et al., 2018). The researcher was more interested in taking a broader view, which allowed for flexibility in exploring interesting insights and perspectives, outside of the confines of a specific question. Given there is limited research on the EP role in relation to self-harm, the researcher felt this approach was more suitable to consider a wider range of literature relevant to this topic area.

Narrative reviews are often critiqued for lacking in rigour and being more susceptible to researcher bias, given the researcher is responsible for selecting the research that is included within the review (Greenhalgh et al., 2018). However, this can also be viewed as a strength as it allows the researcher to purposively select

research relevant to the topic area, maintaining conformity to the research aims. Considering the chosen approach, the researcher acknowledges that the review may not include all relevant literature on the topic. However, the search was continued until it yielded no new themes, insights or significant information, ensuring it was comprehensive (Sukhera, 2022).

Literature Search Strategy

Literature searches were conducted using the EBSCO Host database, Google Scholar, and by hand-searching a key journal related to EP practice: 'Educational Psychology in Practice'. Relevant articles were also identified through an approach known as 'snowballing', where references from related studies were followed.

A search strategy was developed to ensure the search was thorough, and that relevant literature was identified in relation to the topic area (see table 1). The literature titles were screened to determine suitability, followed by a review of the abstracts against pre-defined inclusion and exclusion criteria (see table 2). Whilst UK studies were prioritised due to the contextually dependent nature of the EP role, some studies from further afield were considered when it was felt that they contributed to the topic area. The literature comprised mostly of peer reviewed articles; however, some thesis research was included due to its relevance and contribution to the topic area.

Table 1

Literature Search Strategy

Search	Search strategy
Search 1	("Self-harm" OR "self-injury" OR
Definitions of self-harm and explanatory models	"deliberate self-harm" OR "self-mutilation" OR "self-injurious behaviour")
	AND ("definition" OR "concept" OR "terminology" OR "models" OR "explanatory models" OR "theories")

Search 2 Experiences of help seeking for self-harm	(“Self-harm” OR “self-injury” OR “deliberate self-harm” OR “self-mutilation” OR “self-injurious behaviour”) AND (“help seeking” OR “support”)
Search 3 Educational perspectives on self-harm	(“Self-harm” OR “self-injury” OR “deliberate self-harm” OR “self-mutilation” OR “self-injurious behaviour”) AND (“education” OR “school” OR “learning” OR “teaching” OR “classroom” OR “education system”)
Search 4 EP role in mental health	(“Mental health” OR “wellbeing” OR “emotional health” OR “SEMH”) AND (“Educational psycholog*”) AND (“Role” OR “responsibility” OR “perception” OR “construct”)
Search 5 EP role in supporting/managing self-harm	(“Self-harm” OR “self-injury” OR “deliberate self-harm” OR “self-mutilation” OR “self-injurious behaviour”) AND (“Educational psycholog*”) AND (“Role” OR “responsibility” OR “perception” OR “construct”)

Table 2*Literature Search Inclusion and Exclusion Criteria*

Inclusion	Exclusion
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Participants	Educational professionals (teachers, support staff, EPs)	No reference to educational professionals (clinical professions, healthcare, etc)
Topic	Self-harm, mental health, SEMH	No reference to self-harm, mental health or SEMH
Language	English	Not written in English
Publications	Peer reviewed journals	Not published in peer reviewed journals

Defining Self-harm

There is no universally accepted definition of self-harm within the literature, with ongoing debate surrounding what constitutes self-harm and considerable variation in the terminology used. The terminology used to describe self-harm is often used interchangeably, despite it reflecting different types of behaviour, and can include self-harm, deliberate self-harm, non-suicidal self-injury, self-mutilation and self-injurious behaviour. Silverman and De Leo (2016) suggest that the lack of clarity around the definitions and terms used to describe self-harm present as a significant barrier to the progression of research in this field as it makes it difficult to compare different research studies and make generalisations or extrapolations. The use of language also has implications for practice as it influences professional's perceptions and responses (James & Stewart, 2018).

In the UK, the National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care. They define self-harm as:

‘Self-harm refers to an intentional act of self-poisoning or self-injury, irrespective of the motivation or apparent purpose of the act, and is an expression of emotional distress.’ (NICE, 2022).

Given that this is the definition that is widely available to health, social care and education professionals within the UK, this is the definition that will be used throughout this research. However, it is acknowledged that there is a level of conceptual uncertainty surrounding self-harm and therefore a number of other definitions available, which may be adopted by participants. While the term 'self-harm' will be used to describe behaviours in the present study, other terminology may be referred to when this has been used by researchers within the literature.

The NICE definition differs from other definitions in that it does not place emphasis on the motivation or the intent behind the behaviour. Other definitions, such as that used in the United States, attempt to separate self-harm from suicide attempt, based on the presence or absence of intent to die, often referring to this as non-suicidal self-injury. This is described in the DSM-5 as:

'deliberate and intentional injury to body tissue that occurs in the absence of suicidal intent'. (American Psychiatric Association, 2013).

Some researchers advocate for this distinction within the definition, recognising that different approaches for prevention and treatment are required dependant on the presence of suicidal intent (Muehlenkamp, 2005). However, others argue that this is much more nuanced, with intent described as a fluid concept, which can exist at varying degrees and fluctuate over time (Hawton et al., 2012).

James and Stewart (2018) argue against the dichotomous separation of behaviours into acts of suicidal and non-suicidal self-harm, highlighting the difficulties in determining intent based on observable criteria. In their study, participants described cases where intent was unclear, where intent changed during a single incident or where a person used low-lethality methods but was not experiencing suicidal ideation. They also cautioned that this separation could lead practitioners to overlook the association between self-harm and suicide, with very few practitioners in the study acknowledging that people who self-harm may also feel suicidal. Given the established link between previous self-harm and subsequent death by suicide (Aggarwal et al. 2025), this oversight could have serious clinical implications. The government's suicide prevention strategy acknowledges the association between self-harm and suicide, highlighting the importance of prioritising prevention through the provision of consistent, high-quality care for those who self-harm (Department of Health and Social Care, 2023).

Favazza (1996) attempts to distinguish types of self-harm using the term self-mutilation to refer to 'deliberate destruction or alteration of one's body tissue without conscious suicidal intent'. Importantly, Favazza (1996) makes a distinction between culturally sanctioned rituals and practices which include self-mutilation, such as ear piercing and tattoos, and 'deviant self-mutilation' which refers to 'behaviours that are the product of mental disorder and anguish'. However, the term self-mutilation is thought to be associated with negative connotations, possibly evoking a sense of horror or disgust that society should attempt to move away from (Mangnall & Yurkovich, 2008), meaning it should be used with caution.

Furthermore, the use of the prefix 'deliberate' when referring to self-harm has been viewed as insensitive, with suggestion that it can convey judgement (Kapur et al., 2013). The Royal College of Psychiatrists (2020) cautions against the use of the term 'deliberate self-harm', suggesting that this assigns blame to the individual and makes it sound as if their self-harm was 'a calmly planned action rather than the result of emotional anguish or intense distress'. This raises important questions about how intentionality is understood within definitions such as that proposed by NICE (2022). While the NICE definition includes intentionality to distinguish self-harm from accidental injury, for some individuals self-harm may occur outside of full awareness or control, such as during 'trance-like' or dissociative states (National Collaborating Centre for Mental Health, 2004). In this sense, intentionality may be better understood as a broad concept, rather than implying fully conscious, reflective decision making.

While the UK has attempted to move away from a definition of self-harm which is laden with judgement, research has suggested that many UK practitioners still adopt a US approach, where self-harm is used to refer to acts without suicidal intent and is seen as distinct from a suicide attempt (James & Stewart, 2018). It was found that the criteria used to determine intent was inconsistent between practitioners, with variation amongst practitioners who worked within the same setting (James & Stewart, 2018). It is likely that this variability reflects the ongoing challenges associated with defining and conceptualising self-harm within professional settings, highlighting a need for further work in this area.

Another important distinction when considering the various definitions of self-harm, is between that of self-harm and self-injurious behaviour. While the terms are often used synonymously within the literature, they typically refer to different

behaviours with different meanings (Claes & Vandereycken, 2007). The term self-injurious behaviour is typically used within the field of learning disability to describe behaviours or actions which cause physical harm, such as head banging, skin picking, biting, hair pulling and ingesting inedible objects. These behaviours can occur for several reasons, but they always serve an underlying function, such as to obtain an object or experience, to escape or avoid a situation, to gain positive or negative attention, to receive sensory feedback or to express pain or frustration (The Challenging Behaviour Foundation, 2023). Typically, self-injury takes place in the absence of suicidal intent, however as mentioned previously, it can be difficult to make a clear distinction here (Claes & Vandereycken, 2007).

Claes and Vandereycken (2007) reflect the need for a systematic delineation of self-injury from other types of self-harming behaviour in order to establish reliable research on the prevalence, explanation and management of these behaviours, suggesting that the current interchangeable use of these terms within the literature is a source of serious confusion.

Overall, the literature highlights the ongoing challenges associated with defining and conceptualising self-harm and the interchangeable use of language, which can be problematic not only for the people who are experiencing self-harm but for the progression of research in this area.

Explanatory Models and Theories of Self-harm

Research into the reasons for self-harm is complicated by the lack of agreement regarding terminology and how self-harm is defined. However, there are a number of models which attempt to explain self-harm, some of which are described here.

The four function model by Nock and Prinstein (2004) explains self-harm as serving four primary functions, based on two key dimensions: whether the function is internal (automatic) or interpersonal (social), and whether it removes something unpleasant (negative reinforcement) or adds something desired (positive reinforcement). The four functions include automatic negative reinforcement, where self-harm reduces intense negative emotions or distressing thoughts; automatic positive reinforcement, where self-harm creates positive feelings or sensations, such

as feeling alive or real; social negative reinforcement, where self-harm helps a person escape or avoid difficult social situations or demands and social positive reinforcement, where self-harm communicates distress and may lead to attention, care, or support from others. Overall, the model highlights that self-harm can function both to regulate emotions and to influence social interactions, in different ways.

Adding to this, Klonsky (2007) also proposes a functional model for self-harm, with seven key functions. Based on a systematic analysis of the empirical research into the functions of self-harm, Klonsky (2007) suggests there is strong converging evidence for an affect-regulation function. It is thought that self-injury is preceded by negative affect, which is then reduced or relieved following self-injury, suggesting it is most often performed with intent to alleviate negative affect. The other functions of note within the literature include anti-dissociation, anti-suicide, interpersonal boundaries, interpersonal influence, self-punishment and sensation seeking.

Chapman et al. (2006) propose an experiential avoidance model of self-harm, suggesting that it is primarily maintained by negative reinforcement in the form of escape from or avoidance of unwanted negative emotional experiences. Essentially, an emotionally evocative event occurs, triggering an aversive emotional response (such as negative thoughts, feelings or bodily sensations). The individual experiences an urge to escape from the unpleasant state of arousal and engages in self-harm, which reduces or eliminates the emotional arousal, negatively reinforcing self-harm and becoming a vicious cycle.

The emotional cascade model by Selby et al. (2008) suggests that 'emotional cascades' occur when a person intensely ruminates on negative affect. This rumination amplifies the negative feelings, creating a cycle of escalating distress, leading to dysregulated behaviours, such as self-harm, which distract from the rumination.

While people appear to engage in self-harm to regulate affect, Bresin and Gordon (2013) suggest that the exact mechanisms that cause NSSI to lead to negative affect remain unclear. They propose an underlying biological cause, suggesting that individuals who engage in NSSI have lower baseline levels of opioids. Engaging in NSSI then releases opioids which restores homeostasis and regulates affect. Yan and Yue (2023) attempt to further understand the biological mechanisms involved in NSSI and suggest that individual vulnerability traits, environmental and biological factors affect the occurrence of NSSI. While the neural

and genetic mechanisms underlying NSSI remain uncertain, neuroimaging research focusses on areas such as the amygdala, cingulate gyrus, prefrontal lobe and other brain regions associated with emotional regulation, pain processing and reward processing. In research using functional magnetic resonance imaging (fMRI), patients experiencing NSSI showed abnormal activation of some brain regions, compared to healthy teenagers.

The cognitive emotional model of self-harm by Hasking et al. (2016) builds on previous models by attempting to integrate emotion regulation and cognitive frameworks to understand NSSI. They suggest that individuals are much more likely to engage in NSSI when they face situations they perceive as emotionally volatile if they also have certain risk factors, including a propensity towards emotional reactivity, negative self-schemas or beliefs about themselves, the belief that self-injury will achieve a desired mental state, the belief in their ability to self-injure or limited belief in their ability to resist it and poor emotion regulation strategies.

Another model which attempts to explain self-harm is the benefits and barriers model (Hooley & Franklin, 2017), which proposes that there are a number of benefits to engaging in NSSI, which transform it into a useful behaviour for many people, including an increase in positive affect, gratification of self-punishment desires, peer group affiliation and communication of distress or strength. However, it suggests that most people do not access these benefits because there are several natural or instinctive barriers that motivate them to avoid self-injury, including a lack of exposure or awareness about NSSI, feelings of self-worth, desire to avoid physical pain, an aversion to NSSI stimuli and social norms. In order for NSSI to occur all barriers must be overcome or lowered.

The integrated motivational volitional model (O'Connor & Kirtley, 2018) attempts to understand the transition from suicidal ideation to behaviour through a three-phase biopsychosocial model. The phases include the pre-motivational phase, which suggests that a combination of vulnerability factors and stressful life events increase sensitivity to signals of defeat. The motivational phase then suggests that an individual experiences feelings of defeat and humiliation from which there is no perceived sense of escape. Volitional moderators, such as access to means, planning, exposure to suicidal behaviour, impulsivity, pain sensitivity, fearlessness about death, mental imagery and past suicidal behaviour, then govern the transition from suicidal intent to behaviour. The model suggests that those with a history of

suicide attempt or self-harm behaviour will exhibit higher levels of motivational and volitional phase variables, impacting on the likelihood of behaviour occurring again.

While these theoretical models are useful in enhancing understanding of the functions of self-harm, Stănicke (2021) suggests that most reviews focus on adult samples or non-clinical adolescent samples, and primarily include data from questionnaires, which have been pre-determined by the researchers. They suggest that in order to capture and understand the complexity of self-harm, studies with different research methods, age groups and clinical and non-clinical samples are required. Stănicke (2021) attempted to address this gap through a qualitative study which explored the subjective lived experience of self-harm among adolescent girls. The findings highlighted three subordinate themes, which represented experiences of self-harm. The first: 'the punished self', suggests that self-harm may be a way to hide from conflicting and non-communicable feelings, such as guilt and being a burden to others. The second theme: 'the unknown self', suggests that self-harm is a way to re-establish a sense of control and balance over overwhelming thoughts and feelings, whilst the third theme: 'the harmed self', suggests that self-harm is a distraction that alleviates the bad feelings and releases something good, making it something to rely on. Overall, the findings from this study support the theory of self-harm as a function of affect regulation, similar to that of Klonsky (2007). However, it adds of level of nuance in relation to adolescent experience which has not been represented within previous clinical samples. In particular, the role of self-identity formation is examined and considered within the implications.

Experiences of Help Seeking for Self-harm

There have been a number of studies which have sought to understand the experiences of young people when seeking help for self-harm by drawing on their voices and perspectives. A systematic review of the literature highlighted that a significant proportion of young people do not seek help for their self-harming behaviour. This was particularly true for clinical services, which were reported to be accessed minimally by adolescents (Rowe et al., 2014). A number of factors were thought to contribute to help-seeking behaviour in adolescents, including age, sex, frequency and method of self-harm and suicidal intent.

Across the studies included in the review, a number of barriers were present, which prevented young people from seeking help for self-harm. These can be understood in terms of interpersonal barriers and intrapsychic barriers. Interpersonal barriers include the belief that others would not understand their self-harming behaviour, fear of confidentiality being breeched, fear of being seen as attention seeking, uncertainty around whether others would help, fear that others would react negatively and fear of being stigmatised. Intrapsychic barriers include the presence of depression and suicidal ideation, minimisation of self-harm as a problem and the belief that one should be able to cope on their own (Rowe et al., 2014).

When adolescents did seek help for self-harm, this was primarily through informal sources, such as family and friends (Rowe et al., 2014). A similar pattern emerged in a cross-sectional study of 856 school-going adolescents by Doyle et al. (2015), where young people reported via a questionnaire that the most common source of support was a friend, followed by a family member. It has been suggested that young people turn to family and friends as an initial source of support because they are trusted and have already developed secure relationships (Rickwood et al., 2005). Therefore, it has been suggested that interventions may be more effective when targeted at friends and family members who might be able to influence formal help seeking in a young person (Doyle et al., 2015; Rowe et al., 2014).

However, it is important to acknowledge that this might be inappropriate in situations where family and friends are contributing to an adolescents self-harming behaviour (Rowe et al., 2014). In a study by Wadman et al. (2018) young people described parental reactions to self-harm as unhelpful or trivialising. These parents were perceived as not understanding or appreciating the emotional difficulties the young people were experiencing or the help they needed. Alongside a desire to protect family from their self-harm, this meant young people were unlikely to seek support from parents.

In addition to friends and family members, Doyle et al. (2015) suggest a potential role for teachers and school staff in supporting young people to access support for self-harm, recognising school as a key setting for detection and early intervention initiatives. This was emphasised by McAndrew and Warne (2014) who suggested for some young people, it was teachers who initiated discussion either directly about self-harm or indirectly about their emotional wellbeing, playing a pivotal role in young people accessing appropriate services. They suggest that raising

awareness and educating professionals within education settings might help to facilitate earlier detection of problems, given these professionals are most likely to come into contact with young people who engage in self-harm.

Further highlighting difficulties related to help-seeking, almost half of the participants in the study by Doyle et al. (2015) reported that they did not seek help prior to self-harming. The most common reason cited by participants for this was that they did not need any help. While most did not elaborate on this, it appeared that they did not perceive their problems as serious and therefore requiring any help. Others suggested that they felt that other people would not understand why they engaged in self-harm.

Seeking help after an incident of self-harm was also not a common occurrence, with a majority of participants choosing not to seek help for the problems that had led them to self-harm. Some participants identified that they did not want anyone to know about their self-harm, which influenced their decision not to seek help. Other factors which appeared to influence decision making related to help seeking included the perception that no one could help and a reluctance to waste other people's time (Doyle et al., 2015).

Norman et al. (2023) added that difficulties may arise not only from the fear of consequences of disclosure but also from the difficulties associated with the cognitive processing of emotions. In their study, participants appeared to lack a clear sense of the self as a coherent, physical whole and expressed a difficulty in describing their inner experiences, making it difficult for them to communicate their subjective feelings, leaving them feeling disconnected, misunderstood and unacknowledged. Within this context, self-harm appeared to replace words as a means of communication. While the failure of words to express feelings was associated with self-harm, finding the right words appeared to play an important role in recovery for participants who had stopped self-harming. For example, some participants talked of the transformative experience of receiving a correct diagnosis and having the words to describe and explain their inner experiences. Where participants found that their own words failed them, they were sometimes able to borrow words from others to express their feelings, such as from poetry, song lyrics or internet memes.

When young people did access support for their self-harm, there was a sense of being let down by clinical services, at an organisational level (Wadman et al.,

2018). Young people frequently reported issues related to long waiting lists, receiving an inadequate number of sessions, experiences of being dismissed, let down or even turned away. Wadman et al (2018) suggested that these systemic and organisational barriers may be difficult for young people to comprehend and accept and can be experienced as rejection or as a sense of not being worthy of help. They also noted that such systemic failures may undermine the attempts of individual clinicians to develop therapeutic connections with their clients, possibly contributing to disengagement.

These findings highlight the need for changes in the existing pattern of service provision in specialist services to ensure a more flexible response which promotes engagement and collaboration. Given some of the barriers associated with accessing support at a specialist level, Wadman et al. (2018) also emphasise the importance of psychoeducational initiatives at a universal level, which provide education and training to parents, teachers and other allied professionals to support their understanding of self-harm.

Hassett and Isbister (2017) recognised the role of gender in help seeking behaviour amongst adolescents who self-harm. In particular, male sensitive attitudes characterised by the desire to uphold characteristics of masculinity and cope with problems independently appeared to impact on help seeking behaviour. Using interpretative phenomenological analysis, they explored how young men make meaning of their decision to seek help, including the factors that facilitated their decision and how they experienced the help they received. Key findings related to the role of an external adult in recognising, normalising and initiating help seeking, challenging and renegotiating perceptions of the need for help, maintaining a sense of independence, choice and control and approaches and techniques used by clinicians to maintain engagement. The findings of this study highlight a number of key considerations for practitioners when engaging specifically with young men, in recognition of the additional barriers that they face when help seeking. This is relevant to EP practice as gendered expectations may influence whether self-harm is disclosed, how adults interpret behaviour and whether a young person is identified as requiring support. Through their work with schools, EPs may be able to support school staff to recognise less visible presentations of distress, challenge gendered based assumptions and create accessible routes of support for young people.

More generally, the factors which might encourage help seeking behaviour amongst adolescents who self-harm include assurances of confidentiality, being treated respectfully, having a trustworthy person to talk to and the option of talking to someone of a similar age and background (Rowe et al., 2014). Adding to this, in a study by McAndrew and Warne (2014) young people identified a number of characteristics which facilitated a positive experience of services, including being listened to, not being judged, confidentiality, trust, being given an opportunity to talk to somebody independent of family and understanding and professional expertise. These suggestions emphasise the importance of listening to the voices and honouring the lived experiences of young people when promoting help seeking for self-harm.

A meta ethnographical review by Dalloz (2024) examined the factors influencing help seeking for self-harm amongst children and young people from ethnic minority groups, recognising that these are likely to be unique reflecting differences in cultural views and values. A synthesis of papers revealed three key themes that reduced help seeking within these groups, including the stigmatisation of self-harm, an upbringing which undervalues disclosure and a misunderstanding of support services, leading to children either not wanting help, wanting help but being unsure how to access it and getting help but not effectively engaging with it. Acceptance is viewed as a pre-requisite to help seeking and this is harder for children and young people who come from cultures that do not hold 'classical Western' views of mental health. The review highlighted that some children came from an upbringing which did not value talking about difficult personal or social issues and this meant they were less likely to value disclosure of self-harm. The researcher concluded that the simplistic view of a 'culturally appropriate service' needs to be reconsidered, ensuring that services are accessible to all (Dalloz, 2024). These findings are relevant to the EP role because cultural interpretations of self-harm may shape how CYP and families perceive professional support. Through consultation and work at a systemic level, EPs may be able to explore these meanings collaboratively and support schools to develop culturally responsive pathways.

Considering the role of family and friends in help seeking has been consistently referred to throughout the literature, it is important to consider their views and experiences in relation to self-harm. This is particularly relevant to the EP

role as EP work often focusses on systemic approaches, which includes parents and wider family. A systematic review by Mughal et al. (2022) focussed solely on parents, friends and families, considering the impact self-harm has on them and the ways in which they can be supported. The review highlighted the significant impact of self-harm on mental health and approaches to parenting, including experiences of hypervigilance and anxiety about the safety of their young person and the disruption to relationships and parental conflict associated with self-harm. A key theme related to parents and families attempting to manage this through help seeking, therapy, peer support and schools. However, there appeared to be an unmet need related to accessible information which supported them in their role.

A mixed methods study by Townsend et al. (2022) similarly emphasised the significant emotional impact of adolescent self-harm on parents, with parents reporting a range of feelings, including distress, shock, anger and confusion. Given that parents' initial responses can impact on their child, including their willingness to share with them in the future (Arbuthnott & Lewis, 2015), it is important that information and support is easily accessible to parents to support their early responses and encourage a response which validates the experiences of their child (Townsend et al., 2022).

Hughes et al. (2016) conducted narrative interviews with 41 parents in an attempt to understand how they make sense of self-harm through consideration of the cognitive and social processes that are involved when making sense of an experience. They used a conceptual framework of sense making alongside the metaphor of a 'map' or 'landscape', which is thought to be disrupted by the bewilderment and confusion associated with discovering their child is self-harming. Parents attempted to make sense of these feelings by ruminating and asking themselves 'why?', followed by the process of information seeking to construct a new 'map' and build a new way of seeing. The researchers suggested a key role for health and social care professionals in supporting parents to make sense of self-harm by demonstrating understanding of their confused reactions, listening to their perspectives and providing them with the information to help them understand their parental roles.

Suggestions such as these were reiterated across the literature, with parents emphasising the importance of being involved in support where possible, having their perspectives considered, having access to practical help (Stewart et al., 2016)

and requesting that health professionals provide more resources in plain English, prioritise involving them meaningfully in support for their children and provide parent support groups and psychological support which they can access themselves (Townsend et al., 2022). These findings highlight some important considerations for EP practice, particularly related to the need to adopt a more explicit family centred approach, which involves parents as collaborative partners, rather than positioning them as passive recipients of professional advice. Given the emphasis on systemic working within EP practice, it is vital that EPs recognise the importance of supporting parents in achieving positive outcomes for CYP. The research suggests that EPs could do this through the provision of accessible jargon free communication, facilitating access to practical resources, signposting or contributing to parent groups, which provide validation and support when they face challenges (Townsend et al., 2022).

Parents also highlighted the importance of professionals' attitudes towards their child, noting that this is not always helpful and can appear judgemental, particularly in cases where young people had self-harmed more than once (Stewart et al., 2016). Parents reflected the systemic constraints addressed previously, perceiving services to be stretched and reporting on how distressing this can be when conveyed to their young person. Again, highlighting some important considerations for EPs related to their approach and use of language in practice.

Overall, this section highlights the variation in help seeking behaviour amongst young people experiencing self-harm, with a number of interpersonal and systemic barriers impacting on willingness to seek help. The literature indicates that help-seeking is not simply an individual choice but is shaped by relationships, professional responses and wider gendered and cultural contexts. This illustrates the valuable role that professionals have in creating safe spaces, building trust and providing information to support young people and their parents. This has relevance for EP practice given EPs work across systems in which self-harm may be recognised and responded to. Consideration of help-seeking therefore helps identify opportunities and constraints that may shape EP involvement in supporting CYP who self-harm. Some of the research considered the role of school staff in initiating conversations about self-harm and promoting help seeking behaviours. Building on this, the perspectives of school staff will be considered in more depth.

Educational Perspectives on Self-harm

Given the amount of time young people spend in education, school staff are well placed to identify CYP at risk of self-harm and offer support in this area.

However, there is evidence which suggests that schools are struggling to do this (Best, 2005). The literature highlights issues relating to the awareness of self-harm amongst school professionals, the attitudes held by school staff, and the need for training and greater professional collaboration in this area (Best, 2005; Walshe, 2016).

Best (2005) asserted that self-harm is barely recognised by teachers, let alone understood, with many teachers reporting feelings of anxiety and low confidence when managing self-harm. In their study, exploring the views of school staff, it was highlighted that school staff often referred to feelings of alarm, panic, shock and being scared, taken aback, 'freaked out' and bewildered when talking about self-harm. It was clear that the emotional impact on school staff was great, and at times overwhelming, which is concerning considering the lack of supervision available within a school context, compared to that of other professionals who work with mental health.

In several of the interviews, school staff mentioned the liaison and referral between schools and other agencies who offer support, including local authority, NHS and charitable organisations. Whilst it appeared that collaboration between services did exist, it seemed inconsistent and unsystematic, with several interviewees emphasising the need for more 'joined-up' support for schools in managing self-harm (Best, 2005). It is possible that this links to the lack of confidence and feelings of incompetence reported by school staff in this area. School staff talked of the need for further training and support in this area, with most not having accessed any explicit training on self-harm in their role. Whilst this is clearly needed, the researcher acknowledged that this is something of a 'chicken-and-egg' problem, with schools unlikely to seek training for staff until awareness of self-harm has been raised (Best, 2005).

Whilst it is likely that awareness has increased since the publication of this research in 2005, similar themes have been identified in research since. For example, when exploring the experiences of secondary school staff in managing self-harm, Walshe (2016) found that whilst they were highly motivated to provide

meaningful support to young people who self-harmed, they also felt unprepared, unskilled and inadequately supported. They talked of the deep sense of frustration and disappointment felt when trying to access appropriate intervention for young people, referencing the high threshold for CAMHS involvement. The emotional impact on secondary school staff was clear, with themes relating to anxiety, distress and frustration mentioned. There appeared to be considerable worry amongst participants around making the situation worse, which they related to feeling deskilled and having a lack of clarity around the remit of their professional role.

More recently, Burn et al, (2025) suggested that despite a willingness to help, many school staff report feeling ill equipped to respond to students who are engaging in self-harm. Several participants in the study, reported being expected to manage complex mental health needs with limited guidance, fragmented support and inconsistent training, demanding them to rely on their instincts to remain calm and prevent escalation. Teachers who felt unprepared described how the limited training they received exacerbated anxiety and undermined their confidence in responding appropriately. Several participants reported feelings of guilt or denial after discovering a young person's self-harm, as well as anxiety about saying the wrong thing and potentially triggering further harm. School staff advocated for a whole school approach to responding to self-harm, with training which is accessible to all staff within the school community, not just teachers or mental health teams. They also suggested that it would be helpful to have guidance on what to say and how to say it when a student discloses self-harm, going beyond procedural reporting. They viewed a whole school approach as essential in fostering shared understanding, ensuring consistency in responses and promoting a culture where safeguarding is a collective responsibility.

In addition to this, young people in the study felt strongly that self-harm should be included in the curriculum and discussed more openly within schools to raise awareness and reduce stigma, which they saw as a barrier to help seeking (Burn et al., 2025). They felt that while assemblies can be useful for sharing information, small group discussions were more appropriate for sensitive topics as they provide a more comfortable space for conversations. Young people also stressed the importance of being informed about relevant school policies and the support available to them, with several noting that uncertainty about where to seek help could delay or prevent disclosure. Both staff and students agreed that clear step-by-

step guidance on what happens after a disclosure was necessary. The researchers acknowledged the lack of research and evidence informed guidance for addressing self-harm in schools in the UK and proposed a set of evidence informed principles of practice specific to self-harm which can be implemented by schools.

The lack of awareness of self-harm amongst educational professionals means that it is often defined, understood and conceptualised in different ways. There are a number of unfounded beliefs or ‘myths’ about self-harm, which inevitably impact on how children and young people who self-harm are perceived and responded to (Fox & Hawton, 2004; Knightsmith, 2015). These unhelpful beliefs and responses can cause further damage to children and young people, often triggering further self-harm (Spandler, 1996). This necessitates the need for additional training in this area to raise awareness amongst school professionals.

Several studies have sought to explore how school staff define and conceptualise self-harm and have demonstrated that there is great variance amongst professionals. In one study, participants shared opposing views on what they believed classed as self-harm based on intentionality, duration and severity of the harm, with some suggesting that it falls on a continuum (Simm et al., 2008). This is just one example, but it helps to illustrate that even amongst a small group of participants the way in which self-harm is understood and defined can vary considerably. This was reiterated by Walshe (2016) who found that participants had a variety of opinions around what is and is not defined as self-harm, along with the possible reasons as to why a young person might self-harm. Burn et al. (2025) added that whilst school staff recognised self-harm as being linked to a number of intersecting factors, such as academic expectations, identity-related struggles, peer dynamics and social media, some colleagues and parents still held judgemental attitudes about self-harm. They viewed such stigma as deeply rooted in generational and cultural attitudes, where mental health is not openly discussed and is perceived as ‘silly’ or ‘shameful’. Participants emphasised the need to challenge these attitudes and improve colleagues understanding of self-harm.

A common conceptualisation of self-harm amongst school staff is that it is a form of attention seeking. Dowling and Doyle (2016) highlighted that despite school staff showing concern for students who self-harmed, they also sometimes had negative attitudes towards them, particularly to those who they perceived to be advantaged or from a ‘privileged’ background, suggesting that they were ‘indulged’,

‘spoiled’ and ‘attention seeking’. Similarly, Walshe (2016) noticed that many participants in their study saw attention as a reason for self-harming behaviour, with a strong division between participants who saw self-harm as attention seeking and those who saw it as attention needing. Those who saw self-harm as a form of attention seeking tended to think this was true of incidences of self-harm that were minor or more significant. These beliefs about self-harm are significant as they can have implications when it comes to children and young people reporting self-harm (Waller et al., 2023). Young people in the Burn et al. (2025) study noted that the perception of self-harm as ‘attention seeking’ can discourage them from seeking help. They felt that schools should actively challenge these misconceptions by promoting education and open discussion which raises awareness.

On the other hand, there has been research which has found that school staff have contrasting views to those described previously. Smith (2022) found that school staff were approaching self-harm in a way that was destigmatising, favouring a compassionate approach where they remained mindful of how they presented themselves to students who had self-harmed. They intuitively attributed self-harm to childhood experiences and contextual factors, such as pressure and shame, and saw it as a way of coping with difficult feelings and communicating distress, rather than attention seeking. The researcher suggests that this could reflect a wider shift towards more non-judgemental attitudes of self-harm in society or as a result of the recent drive for training in schools in this area. However, we know from recent research that there is still a long way to go in order to achieve this across schools in the UK, with many not accessing appropriate training and support (Burn et al., 2025)

School staff have advocated for further training to understand self-harm, throughout the literature, reflecting the perceived lack of confidence and competence they often feel in this area (Best, 2005; Burn et al., 2025, Dowling & Doyle, 2017; Walshe, 2016). A small amount of research has attempted to explore the impact of this kind of training on school staff’s knowledge, confidence and attitudes to managing self-harm (Glennon et al., 2019; Groschwitz et al., 2017). One example of this is a study which was carried out in Southern Germany exploring the impact of a two-day workshop for school staff as part of the ‘Strong Schools Against Suicidality and Self-injury’ programme (Groschwitz et al., 2017). The workshop aimed to educate school staff on self-harm, focussing on the epidemiology, aetiology and associated risk factors. Pre and post measures collected from 267 participants

indicated that there was an improvement in confidence, perceived knowledge and knowledge following the workshop, which was persistent at 6-month follow up.

Similarly, Glennon et al. (2019) found that training positively impacted on participants perceived knowledge and self-efficacy when responding to self-harm. They evaluated a one-off training session, which focussed on self-harm prevalence, warning signs, initial responses, risk assessment and recommendations for students, staff and parents. Whilst these findings are promising, it is difficult to ascertain what it is about the training that is having a positive impact on school staff.

Lee (2016) attempted to understand participant experience on a deeper level, capturing the meaning and psychological processes at work. The experiences of 10 key pastoral staff in a secondary school were explored following a workshop on adolescent self-harm. An overarching theme of 'connectedness' emerged from the data. The researcher interpreted this through the psychodynamic model of containment, suggesting that the training provided a secure base for sharing, exploring and containing anxiety around self-harm. The active experience of feeling supported, listened to and understood by peers allowed participants to draw on their own 'lived experiences' and reflect on the emotional and psychological processes involved in self-harm.

The Evolution of the EP Role in Supporting CYP Mental Health

The role of EPs in supporting CYP mental health is one that has evolved in response to the changing social and political landscape. The legislative context within which EPs work has been forced to change over time to reflect the growing numbers of CYP experiencing mental health difficulties (Hill, 2013). A greater emphasis has been placed on promoting the development of social and emotional skills which underpin effective learning, positive behaviour and regular attendance within the legislation. However, this has not been a straightforward journey, and the role of the EP has changed and adapted considerably along the way. A brief overview of the changing social and political landscape impacting on the EP role is discussed here.

The addition of the 1996 Education Act afforded EPs greater political protection; however, it also restricted the range of work in which they were able to engage due to the tighter statutory timeframes, making the role increasingly narrow

and assessment focussed (Hill, 2013). There was a shift in political agenda in 1997, with the appointment of the Labour government, which focussed more on the inclusion of pupils with SEN and challenging the widespread assumptions about SEN. A review of the EP profession was commissioned by the Department for Education following this, which helped to illustrate the wide range of skills that EPs had which could support the new government agenda. This led to EPs taking up new positions and expanding their roles to include work with mental health services and youth offending (Hill, 2013).

In response to increasing levels of mental health issues amongst CYP in 2008 the government launched the 'Targeted Mental Health in Schools (TaMHS) Programme', which aimed to 'transform' the delivery of mental health support to children aged 5 to 13 years by offering additional funding to schools with a focus on early intervention and prevention (Department for Children, Schools and Families, 2008). EPs were actively involved in the implementation of this initiative and were recognised as a key group in relation to mental health provision within schools, with recognition given to their ability to aid links between schools and specialist agencies, such as CAMHS (Department for Education, 2011).

The inclusion of 'SEMH' as a category of need in the SEND Code of Practice (2015) further influenced the work of EPs, bringing the concept of 'mental health' further into the EP remit (Norwich & Eaton, 2014). This change in statutory guidance saw a shift in narrative from 'behaviour problems or difficulties' towards an all-encompassing definition which recognised that behaviour may 'reflect underlying mental health difficulties such as anxiety or depression, self-harming, substance misuse, eating disorders or physical symptoms that are medically unexplained'. However, this reframing has prompted some debate within the profession, particularly regarding the extent to which it draws on language more commonly associated with 'psychiatric disorder'. This has raised questions about the extent to which medicalised models of need align with the values and practices of educational psychology (Norwich & Eaton, 2014). Nevertheless, the introduction of SEMH reflects a growing professional engagement with mental health as a core aspect of EP work.

CYP mental health returned to the government agenda in 2017, with a commitment to invest more in mental health services to transform the support available to children and young people. The 'Transforming Children and Young

People's Mental Health Provision: Green Paper' outlined the government's plan to ensure that all children and young people had access to high-quality mental health support at the right time, regardless of where they lived (Department of Health & Department for Education, 2017). The strategy centred around schools and colleges, through the implementation of Mental Health Support Teams (MHSTs), which aimed to increase capacity for early intervention and prevention within the school environment. While EPs were not directly implicated in this strategy, it was possible that this would impact their work, particularly as role boundaries were being defined. Traditionally, EPs were viewed as one of the most common sources of support drawn upon by schools to support CYP mental health (Marshall et al., 2017) however the introduction of specialist teams within schools could lead to a shift in this area.

Considering the adaptive nature of EP practice and the fact that it is shaped heavily by the social and political landscape, it can be difficult for EPs to establish a professional identity for themselves. This feels particularly relevant when it comes to the EP role within CYP mental health, an area which has increasingly become the focus of research.

Constructions of the EP Role in CYP's Mental Health

The role of the EP in supporting CYP mental health is often constructed and understood in different ways, both within the profession and by others. It is likely that this reflects the changing nature of the EP role in this area and the lack of role definition. Miller (2016) explored how constructions of mental health varied between Clinical and Educational Psychologists, with a focus on how they perceived their role and the role of others in relation to supporting mental health in secondary schools. They found that there was considerable variation in the way in which mental health was constructed between the two professions, with suggestion that EPs in particular had no unified concept of mental health. EPs communicated a variety of understandings of mental health shaped by their experiences and theoretical frameworks, which the researcher suggested was likely as a result of EPs having less experience and training in this area.

In terms of their work in supporting mental health in secondary schools, EPs saw themselves as being able to fill the gaps left by other services, working with the systems around CYP and offering whole school approaches. They sought to

understand the perspectives of young people and work collaboratively with families and other professionals, offering a unique meta-perspective of schools' needs (Miller, 2016). However, EPs did acknowledge that their work in this area can be restricted due to lack of training, limited time and resources within the service delivery model and confusion amongst other professionals around their role. Clinical Psychologists, on the other hand, considered EPs to be experts in learning and education provision but felt that they had unclear professional boundaries in terms of their work in mental health. The researcher attributes these discrepancies in perception to incomplete information about the role of the other and professional defensiveness in a context where resources and funding are limited (Miller, 2016).

These findings illustrate the varying ways in which the EP role in CYP mental health is understood and conceptualised both within and outside the profession. However, they should be interpreted with caution given the small sample size. Carney (2017) sought to further explore how newly qualified EPs defined and understood their role in mental health and found that they tended to hold a positive definition of mental health, recognising that supporting emotional wellbeing was a core aspect of the EP role. However, in practice they appeared to take a more medical definition of mental health, viewing it as the absence of mental health condition. Based on these findings, the researcher asserted that EPs need to have a clearer conceptualisation of the relationship between their professional role and what they label as mental health in schools.

It is important to bear in mind that this research focussed on 'developing EPs', comprised of trainees and those who had been qualified for less than 5 years. It is possible that it is more difficult for them to define and make sense of their role in this area because they are new to the profession and are learning to navigate the competing discourses and ways of working within mental health. This view is shared by Davies (2020) who found that TEPs struggled more with role ambiguity surrounding the EP role in mental health, viewing themselves as 'outsiders'. They suggested that this had implications for the HCPC and doctoral training providers in relation to reviewing the expectations and experiences of TEPs on placements to gain insight into how well it prepares them to take up a role in mental health at an individual, group, organisational and community level.

Overall, it is recognised that greater clarity is needed from policy makers regarding the role of the EP and where they sit in the current plans to transform CYP

mental health (Davies, 2020). As a profession, EPs have traditionally been underrepresented within policy and legislation relating to CYP mental health, although this now represents a significant area of their work (Purewal, 2020). The lack of clarity and professional boundaries within this area can lead to uncertainty and professional insecurity within the profession (Hill, 2013). Interestingly, most of the research which has sought to understand how the EP role is constructed within a mental health context has come from doctoral theses, further supporting the notion that trainee EPs are trying to make sense of their role in this area as they develop their professional identities. However, this may also reflect qualified EPs having fewer opportunities to publish research post qualification.

The EP Role in Supporting CYP Mental Health Across Different Levels

In response to recent government agenda prioritising CYP mental health, Purewal (2020) sought to further understand the role of the EP in supporting SEMH, with the aim of contributing to a stronger professional identity in this area. Findings demonstrated that EPs are involved with a relatively high amount of SEMH work across the five core functions of the role (Scottish Executive, 2002), across multiple systems and age ranges. EPs contributed to work in this area through their knowledge of psychology and school systems and high levels of consultation practice. However, there were some barriers to practise in this area, including the low understanding of the role outside of the profession. Despite the knowledge and skills of EPs in this area, many reported to having limited involvement in green paper proposals, illustrating their lack of recognition within policy initiatives. Purewal (2020) called for EPs to be more fully included as a professional group within mental health policy.

The key areas of work with which EPs engage when supporting CYP mental health are explored in more detail here.

Consultation

Purewal (2020) identified consultation as a unique area of practice specific to the EP role within mental health. Consultation is the process by which EPs work collaboratively with others to solve problems and come to shared decisions (Wagner,

2000). Underwood (2022) sought to understand what was unique about the approach taken by EPs in consultations focussed on SEMH, with a particular focus on how they facilitated collaboration through their use of language. The findings suggested that there were a number of ways in which EPs facilitate collaboration during joint consultations, including through the use of solution focussed approaches, scaffolding, offering containment and using language of 'we', which implies everyone is in it together. These approaches appeared to lead to changes in the way events were described, leading to the development of a shared understanding and agreement of next steps and strategies for support. This supported school staff and parents to develop self-efficacy and feel empowered when making decisions relating to the mental health of the CYP with which they were concerned.

Therapeutic Work

EPs are considered as a key therapeutic resource for young people within an educational context, with considerable support throughout the literature for their engagement in therapeutic work (Atkinson et al., 2011; MacKay, 2007). However, this is an area which has been subject to considerable discussion within the profession, with issues being raised in relation to role boundaries, competency, time limitations, lack of clarity about what constitutes as therapy and access to specialist supervision (Atkinson et al., 2011).

MacKay (2007) called for the resurgence of therapeutic work within EP practice, stating that historically this was a key part of the EP role, and a valued resource to children and young people. It has fallen in and out of favour within EP practice in response to the changing social and political context, which inevitably led to greater statutory demands being placed on EPs. However, more recently Atkinson et al. (2011) reported an increase in the number of EPs undertaking training in therapeutic work, as part of the doctoral training programme and through CPD. They outlined a number of therapeutic approaches being used within EP practice, including narrative solution-focussed brief therapy (SFBT), personal construct psychology (PCP) and cognitive behavioural therapy (CBT).

CBT is a specific example of an evidence-based therapeutic approach which is often utilised within EP practice. Rutter and Atkinson (2022) highlighted the wider

contribution of CBT as a therapeutic modality within different parts of the EP role, suggesting its flexibility as a model which can be used within different contexts. EPs described using CBT across different parts of their role, including through the delivery of manualised interventions with CYP but also within consultation, assessment, multi-agency work, training, supervision and research. They suggested that drawing on a CBT framework in other areas of their work helped to 'formulate' and construct 'shared understanding' which supports acceptance and change. However, despite its widespread use within EP practice, a recent meta-analysis has called into question the efficacy of CBT-based approaches when working with CYP who self-harm (Johansson et al., 2025). This highlights the importance of EPs maintaining an awareness of emerging evidence and adopting a cautious, reflective approach when using CBT-based interventions with CYP who self-harm.

Whole School Approaches and Systemic Work

Another key theme relating to the practice of EPs within mental health that is present throughout the literature, relates to their position to be able to work systemically with schools. Harvest (2018) suggests that EPs are well placed to support schools across the ecological system due to their positioning at the intersection between psychology and education. They identified several ways in which EP work addresses CYP mental health across all areas of Bronfenbrenner's ecological systems theory, including through the promotion of inclusive school culture and ethos, staff development, policy development and collaboration with other services. These findings build on previous research, providing a richer and more complex picture of the EP role, framed within the complex school and community systems within which EPs operate.

Birchall (2021) reiterates the need for work at a systemic level to promote the wellbeing of the whole school community, drawing links between teacher wellbeing and pupil outcomes. Research has highlighted the link between teacher and student wellbeing, particularly emphasising the importance of teacher presenteeism and the quality of teacher-student relationships (Harding et al., 2019). Birchall (2021) suggests that EPs can support teacher wellbeing through the provision of individual and group supervision, providing staff with a safe space to reflect on their role and share concerns. They also suggest training and professional development as a way

to promote wellbeing amongst school staff, an area of EP practice which is commonplace. Through this wider systemic work, which addresses teacher wellbeing, EPs can indirectly impact the wider school community and CYP.

In light of recent government guidance, which saw the implementation of MHSTs within school settings, Skene (2023) sought to explore the contributions of EPs within this system. EPs were described as contributing at multiple levels of the system, with a key role in driving whole school approaches, enabling personal and professional development of MHST professionals and facilitating relationships between MHSTs and schools. This again illustrates how EPs can indirectly promote the mental health and wellbeing of CYP through joined up working at a systems level.

The Role of EPs in Supporting an Understanding and Reducing the Risk of Recurrent Self-harm

The literature clearly necessitates the need for further training, professional collaboration and support for school staff in managing self-harm. Considering that EPs are equipped with knowledge of school systems, emotional wellbeing and child development, they are thought to be well placed to offer support in this area (Reichardt, 2016).

A key paper by Lewis et al. (2020) recognises School Psychologists as being in a prime position to advocate for self-harm to be prioritised within schools. They suggest a number of ways in which School Psychologists can advocate for effective support for students who self-harm, including working at a school or systems level to ensure self-harm is prioritised and effective policies are in place, raising awareness through staff training and professional development and working directly with children and young people to support their understanding of healthy and unhealthy coping behaviours. They propose that effective advocacy can result in real changes in how people who self-harm are perceived and responded to within school settings, which can significantly impact on levels of confidence, wellbeing and self-respect amongst young people.

They do however recognise that whilst School Psychologists have some knowledge and understanding of self-harm, they may not have received professional training in this area and so reiterate the importance of School Psychologists keeping

up to date with current knowledge and engaging in ongoing professional development to position themselves for advocacy. Whilst this paper is based within an American context, where the role of a School Psychologist differs from that of an EP based in the UK, it was included in this review as it is one of very few papers which directly addresses the role of EPs in supporting schools to respond to self-harm.

In addition to this, it has been suggested within the literature that EPs are well placed to design and deliver training in this area, drawing on psychological frameworks to support school staff to develop an understanding of self-harm and approaches to support (Reichardt, 2016; Walshe, 2016). However, Lee (2016) raises the issue of preparedness of EPs in delivering training on self-harm, calling for a review of the educational psychology doctorate training courses in terms of whether self-harm and mental health are embedded within the curriculum. Evans et al. (2018) adds that caution is required when designing training in this area, ensuring that particular attention is paid to the quality of the training and its underpinning evidence base. This is a particularly important consideration, given that unhelpful attitudes and responses to self-harm can cause further harm to children and young people (Spandler, 1996). Lee (2016) suggests a framework for EP practice when delivering training in this area, based on the key components which they felt contributed to facilitating 'containment'.

A role has also been suggested for EPs in terms of offering ongoing, supervisory support to schools who are supporting children and young people who self-harm (Lee, 2016; Reichardt, 2016; Walshe, 2016). Considering the emotional impact on school staff members, Lee (2016) recommends that they have a protected 'mental space' in which they can take a step back from the self-harm and consider their responses. They suggest that EPs are well placed to support school staff in this way through individual or group reflective supervision sessions, which facilitate a sense of 'containment'. Reichardt (2016) also advocates for this kind of approach, recognising the value of 'containing the containers', or in this case the staff members who are working with the children and young people.

Depending on levels of professional competence, EPs may also offer therapeutic interventions in school to support CYP who are engaging in self-harming behaviours (Reichardt, 2016). However, there is minimal research which explores this in any kind of depth.

Evans et al. (2018) stated the importance of recognising the structural constraints that schools are continually subjected to. They found that the main barriers to self-harm prevention and intervention for school staff centred around the lack of resources and time available, particularly within the curriculum. Similarly, Groschwitz et al. (2017) recognised that there is a need for improvement on a school level when it comes to accessing resources and involving school administration in order to facilitate change. The position of EPs within schools means they are well placed to support with change at an organisational level through the development of whole school approaches or policies related to self-harm. (Walshe, 2016).

Despite being able to offer support across various levels, research by Townsend et al. (2022) suggests that parents perceived support from School Psychologists related to self-harm as the least helpful, when compared with other professionals. Whilst the paper does not expand on the reasons for this, it does highlight the need for accessible information, meaningful parent engagement and increased parental support more generally, potentially highlighting areas relevant to EP practice.

Chapter Two: Empirical Paper

Abstract

Given the growing concern regarding the mental health of children and young people, there has been increased recognition within government proposals of the role of schools in supporting CYP mental health. A specific area of concern where school staff report feeling reduced levels of confidence and expertise relates to self-harm. Considering schools have well established and ongoing relationships with EPs and often draw on them for support, it is important to consider how EPs could support schools in this area. More generally, the EP role in CYP mental health is one which has been debated within the profession and has evolved over time, making it difficult to conceptualise and define. Given these difficulties, the present study aimed to understand the EP role in supporting CYP, parents and schools to respond to self-harm, helping to define their role in this area. It also sought to explore how well-equipped EPs feel to carry out this work, through consideration of the key barriers and facilitators. Semi-structured interviews were completed with seven qualified EPs working in the UK to explore their perspectives. Reflexive thematic analysis was used to identify key themes within the data. This highlighted the role that EPs currently play in supporting CYP, parents and schools to respond to self-harm, including the distinct skills and perspectives that they bring. However, it also highlighted that the EP role is constrained by a number of barriers, including their positioning and role boundaries, limited training, difficulties associated with multi-agency working, structural constraints within service delivery models and uncertainty surrounding the definition of self-harm. The findings also highlighted a number of factors which support EP practice, which are considered in terms of implications for EP practice, organisations and training providers. Limitations and directions for future research are also explored.

Introduction

In recent years, concerns have continued to grow regarding the mental health of children and young people. The most recent statistics estimate that around 1 in 5 young people aged 8 to 25 have a probable mental health disorder (NHS Digital,

2023). The government called for national action in the 'Transforming Children and Young People's Mental Health Provision: Green Paper' after recognising that 'children with a persistent mental health problem face unequal chances in life'. They placed schools and colleges at the centre of their strategy to improve CYP mental health, with a focus on whole school approaches which promote early intervention and prevention (Department of Health & Department for Education, 2017). There is evidence which suggests that schools and colleges play a vital role in identifying mental health needs at an early stage, referring young people for specialist support and working jointly with other professionals to support CYP (Marshall et al., 2017).

A specific area of concern, often linked to CYP mental health, is that of self-harm. Self-harm is defined and understood in various ways throughout the literature. However, the universal definition as outlined by the National Institute for Health and Clinical Excellence (NICE) refers to self-harm as:

'Self-harm refers to an intentional act of self-poisoning or self-injury, irrespective of the motivation or apparent purpose of the act, and is an expression of emotional distress.' (NICE, 2022).

KnightSmith (2015) states that self-harm is 'usually conducted at times of anger, distress, fear, worry, depression or low self-esteem in order to manage negative feelings'. It is estimated that around 17% of young people have self-harmed in their lifetime, with the average age of onset around 12-13 years (Gillies et al., 2018). Research in this area suggests that self-harm is increasing amongst certain groups, with a 68% increase reported amongst girls aged 13 to 16 from 2011 to 2014 (Morgan et al., 2017).

Similarly, a study comparing two cohorts in the UK, observed a large increase in reported self-harm from 2005 to 2015 (Patalay & Gage, 2019). Whilst this is concerning, many young people do not seek professional help for their self-harm and so it's true prevalence may be underrepresented within the data. Given that self-harm peaks in adolescence, a time when the school environment is of significance in a child or young person's life, it is important that schools and colleges are adequately equipped to offer support in this area. The NICE guidelines emphasise the importance of educational settings having clear policies and procedures in place for staff to support students who self-harm (NICE, 2022).

When supporting CYP with their mental health schools will often draw upon external professionals for support, including that of EPs (Marshall et al., 2017). The

role of EPs in supporting CYP mental health is one of which has evolved over time, particularly since the introduction of the 'SEMH' category of need in the SEND Code of Practice (2015). The work of EPs in this area typically spans across the five core functions of the role, which include assessment, consultation, intervention, training and research (Scottish Executive, 2002). Given the increasing prevalence of self-harm amongst CYP and the level of responsibility placed on education settings to identify and respond to self-harm, it is likely that this is an area that EPs will come across within their work supporting CYP mental health. However, there is a considerable gap in the research relating to their role in this area.

Summary of the Relevant Literature

The increasing number of CYP engaging in self-harm has led to its recognition as a significant public health issue that requires urgent attention. In England, the government have proposed a 5-year cross sector suicide prevention strategy, which prioritises continued action across the NHS, local government, voluntary and community sectors to take preventative action to reduce the suicide rate and improve support for people who have self-harmed. The strategy recognises certain priority groups, who require targeted intervention in this area, including children and young people (Department of Health and Social Care, 2023).

Schools and colleges are recognised as playing an integral part in suicide prevention within the strategy, by providing learners with safe, supportive learning environments with early targeted support as part of a whole school approach to mental health and wellbeing. To build on progress to improve mental health support and suicide prevention within schools, the DfE is committed to continuing the roll out of mental health support teams in schools, reviewing the RSHE guidance to consider the inclusion of suicide and self-harm prevention within the curriculum, offering schools funding to train senior mental health leads, funding anti-bullying organisations and working with universities to embed its suicide-safer universities guidance (Department of Health and Social Care, 2023).

Despite the emphasis on schools and higher education settings to provide preventative support related to suicide and self-harm, a recent research study has highlighted that school staff often feel ill-equipped to respond, with clear guidance lacking (Burn et al., 2025).

Teachers and education professionals are often amongst the first to notice signs of self-harm and are well positioned to facilitate early intervention and referrals to other services (Newlove-Delgado et al., 2015), with trusted relationships with school staff noted as playing a vital role in help seeking amongst adolescents (Colville et al., 2024). However, despite this willingness to help, many school staff report feeling unprepared to respond to students who engage in self-harm, citing gaps in training, knowledge and a lack of confidence within the school environment (Best, 2005; Walshe, 2016). Limited knowledge amongst school staff can result in negative emotional reactions from staff, including fear, panic and repulsion (Best, 2005), which may inadvertently discourage help seeking amongst young people (McAndrew & Warne, 2014). Across the literature, school staff have advocated for further training to support them in their role related to self-harm.

Given the significance of school staff involvement in supporting CYP who are engaging in self-harm, there is minimal research and guidance in the UK which specifically focusses on addressing self-harm in schools. The most recent NICE guidelines attempt to provide practical advice and guidance for school staff, including a focus on policies and procedures to support school staff, a designated lead to ensure policies are implemented and guidance on seeking advice from mental health professionals (NICE, 2022). However, until recently there has been a distinct lack of evidence informed frameworks to guide schools, meaning it is the responsibility of individual schools to establish their own protocols and responses (Burn et al., 2025).

Researchers from the University of Cambridge attempted to address this gap by drawing on the perspectives and lived experiences of students and staff members to develop contextually relevant and feasible recommendations to influence help seeking within schools (Burn et al., 2025). They developed a set of evidence informed principles of practice, aligned with the Education Endowment Foundation's Implementation in Schools Framework, which offers guidance on how schools can create supportive environments which foster early identification and compassionate responses. The framework conceptualises implementation as an iterative process, which includes four stages: explore, prepare, deliver and sustain. For effective implementation, schools are encouraged to adopt three key behaviours: engage, unite and reflect.

Throughout this research, participants consistently endorsed the implementation of whole school approaches to self-harm, which offer flexible and

accessible support to pupils who need it. Staff advocated for a unified approach across the school environment, where practice is shared and training is accessible to all members of the school community (Burn et al., 2025). Given the positioning of EPs within the school system and their involvement in whole school, systemic working they could be well positioned to support schools to implement these recommendations. They have knowledge of school systems, emotional wellbeing and child development, making them well placed to offer support in this area (Reichardt, 2016). The literature suggests that EPs could have a more substantial role in policy development, staff training, supervision and direct work with CYP who are engaging in self-harm (Lewis, 2020; Reichardt, 2016).

However, there is very minimal research that explores their role in any depth or considers their levels of confidence related to self-harm. At a broader level EPs appear to engage in a high level of work related to CYP mental health, including consultation, therapeutic work and whole school approaches (Purewal, 2020). However, this area remains widely debated within the profession, with concerns raised regarding EPs level of training, experience and the boundaries of their role (Miller, 2016). This is especially evident in relation to self-harm. Researchers have questioned whether EPs are prepared to engage in this work given the level of professional training they receive (Lee, 2016; Lewis et al., 2020). The role of EP's in CYP mental health has evolved considerably in response to the changing socio-political landscape, with varying emphasis placed on mental health over time (Hill, 2013). As a result, some EPs may find it challenging to clearly conceptualise their role and establish a professional identity in this area, which may in turn impact their confidence and willingness to engage in work related to self-harm.

The Present Study

There is a clear need for further research into the EP role in supporting CYP and schools to respond to self-harm, given the lack of research currently available in this area. Whilst EPs are implicated in some of the research exploring educational perspectives on self-harm, there is very little research which directly explores their views or perceptions in relation to their role in responding to self-harm. Considering the evolving role of EPs in CYP mental health, it might be challenging for EPs to conceptualise and reflect on their role when it comes to supporting self-harm. As well

as this, we know that self-harm provokes fear and anxiety amongst professionals, with varying levels of confidence when it comes to working with children and young people who self-harm (Walshe, 2016). There is no research currently which has sought to explore how EPs feel in relation to work in this area, and this presents a significant gap in the knowledge base, providing a rationale for the current study.

The current study aims to explore the current work of EPs in relation to self-harm, helping to further understand their role in this area. It also seeks to explore how well-equipped EPs feel to carry out this work, through consideration of the key barriers and facilitators within their work with CYP, parents and schools. The intention is to identify areas of practice in which EPs may require further support and guidance, with implications for training providers and EP services.

Research Questions

- 1) How are EPs currently supporting CYP, parents and schools to respond to self-harm?
- 2) Do EPs feel equipped to support CYP, parents and schools to respond to self-harm?
- 3) What do EPs see as the key barriers and facilitators to their work in supporting CYP, parents and schools with self-harm?

Methodology

Epistemological and Ontological Position

Ontology is the study of the nature of reality or what is real, whilst epistemology is the study of knowledge or what we think we can know (Braun & Clarke, 2022). These philosophical positions are important in research as they underpin how research is designed and interpreted. The researcher is approaching the present study from a position of critical realism. Critical realism is concerned with identifying explanations and causal mechanisms through a focus on what people can achieve within the social contexts in which they operate. It sees reality like an iceberg, with most of it being invisible to the observer. It posits that causal mechanisms exist below the surface, giving rise to the experiences and events we

observe in the real-world. Critical realism goes beyond rich descriptions to uncover the causal mechanisms that generate events (Stutchbury, 2021).

In relation to the present study, critical realism would assume that EPs roles are shaped by an interplay of structural mechanisms (e.g policy, organisational structures, training pathways) and individual agency. It suggests that our knowledge of this is partial, constructed through EPs accounts of their experiences and perceptions, yet can still provide insight into the real mechanisms at work (Willig, 2013). Aligned with a critical realist paradigm, the present study aims to move beyond describing what EPs do to explore why they do this, offering insights to inform practice.

Bhaskar (2013) distinguishes between three key concepts within critical realism: the empirical (the experiences and perceptions of subjects), the actual (events that occur in the real-world) and the real (deeper level structures and causal mechanisms). This provides a framework for researchers to look beyond observed events to identify the underlying mechanisms. The present study is seeking to explore how EPs are supporting CYP, parents and schools to respond to self-harm (the actual), how they perceive and experience this work in terms of confidence and preparedness (the empirical) and the barriers and facilitators to work in this area, in an attempt to understand the underlying mechanisms that enable and constrain practice (the real).

Research Design

The study adopts a qualitative research design to explore the role of EPs in supporting CYP, parents and schools to respond to self-harm. This design is appropriate for capturing the complexity of the EP role and generating rich, contextualised insights into their professional experiences within this area. While critical realism is methodologically pluralistic and acknowledges that data can be generated through a range of methods, this study utilised semi-structured interviews as the primary means of accessing participants' experiences and perspectives. This enabled the researcher to gather EPs' accounts, providing access to the empirical domain through their lived experiences, perceptions, and interpretations of supporting self-harm. These accounts are understood as partial and fallible, shaped by professional role, context, and language, and situated within wider organisational,

systemic, and cultural structures. As such, they will not be treated as direct representations of reality but as a basis for theorising the underlying mechanisms influencing EP practice in this area. Although additional methods of data collection could have been utilised, interviews were deemed sufficient to generate rich, detailed accounts of EP experiences which enable further exploration into the underlying mechanisms driving practice.

Reflexive thematic analysis was used within a critical realist framework to analyse EPs' accounts of their experiences. This approach enabled the researcher to move beyond surface level description through interpretive engagement with the data, whereby themes were not treated as simple reflections of patterns in the data but as analytic constructs used to generate meaning and to theorise the underlying causal mechanisms shaping EP practice (Braun & Clarke, 2022). Consistent with a critical realist perspective, the analysis sought to identify recurring patterns in participants' accounts as a means of exploring conditions and underlying mechanisms influencing EPs' responses to self-harm. This was particularly important given the study's aim to develop a deeper understanding of the role of EPs in responding to self-harm and to identify factors that may inform and strengthen future practice. The researcher considered using interpretative phenomenological analysis (IPA) to analyse the data, allowing deep exploration into individual participant experiences. However, the researcher was more interested in generating general patterns and themes across EP practice, given the limited research in this area, which was better suited to reflexive thematic analysis.

Participant Sample and Recruitment

Participants were recruited using a purposive sampling method, meaning they were intentionally selected based on specific characteristics, experience and knowledge relevant to the research questions (Patton, 2015). Participants met the inclusion criteria if they were qualified EPs working within the United Kingdom. It was requested that participants had some experience of working with self-harm in order to reflect on their experiences. However, no criteria were imposed in relation to the type of work they had engaged in or the level of their involvement as the researcher was interested in seeking a range of experiences and acknowledged that experiences were likely to vary.

The participant sample was recruited through existing relationships with Educational Psychology services, with Principal EPs acting as the gatekeepers. Information about the prospective study was shared with Principal EPs via email (see appendix A) and they were asked to distribute this within their service and wider networks, including through the National Association of Principal Educational Psychologists (NAPEP). The information was also shared on platforms commonly used by EPs, including EPNET, X and LinkedIn to recruit participants more widely from a variety of different contexts with a range of experiences. A recruitment flyer (see appendix B) was shared, inviting EPs to contact the researcher should they be interested in taking part.

The researcher aimed to recruit eight to ten participants. While it can be difficult to define the ideal participant number within qualitative research, the researcher believed this sample size, given consideration of the study aims, participant specificity and intended analysis provided sufficient information power (Malterud et al., 2016). In total, seven EPs working across a range of contexts were recruited to participate in the study. Although this number was slightly below the intended sample size, the researcher determined that all relevant recruitment channels had been fully utilised and that the sample was sufficient to provide a rich and meaningful account of EPs' experiences in this area. It is important to note that a small minority of the participants recruited for the study had a pre-existing professional relationship with the researcher through the service context in which they worked. Whilst this does have the potential to introduce bias into the research, the researcher reflected on this openly within their reflexive journal and considered the steps they could take to mitigate the impact of holding a dual role. This included having a conscious awareness of any areas of over familiarity, asking open questions and being open to any new insights or perspectives offered by participants, without overly relying on the pre-defined interview schedule. Further information relating to the EPs role and service context can be seen in Table 3 below.

Demographic Information

Table 3

Participant Demographic Information

Participant	Role	Service context
1	Specialist Senior Educational Psychologist (SEMH)	Local authority
2	Specialist Senior Educational Psychologist	Traded service
3	Educational Psychologist	Local authority
4	Educational Psychologist	Private practice
5	Specialist Educational and Child Psychologist	CAMHS (learning disabilities)
6	Educational Psychologist	Local authority
7	Specialist Educational Psychologist (SEMH) and Associate Educational Psychologist	Local authority and private practice

Data Collection

Semi-structured interviews were used to collect the data, providing a structure in which key areas could be explored with the flexibility of being able to follow up on interesting information or perspectives offered by participants (Robson, 2011). An interview schedule was designed to guide the interviews; however, this was used flexibly to allow for exploration of participant insights and experiences (see appendix C). The interview schedule included some 'what' questions to open the topic and enable EPs to provide descriptions of their practice, helping to identify key patterns and ideas that could be explored in greater depth. As the research was interested in gaining further insight into the work EPs were already engaging in related to self-harm, it felt appropriate to ask questions which provided access to the actual and empirical level. To move beyond this descriptive level and begin to uncover the causal mechanisms influencing EP practice, the researcher attempted to ask follow-up questions, including 'how' and 'why' questions to gain further depth. This was not necessarily reflected within the pre-prepared interview schedule as these questions typically arose in response to participants' accounts during the interview. However, some additional prompts and follow up questions can be seen in appendix D.

To minimise bias and avoid leading questions which might reflect the researchers' own views, open ended questions were used throughout the interviews. The researcher used prompts such as 'I was just wondering' and 'are you able to tell me a bit more?' to encourage participants to elaborate on their responses. The researcher concluded each interview with a broad open-ended question, inviting any additional thoughts or reflections, which often prompted further discussion from participants.

The researcher considered using a focus group approach but given the sensitivity of the topic this was deemed inappropriate due to the risk that it could exacerbate potential vulnerabilities and anxiety within a group setting and impact on participants' willingness to reflect openly on their experiences. The interviews were conducted via Microsoft Teams to increase accessibility and provide greater flexibility for participants.

Pilot Interview

The researcher carried out one pilot interview to ensure that the interview questions were clear and relevant to the study and to identify and to resolve any ethical and practical issues associated with the research procedure ahead of data collection. The pilot interview was carried out with an EP who was known to the researcher through their local authority placement. The researcher asked the participant to provide feedback following the interview on the process and whether there was anything they felt needed to be amended. The pilot interview did not highlight any specific practical challenges associated with the interview process, and the interview questions were deemed appropriate for the purpose and scope of the research project. The participant identified areas of strength related to the researchers gentle and supportive approach, suggesting the interview supported them to reflect on their experiences more deeply. Following the pilot interview, the researcher was able to reflect on their own positioning as a researcher and a TEP working within the same service as the participant (see appendix E for sample of reflexive diary entries). Whilst the researcher did not feel that their approach skewed the findings, it did make the researcher more consciously aware of the bias that this could introduce, and they subsequently reflected on this in supervision and considered the steps that could be taken to mitigate these risks in future interviews.

As the pilot study did not result in any significant changes to the interview process, the researcher decided to include the findings in the final analysis to ensure that the participants' rich account of their experience was retained.

Data Analysis

The data was analysed using reflexive thematic analysis, following the six-phase framework developed by Braun and Clarke (2006; 2022). Thematic analysis is described as a method for developing, analysing and interpreting patterns of meaning across a qualitative data set through the process of coding (Braun & Clarke, 2006; 2022). The researcher adopted an inductive approach to analysis, meaning, the analysis solely reflected the content of the data rather than being narrowed or shaped by existing research or theoretical frameworks.

Braun and Clarke (2006; 2022) posit that analysis happens at the intersection between the dataset, the context of the research and the researcher skill and locatedness. They believe that researchers come with their own sets of beliefs, values and identities which cannot be separated from the analysis. They suggest that themes do not merely emerge passively from the data but are actively produced by the researcher through their engagement with the data set. Given this, the reflexive element of thematic analysis is fundamental to the analysis process, allowing the researcher to critically reflect on their role, practice, process and values and consider what their position might enable and exclude within the research. The researcher therefore kept a reflexive journal throughout the research process to document their decisions and reflect thoughtfully on their identity, position and what they might bring to the research process. The six phases of the analytical process can be seen in table 4 below.

Table 4

Six Phases of Reflexive Thematic Analysis (Braun & Clarke, 2022)

Phase of Analysis	Researcher Approach
Familiarising yourself with the dataset	Phase one of the analysis requires the researcher to familiarise themselves with the dataset, through a

process of immersion and critical engagement (Braun & Clarke, 2022). In this phase, the researcher listened to the audio recordings of the interview's multiple times, whilst editing the transcripts that were produced by Microsoft Teams. This helped to ensure that the transcripts accurately reflected the interview content but also allowed the researcher to immerse themselves in the data. The researcher then read through the transcripts several times, before taking some initial notes and highlighting any key points. Braun and Clarke (2022) emphasise the importance of critically engaging with the data during this phase, by actively making sense of information, contesting and challenging how things could be different. The researcher considered this whilst making initial notes and keeping a reflexive journal. The researcher moved between electronic and hard copies of the data throughout the analysis, noticing that moving between these promoted new reflections and insights.

Coding

The next phase of the analysis is coding. This is a systematic process whereby the researcher captures specific meanings within the dataset that are relevant to the research question (Braun & Clarke, 2022). Codes can be descriptive or interpretive in nature and should parse out diversity of meaning. To ensure a systematic approach to coding the researcher went through each transcript carefully, highlighting any sections of the text where they noticed something interesting or relevant to the research question (see appendix F). The researcher repeated this process multiple times to ensure the process was thorough and rigorous.

Generating initial themes	Once the coding was complete, the researcher moved on to developing initial themes. According to Braun and Clarke (2022) themes capture a wide range of data that are united by a shared idea or meaning. It is emphasised at this stage that themes are likely to be provisional and tentative, evolving as the analysis progresses. The researcher began to generate initial themes by engaging with the codes and identifying similarity of meaning. The researcher then clustered together codes that were potentially connected, considering the story that they were telling about the data (see appendix G).
Developing and reviewing themes	The next stage of the analysis involved reviewing and refining the initial themes through a process of re-engagement with the coded extracts and the dataset as a whole (Braun & Clarke, 2022). This allowed the researcher to review the viability of the themes they had already identified and explore whether there was scope for better pattern development, ensuring a rich and nuanced analysis (see appendix H). At this stage, the researcher developed a thematic map to provide a visual representation of the possible themes, supporting the researcher to look at the dataset from a different perspective. This was a recursive process, whereby the researcher expanded, refined and changed themes several times until they felt they accurately reflected the dataset.
Refining, defining and naming themes	This phase involved further development and refinement of the identified themes, considering how they would be defined and named. The theme definition should illustrate the key takeaway of each theme, whilst also considering the overall story the

	analysis builds towards (Braun & Clarke, 2022). At this stage, the researcher revisited the transcripts checking that the theme definitions fit with the data, whilst identifying relevant quotes which helped to illustrate each theme. The researcher then named each of the themes, attempting to capture the essence of the theme in a way which engages the reader (see appendix I).
Writing up	The final phase of the analysis is writing up. Braun and Clarke (2022) view this phase as embedded in the analytic process, with the analysis continuing to be produced as it is being written. This phase should continue to shape the detail and flow of the analysis, bringing together the analytic story. When writing up the analysis section, the researcher combined data extracts with analytic narrative, to highlight the interpretation of the data and its meaning.

Ethical Considerations

The study was carried out in accordance with ethical guidelines set out by the School of Education and Lifelong Learning Research Ethics Committee at the University of East Anglia. An initial ethics proposal was developed in line with the British Educational Research Association (BERA) Guidelines for Educational Research (2024) and the British Psychological Society (BPS) Code of Human Research Ethics (2021). Ethical approval for the project was granted in June 2025 (see appendix J).

Prior to taking part in the study, prospective participants were provided with an information sheet (see appendix K), which detailed what taking part in the research would involve, as well as any potential risks, to ensure participants could provide informed consent (BERA 8, BPS 4.1). It was made clear to participants at this stage and prior to completing the interview that they were free to withdraw their consent, for any reason and at any stage before the analysis of the data (BERA 31).

Participant information was gathered and stored in line with General Data Protection Regulations (GDPR) (Data Protection Act, 2018). Completed participant consent forms were stored in password protected folders on OneDrive and were only accessible to the researcher. At each stage of the research, where possible, the researcher ensured that participants remained anonymous (BERA 39, BPS 5). Each participant was given a pseudonym upon agreeing to take part in the study so they could not be identified during the reporting of the research and any identifiable information within interview transcripts (such as information about the participants service or location) was redacted. The researcher kept a re-identification list, which included participant names and contact details, in the event that a participant wished to withdraw from the study. This was stored in a separate password protected folder on OneDrive, which was only accessible to the researcher, to prevent deanonymisation. Following completion of the project, participant information and data will continue to be stored in accordance with the UEA Information Classification and Data Management policy for 10 years beyond the last date the data were used.

Given the sensitive nature of the topic area, it was important that the researcher considered any potential harm that could arise to participants during the research, attempting to minimise these risks where possible (BERA 34, BPS 4.3). As the participants were EPs and likely already involved in conversations of this nature within their practice, the researcher determined that the risk of harm was low. However, given EPs were being encouraged to reflect on their practice the researcher acknowledged that this could lead to feelings of discomfort or distress. In order to mitigate these risks, the researcher designed the research questions sensitively to avoid placing blame on participants and ensured that participants were aware that they did not have to answer any questions they did not feel comfortable with and could take breaks at any point during the interview. The researcher exercised their own professional judgement during the interviews, deciding to cease interviews or offer breaks upon noticing participant distress.

Following completion of the interview, each participant was provided with a participant debrief sheet (see appendix L), which outlined what and how they could access support should they feel affected by participating in the research (BPS 10). This included signposting to professional supervision, workplace counselling services and external support services. Additionally, the use of a pilot interview

allowed the researcher to consider any potential ethical concerns and make amendments as necessary, aiming to reduce the likelihood of risks to participants.

Findings

Figure 1

Thematic Map

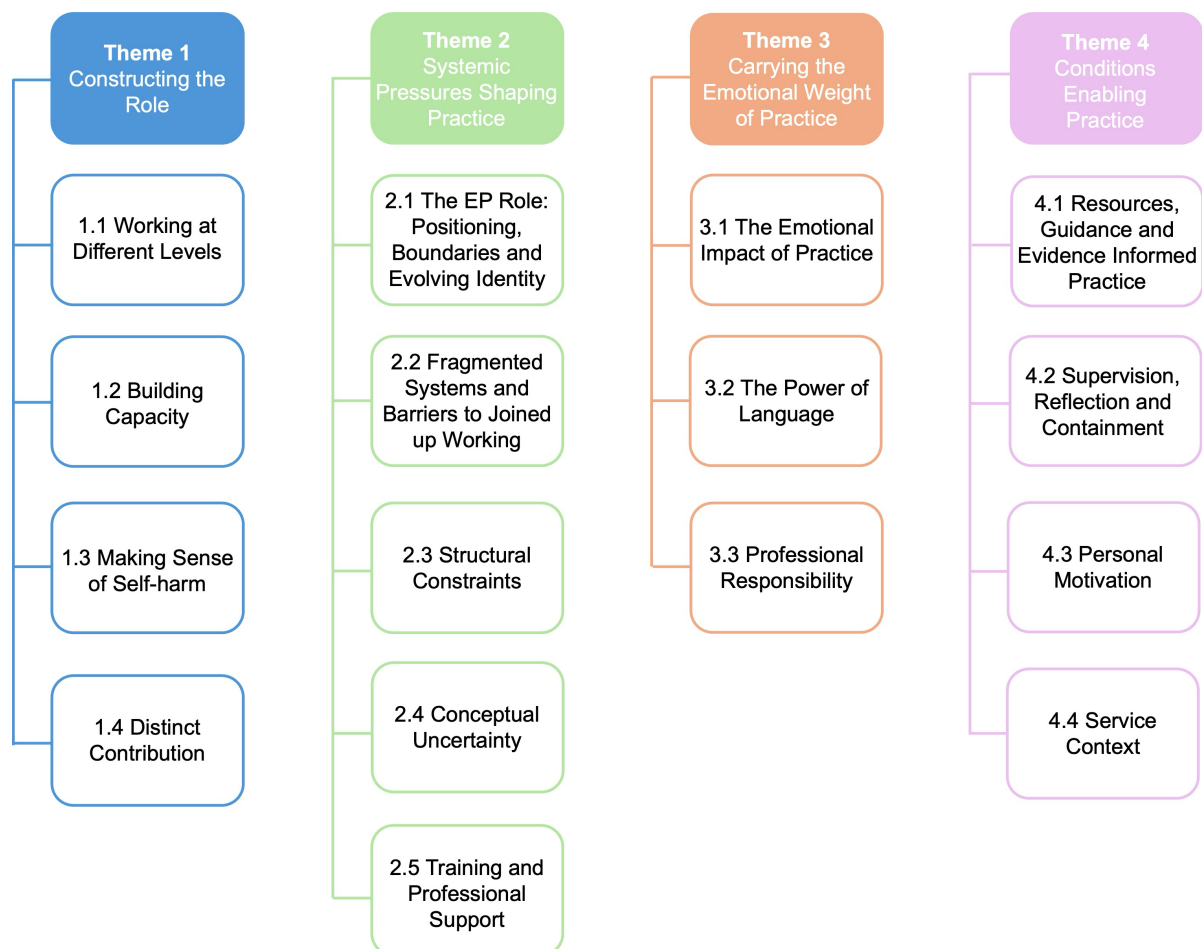
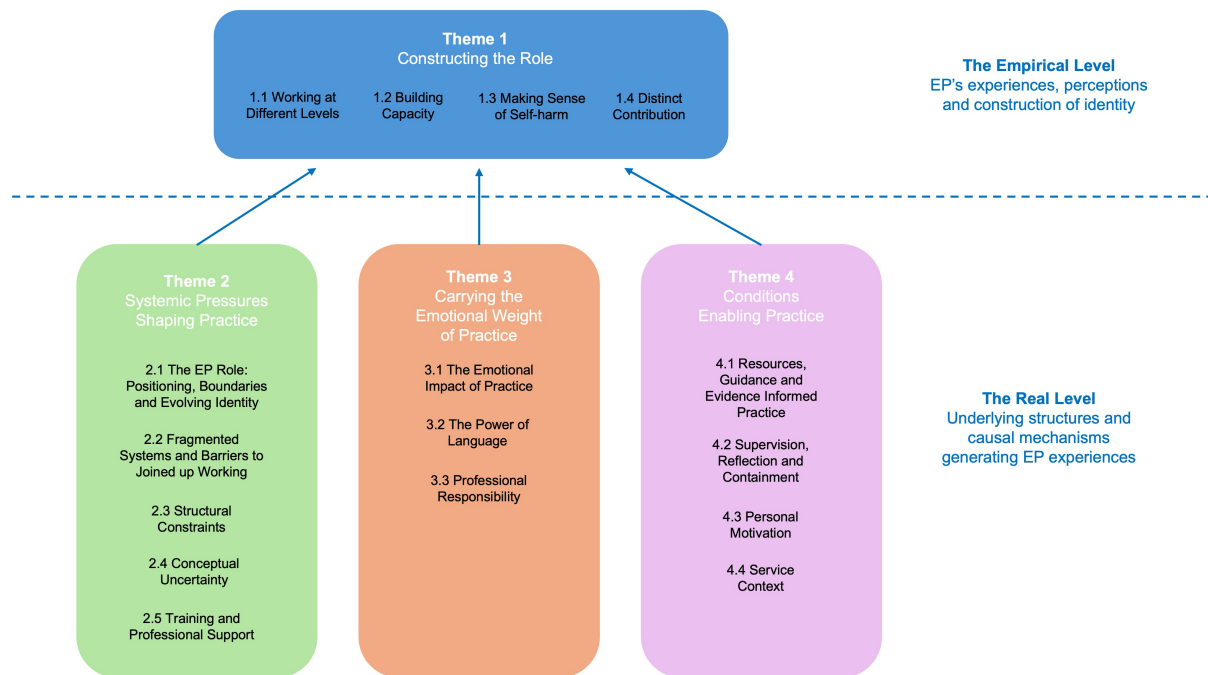


Figure 2

Critical Realist Mapping of Themes and Mechanisms



Theme 1: Constructing the Role

Theme 1 captures EPs perceptions and understanding of their role in supporting CYP, parents and schools to respond to self-harm. It reflects their practice experiences in this area and highlights the distinctive knowledge and skills they contribute.

Subtheme 1.1: Working at Different Levels

This subtheme captures the variety of work carried out by EPs, across multiple different levels when supporting CYP, parents and schools to respond to self-harm.

Participant 7 highlighted the varied nature of EP involvement in this area, with work ranging from direct therapeutic intervention with children and young people, to supporting school staff, parents and other professionals.

“So I would say that I have ongoing cases that I'm involved, that I'm doing therapeutic intervention with children and young people who self-harm and within that, I support schools in terms of their role within that. I work also alongside with parents and support them how they respond to those

situations. I work also with other professionals. I signpost as well what I feel like is out of my remit so within that I do that a lot.”

This holistic approach to support was consistent across EP practice, with several EPs recognising the value of working with parents and schools, as well as directly with the child or young person. Participant 6 described how they were involved in direct work with a young person over a number of sessions, whilst also supporting parents and making onward referrals to ensure joined up working.

“...being able to build up that relationship over a few sessions meant that he was able to open up about his kind of identity struggles and recognise that I was a safe adult rather than just kind of parachuting in for an hour and then leaving. At other points it's been signposting so with the parent that rang me up and said that my daughter took an overdose, kind of checking that they'd gone to the hospital, which they hadn't, and explaining to parents why that might be a good idea and then seeking kind of consent from them to refer it on to Children's Services as well and kind of get additional support in place there and make sure that the social worker who was involved in the family had an oversight of what was going on. And sometimes it's just ensuring schools are following their own safeguarding practices.”

Taking a more indirect approach to support, participant 3 talked about their involvement in supporting parents and school staff, through recommending appropriate provision, making referrals and contributing to policy.

“I think hopefully recommending appropriate provision or recommending appropriate referrals or changes in high quality first teaching, etcetera for the young person to lessen... to help the school, maybe to understand the function of the self-harm or the antecedents or consequences of the self-harm. Maybe educating parents a bit more around that as well I think too. And I mean in an ideal world, contributing to things like policies that already exist in school, around supporting mental health and well-being and practices around risk management and safety planning and all of those types of things.”

Participant 7 illustrated one way in which EPs support school staff to develop their understanding and approach to self-harm is through the delivery of training and contribution to policy development.

“And also I did the presentation on self-harm for them as a kind of CPD top up. So that was kind of with school staff and then obviously trying to feed into their policies again especially in secondary schools how that reflects there.”

This was further emphasised by participant 2 who talked about their experiences of supporting schools at a wider level through policy development.

“I have done some training a long time ago back in the local authority who did some policy training, so it was, I did it a few times, which was essentially I gave people, not a blank policy, but as part of their safeguarding policy. And we were talking about self-harm and embedding it in their policy and we would go through, I don't know how interesting the sessions were, but we would go through almost writing a policy for schools so that they had a... that was embedding the responses and how people should respond. So that was much more in that broader picture of how are we... how are we going to respond as a school?”

Subtheme 1.2: Building Capacity

Building on the previous subtheme, which explores the various levels of EP involvement in managing self-harm, this subtheme captures how EPs attempt to build capacity in those working most closely with CYP.

Participant 7 recognised the need for this type of indirect involvement given the constraints of the EP role, related to time and capacity.

“And I'm like, yes, but if you don't have the time, I can't really do much directly so I do indirect with them”

Participant 2 further reflected this, recognising the value in empowering the people that are having the most direct involvement with CYP.

“it's fair to say that that in terms of working with young people who might be self-harming or who are presenting that sort of profile, we're often not the people as in a lot of cases for EPs, we're not around the young people all day,

every day and so you are trying to empower the people that are working with them to feel confident”

Participant 1 felt that an indirect approach, which empowers and builds confidence amongst school staff, is the most sustainable way in which EPs can offer support.

“There are lots of ways we can support, but I think from my view I do feel that probably the best, the best way that we can support is that more systemically, more, more sort of indirect work. I think that's going to have the biggest sort of sustainability I think going forwards, you know giving the staff the confidence and empowering them to understand that they are enough, that they are supporting the young person just being there to support them emotionally is... is enough and so I do. Yeah, I do think that in terms of supporting we kind of have a role, I think primarily to support the staff to support the young person and giving them the yeah, the tools and the confidence to be able to support them is so important.”

EPs consistently reflected the need to build confidence and capacity amongst school staff. As mentioned by participant 6, one way in which they can do this is through the delivery of staff supervision.

“I mean, even if the role is supporting, so with some of the SRBs I have done some supervision with the lead teachers and with some of the teaching assistants working with the young people, because although they're not trained to do therapy for self-harm, they're still doing it and you know, if we can offer some kind of support in helping them to understand context and just check in with them and their well-being because then they can be a consistent adult whereas we can't. Yeah. So I think possibly systemically our role is to support staff to be equipped and to look after themselves so they can then look after and kind of push the signposting and have the energy to write hundreds of emails to whoever it is to get the right help somewhere.”

Participant 3 reflected on the role of supervision in containing school staff and supporting them to manage the emotional aspect of working with CYP who are engaging in self-harm.

“So I think it was a good chance for the class teacher to just kind of say this is actually frightening me quite a lot, like, can people hear this? And I think she was feeling very much like I shouldn't, I don't know how to deal with this as a teacher like, this isn't, I'm not a mental health professional, I've got like, yeah, a lot of fear. So I think a lot of it was about kind of containing some of that for her, but also, like, empathising with it and helping her to see that. Oh, God, all of us feel like we don't want to do the wrong thing, etcetera, etcetera.”

In addition to supporting school staff, participant 5 talked about how they work closely with parents, recognising the role that parents can play in perpetuating difficulties.

“A lot of work with parents which feels, which is right to do, but sometimes it feels a bit strange because we're a mental health service, so we're supporting the mental health of that child but actually most of our work or a lot of our work is around supporting the parents, the school, the systems to support the child and often the difficulties or the perpetuating factors are within the parents, within their own blockages, and then that becomes a relational difficulty in which the child doesn't feel you know, as though their needs are being met.”

Subtheme 1.3: Making Sense of Self-harm

This subtheme reflects the role of the EP in making sense and understanding self-harm, including challenging misconceptions and unpicking the function of self-harm.

Participant 7 talked about the role of the EP in bringing a psychological perspective to support school staff to understand the function of behaviour, noting that they do not always recognise behaviour as self-harm.

“then I have also situations that you know, in a primary education, children do display self-harming behaviours that school not necessarily seeing that as self-harming so then my role within them is like lots of psycho education for members of staff thinking about the function of the behaviour from the psychological perspective.”

Participant 2 reflected the need to break down why young people engage in harming behaviours, considering the factors that may be contributing to their difficulties, such as neurodivergence, sensory seeking and as a means of expressing frustration.

“I think... when I've been, I mean the initial things are about just understanding and breaking down that understanding initially and I think that the thoughts I've often had are about harm amongst so particularly young people who might present neurodiverse profiles who harm for perhaps different reasons for sensory reasons for frustration or whatever reasons, and trying to understand that so I think the thoughts are about understanding why young, you know why young people use what would be termed harming behaviours.”

A similar perspective was shared by participant 3, who suggested a role for EPs in educating parents to understand the function of self-harm, recognising that this understanding can impact on how self-harm is approached or responded to.

“And some psycho education around the function of it, because I think one of the things when you start doing research into it that you find out is that parents are... forbidding your child to do it. Well, it's like, well, it's an addictive type behaviour, isn't it? So it'd be exactly the same as somebody who's addicted to alcohol, just locking them in the room and expecting after a week for them to no longer be an alcoholic like, that's not how it's going to be. There's a function for the behaviour and I think educating parents around that, that's quite often common in our role anyway”

EPs consistently recognised a role for them in supporting others to understand what self-harm is, potentially challenging some of the common misconceptions surrounding self-harm. For example, participant 4 talked about viewing self-harm as more than cutting.

“And then I think part of it also includes understanding that it isn't just cutting. Like self-harm behaviours go beyond just cutting right? There are kind of deliberate risk as well”

Participant 7 talked about the power of demystifying self-harm and supporting people to see beyond the idea that self-harm is linked to an intention to end life.

“It's like people think that self-harm, suicidal ideation means end of their lives. They can't see that as a continuum you can't see the socially acceptable ways of you know, self-harm behaviours that we all engage in and so demystifying that can be very powerful.”

Subtheme 1.4: Distinct Contribution

This subtheme reflects the distinct contribution and skills that EPs believe they bring when supporting CYP, schools and parents to respond to self-harm, in comparison to other professions.

Participant 2 felt that EPs were well placed to offer support in relation to self-harm given their psychological understanding, consultation skills and ability to be able to consider the wider context and gain a holistic perspective of the young person's needs.

“Yes, I think we're well placed because I think we bring, we bring that sort of we bring a set of skills. So we bring a, you know hopefully an EP brings a set of sort of a psychological understanding skills alongside, a set of sort of consultation skills, the ability to be able to really tease out what's important, what might be happening, understanding function, whatever it may be in a situation. So I think that we are useful in that sense, we go into schools, we meet with parents so we try and get this nice whole picture of a young person. I think that's what we do effectively and what other services perhaps don't have the luxury of doing, you know they may not speak to parents as much or they may not get the school context or whatever it would be, so we would have that luxury a little bit so I do think we are well placed to help understand that.”

Participant 3 further emphasised the way in which EPs are positioned to work with children and young people in different ways to school staff.

“I mean I'd like to think that we've got different skills sets to school staff, but I also think that we are able to work with children in very different way to school staff. They don't get times to sit for an hour with kids and have a chat, like

they literally have minutes in secondary schools between lessons so we have the privilege, I suppose, of being able to have the time with children and young people to seek their opinions to kind of find things out and they might have never told anyone else so suppose”

Participant 2 described the core skills that EPs have that help them to problem solve and move situations forward.

“So that's where the core EP skills come. You know that the ability to help structure problem solving, whatever that looks like to help you know move situations forward through whether it be research or project or systems or individual casework, you'd have that ability to move forward.”

In addition to these skills, participant 6 felt that the way in which EPs interact with people and create safe spaces is their greatest tool.

“I mean, I think our greatest tool is without sounding arrogant is the way that we interact with people and the way that we set up a safe space and just the how we check in with people before we start launching into our millions of questions and being willing to let them take the lead in the small time that we've got so that they do feel safe and can trust the questions that we're asking.”

EPs also felt that their understanding of psychology and ability to apply psychological frameworks and approaches was unique to their role when supporting CYP, parents and schools to respond to self-harm. Participant 7 talked about using psychological frameworks to better understand a child's needs.

“Again, I think about Maslow's hierarchy of needs again, thinking about your psychological hat.”

“So my work with him started really to understand what's going on for him and try to understand his lived experience, what it means and slowly, slowly with my work I brought lots of kind of expertise and different modalities and thinking about narrative-based approach in terms of like thinking about the strengths and the resilience factors.”

Theme 2: Systemic Pressures Shaping Practice

Theme 2 explores the systemic barriers which impact on EP practice when supporting CYP, parents, and schools to respond to self-harm. Drawing on their practice experiences, it considers perceptions of the EP role and its evolving professional identity, obstacles to collaborative working, structural and systemic constraints, and difficulties relating to the conceptualisation of self-harm, as well as limitations in training and professional support.

Subtheme 2.1: The EP Role: Positioning, Boundaries and Evolving Identity

This subtheme captures the complexities of the EP role, in relation to evolving professional identity, how the role is perceived by others and the impact this has on how EPs position themselves.

EPs consistently highlighted difficulties related to how others perceive and understand their role. Participant 6 reflected on this, acknowledging that this is also a challenge for EPs themselves.

“They don't particularly seem a lot of people still don't seem to know what we do, which is fair enough because I struggle to know what we do sometimes.”

This was further emphasised by participant 3 who implied that it was difficult to define and explain the role to parents.

“Yeah, I find it hard when I have to. When I say to parents, you understand what an EP do and they go not really. I'm like oh God here I go...”

Participant 4 suggested that the assumptions held by other professionals about the EP role can make it difficult to work in different ways.

“I feel like there's also something in there around how we're perceived... Both amongst our colleagues in health who kind of their training is what it is as well as our colleagues in education who, who kind of are either SENCos or teachers or counsellors, you know, in school counsellors that kind of thing. There's a sense of who we are before we walked into the school, into the building, and so if the last, if I've gone into a school and the last three EPs the last five EPs have always done something in a particular way, there's an expectation of me and so that initial introduction is super important,

but it can also be the barrier that stops you from getting involved in that kind of work...”

EPs talked about how they are often perceived by others as experts in cognition and learning, limiting their opportunity to engage in work in other areas. Participant 7 talked about how this view of the EP role makes it difficult for other people to know how to use their expertise.

“I think that one of the barriers is like other people don't know how to use your expertise because there is assumption that you're just there for their learning and you do somehow you do standardised cognitive assessments, I've done only a few when I was assistant and when I had to do them in training. I've never done them before. I understand them. I see the value, but there's so much to prove. But it's also like people think that you are a person who does just the learning or just this or just the assessment to actually share that with them and to work and to support can be really, really challenging.

Participant 5 suggested that this construction of the EP role reflects the legacy of educational psychology, where historically cognition and learning would have been the primary focus of the EP role.

“I can think of EPs who would just be much happier dealing with more certain areas where there's more certainty and maybe that's a part of the legacy of educational psychology like I said, I think some of the EPs that trained a long time back I think have great knowledge in cognition and learning and that area but then my observation was that sometimes if you poured that out into the area of SEMH, therapeutic intervention, self-harm, that knowledge base and that confidence perhaps wasn't there. So perhaps there's that legacy being passed down and there's maybe a bit of potluck if you get, you know if you've got someone like myself who does work therapeutically, who is more confident to have conversations around it then perhaps as a trainee be just more open to those conversations, but I think you know if you met one of the EPs that was much more interested in cognition and learning, whether you'd have those same opportunities.”

Several EPs reflected on the evolving nature of the EP role and the changing landscape which has brought mental health into focus. This was echoed by participant 3.

“I suppose if you'd have asked me when I wanted to become an EP X amount of years ago, would this be something that we were working with or expected... yeah, expected to support with or was in our remit to support with, I probably would have said I wouldn't... I probably would have said no. So maybe that's just how schools. Well, the whole how mental health in itself has evolved into a much bigger discussion in schools and policies and practices around it have evolved, I suppose.”

Participant 2 reiterated this point, suggesting that historically self-harm would have been viewed as a clinical need and therefore something that EPs may not have been so involved with.

“whilst we do have a sort of a obviously a heavy interest in the application of psychology around schools we don't necessarily, because there is a an overlap with mental health services there is sometimes a grey area, I guess of what becomes a medicalised model and what becomes a clinical need and I think we're having more... historically and I'm guessing I've been doing it for a while, but not for ages. I think historically self-harm would have been seen as a clinical issue and I wonder now whether because of the waiting and the demand on clinical services, I wonder if we as EPs are seeing more, more difficulties that are or perhaps historically not necessarily something we would do the traditional IQ test type model of EP world has evolved. There's a much more... a heavy mental health requirement and I wonder whether we always see that whether we see that necessarily.”

Participant 5 talked about the ongoing debate in educational psychology about the extent to which EPs have a role in mental health.

“there's a sort of an ongoing age-old debate within educational psychology about how far we step into mental health, how far we step into therapeutic practice and I remember reading some papers about it in my training, I'm trying to think of the author, but there are some advocates who really say that that we do need to be working in this field and we do need to

be confident in this and I'm one of those people, but at the same time as you'll know, some colleagues just don't feel confident in this area and almost like they don't. I don't want to say they don't want to, but it's just not their bag."

Whilst there appears to be a tension in how EPs are perceived by others and the work they are able and willing to engage in, EPs generally distanced themselves from a medicalised model. This was highlighted by participant 1.

"Yeah. I think with that particular case, I'm going to admit that it was. Umm. I did feel a bit, you know, not very confident in sort of particularly with it being sort of moving more into that medical side of things. It was, you know, the having to redress and the infections. And I started to think, oh, you know, going back to our competencies and the remit of our role. So I did have to sort of take a step back and think, OK, where is our role and it is much more in that sort of emotional unpicking and understanding the emotional side of it I think or unpicking the function of that behaviour, we definitely have a role to play with that, and then it was thinking, OK, well, where do I draw the line? And actually this becomes much more of a perhaps more of a specialist or a medical, you know. So it's sort of working out where we fit in that, but I definitely think we have a role."

Participant 4 also suggested this, when reflecting on delivering training related to self-harm.

"I'm not training anyone how to do first aid. I'm not qualified in that, so I don't do that..."

Given the historical context of the EP role and distance from the medical model, EPs tended to position other professionals as experts in this area. Participant 4 emphasised how Clinical Psychologists have more experience in this area.

"I know colleagues in clinical psychology, for example, generally speaking, have more consistent experience in this area and therefore the provisions do touch on them differently. So the comments are specific to EPs or specific to psychologists who don't have as regular experience there."

Participant 1 suggested that EPs could work with emerging or lower-level self-harm but then signpost to other services as it becomes more complex.

“And I guess it's also I guess going back to that the remit and where you know, perhaps we would provide training around those kind of emerging lower level self-harm and perhaps when it becomes more complex we could offer some signposting or what the next steps are around that so again, going back to staff, being clear on who to go to for the right level of support, yeah.”

Participant 6 reflected on the difficulties associated with distinguishing therapy from broader therapeutic practice, suggesting that it can be uncomfortable for EPs to navigate this role when they are trying to work within professional standards.

“And I guess for us as well, there's a really fine line, isn't there between being therapeutic and being therapists, because we're not therapists and yet we are, I think we're considered mental health professionals still so we can still do things like EMDR and do that kind of training because we've got the qualifications, but we're structured under education and it's, but mental health is part of that and so it's a really fine balance I think that can be really murky, which can be uncomfortable. And I think because we're trying to make sure we stay within our our limits because of our professional standards that can be really hard.”

Subtheme 2.2: Fragmented Systems and Barriers to Joined up Working

This subtheme considers how fragmented systems and difficulties related to joined up working present as a barrier for EPs working with CYP, parents and schools when responding to self-harm.

Participant 1 felt there were a number of benefits to working closely with professionals from other services, suggesting that this approach would be the dream.

“maybe something like a person centred planning meeting where you've got, you know, members of health, members of, you know, all the different teams together and the young, potentially the young person, if they're feeling comfortable and having their voice as well would be really, you know really important part of that, but having a really safe space to be able to talk through,

develop a shared understanding and a clear action plan, so we're all on the same page. We're not stepping on each other's toes. We've all got a clear role and a clear remit with, with how we're going to support this young person going forward, I think that would be the dream.”

However, despite the perceived benefits of working in this way, participant 1 highlighted that this is not happening often.

“Not so much, I think, sadly. I think the services are incredibly stretched, aren't they? And... So no I no I haven't had any opportunities to, but I think there really should be shouldn't there?”

Participant 2 added to this, reflecting the difficulty of combining services who work under different structures.

“...without getting into political kind of the problem with waiting lists and the problem with demand is that sometimes people are looking for opportunities to reduce numbers rather than increase work, and so that the difficulty of combining services, the difficulty of combining services with different... under different structures, you know, education and health, you know, independent and local authority, you know that there's a real challenge in bringing people together”

The structure and capacity of other services was often suggested by EPs as the barrier to effective collaboration between services. This was highlighted by participant 1.

“And I guess capacity extends beyond our service, doesn't it, the barrier as well is the capacity of other services if you're, you know, if you're wanting to make a referral to other services and they're stretched. So there's a real it kind of goes beyond our service. It's there's a general... Yeah, lack of capacity and time across all services, all services are stretched and at the heart of that we've got these poor young people who are struggling.”

Participant 3 described feelings of hesitancy when referring CYP to other services due to perceived difficulties associated with joint working.

“I think I always get such negative feedback from parents about CAMHS that I’m very reluctant in lots of ways to even bother to recommend to, not to liaise with because I know obviously it would be great to work with them more because they’re speciality, that’s their area of specialism however whenever I say to parents, all I get is like an eye roll like oh, they’re not going to do anything. But no, we don’t work together in a joint way like that, no.”

Several EPs described the level of effort required to sustain professional relationships and engage in joined up work. This was reflected by participant 6, who suggested that they had to push for this to happen.

“I think it’s quite rare that we get to work with other professionals unless we push it.”

Participant 4 also reflected similar experiences when working with schools, suggesting it requires more effort to get them on board.

“So it’s not to say the school staff aren’t into it, but it feels.... like there’s a greater momentum required to get that initial OK.”

Another barrier to joined up working identified by EPs related to information sharing between services. Participant 4 talked about a recent experience where this presented as a barrier to collaborative working.

“...last week I think it was I had a really tough experience trying to build some collaboration around it was a very, very complex situation and it involved self-harm. It also involved some suicide ideation and suicide attempts and other kinds of neglect and abuse and stuff like that. It had been closed to social care. Social care were aware of it, but were no longer offering ongoing input and what was tricky was understanding how much social care were aware of or what they were aware of, what they had closed and what they were still open to, and because of the time... Was it a time thing? I ended up speaking with the information teams about whether or not information could be shared with me because of agent the, you know, cross agency, multi-agency work and GDPR and stuff like that. But I’m a big proponent of GDPR. I’m massive we should own our own data and at the same time, I recognise that that creates barriers for collaborative working.”

Participant 6 further emphasised this, reflecting the challenges associated with not being provided with all the relevant information.

“And I think there are huge barriers at schools. I don't know why. I don't know if it's like data protection or GDPR or something, but some schools just don't tell you and then it comes up like a few weeks later, you see a piece of paperwork or you have a conversation with parents and they're saying that's a really big part of the narrative and that completely reshapes your formulation and the work that you would have done with the young person...”

This was also highlighted by participant 3, who identified challenges with information sharing from schools.

“It's disclosed afterwards or yeah, and often in schools and I get it things are done on a need to know and if the young person doesn't disclose and the school don't think it's relevant, they wouldn't tell me. I mean, why they wouldn't think it was relevant? God only knows. But, you know, the needs to know with the... the child protection and the safeguarding, like sometimes you just never, you just don't find out.”

Subtheme 2.3: Structural Constraints

This subtheme represents the structural constraints that impact on EP practice when supporting CYP, parents and schools to respond to self-harm, including the context of the service in which they work, time and capacity and service position or policy on self-harm.

EPs talked about feeling restricted in what they can do with CYP and schools due to constraints within the structures in which they work. Participant 5 reflected on changes within the profession which mean they spend less time building relationships with children and schools.

“I think that's what lots of EPs who have been in the profession a long time often talk about is they sort of they rue the old days where they were able to work within the school and get to know the children and the families and the environments. And so perhaps in working in that way could provide

opportunities to sort of get to know a child and their situation and to support them a bit more, yeah.”

While EPs are well placed to offer support in this area, participant 6 feels the limited time and capacity available to EPs makes it difficult to engage in relational practice.

“I want to say yes because I think we're unlimited in what we can do as EPs because of our understanding of the context of education, of relational practice and working across the dynamics of family, teachers and young people. No, because we often don't have time, and that limited capacity when you've got to be relational and have time to see a young person more than once.”

Participant 1 reflected specifically on how issues associated with capacity present as a barrier to therapeutic work with young people, potentially reflecting the need to engage in more indirect work, as mentioned previously.

“I think time is a bit of it or capacity and time is a bit of a barrier because I think with all the best will in the world, it would be lovely, wouldn't it, to be able to actually have some dedicated time with a child really getting to understand them therapeutically and understanding you know what, what might be driving some of these responses and how we can support that and provide some alternative healthier strategies to manage some of those you know those feelings or you know... So I mean, we do have the skills to be able to support therapeutically and understand what you know what might be driving some of these responses. But sadly I don't think at the moment we have the time or the capacity to.”

Participant 6 added to this, suggesting that EPs aren't inherently different to other professionals but are constrained by the systems around them, making engagement in therapeutic work more challenging.

“It's so context specific, but I don't see us EPs as inherently different to clin psychs or counselling psychs or other practitioner psychologists in our capacity and ability to manage it, I think it's more the stuff that happens

around us that allows us to do the work. Traditionally, EPs don't have the time and space and opportunity to do the therapeutic work so we generally don't."

Commenting on their own workload, participant 7 recognised that this presented as a barrier to practice.

"I have ten schools and I'm working three days, sorry three and a half and I'm working only technically during term time, which is not true. But you know what I mean so there are lots of barriers there, barriers in terms of people's capacity."

Statutory demand was cited as a reason for limited capacity by participant 6. "whilst training in the local authority that I was in it as all statutory work, so very limited capacity around time."

EPs working within traded service contexts also felt that this could present with some challenges, including the way in which schools commission and pay for services. This was highlighted by participant 2.

"a barrier for a traded service is the nature of trading, the nature of schools needing to enter into an agreement to I say pay for, but that's ultimately what is happening in a service"

Participant 3 further emphasised this, recognising that schools are working within an economic climate associated with financial instability, meaning they have to prioritise how to use support.

"Yeah, especially with the economic kind of climate that schools can't really afford to buy too much of our time and what they are buying, they want to use really what they feel is most constructively."

This was reiterated by participant 6.

"I did try to do some more work with one of my teams, but because we were traded, the school didn't want to how to word it politely didn't want to spend their limited resources on one particular child alone where they didn't see that there would be for I think from their words, value in pursuing that which was a real shame."

Finally, EPs talked about the need for clear policies and a consistent service position or approach to managing self-harm. This was emphasised by participant 1.

“I think a clear service response as well as you know, a pathway almost... you know, this is as much as we can do to support when the cases are at this sort of tier, but actually this is what you know, a more specialist sort of tier might look like as well. So there's something about having a bit more of an up to date knowledge and skills and that kind of thing and to sort of to give us the confidence. But there's also something about our service having a clearer procedure as to who is best placed and how do we approach that because I know that we do have a critical incident lead and it's great to have that. But there is only one of them, or possibly 2, but you know they're stretched.”

Participant 4 reflected the need for clear policies and guidelines, recognising that this is not always the case within local authorities.

“...so I think part of it is also having clear policies, actually just something that's come to mind is that I don't know necessarily that every local authority psychology service has clear policies and guidelines on this is what we do in these sorts of situations. It's not just self-harm. It's, you know, suicide ideation. It's kind of whatever.”

In addition to clear policies and guidelines, participant 6 highlighted the need for a clear service statement that can be used in reports and a process for recording information.

“I think maybe just to reiterate the thing about writing it in reports as well by just knowing how to do that well would be useful. So having kind of exemplars and stuff or like the set paragraphs and stuff that had to go in, yeah. Yeah, because it's the whole process and how to feed that back into the systems that we've got because I appreciate that [our system] is absolute garbage. And when you get a phone call from a parent saying things like my child took an overdose where does that get recorded?”

Subtheme 2.4: Conceptual Uncertainty

This subtheme reflects the challenges professionals have in relation to defining and conceptualising self-harm.

EPs struggled to define self-harm in a consistent way, highlighting the subjective and socially constructed nature of the concept. Participant 3 highlighted this when reflecting honestly about their difficulty in defining self-harm.

“that's another thing I'm unsure what really, I still think I'm developing my understanding of I suppose what counts as self-harm because in theory we could argue drug use is self-harm in theory”

Adding to this, participant 3 reflected on how self-harm is more difficult to define in comparison to other areas of need.

“Yeah, because I know what an addiction is like. If you were to ask me to define an addiction, it's a behaviour that you can't stop and it's having a detrimental impact on your day-to-day functioning. Same with anxiety. If it's been present for X amount of weeks... like I get that but with self-harm, would I be able to give you such a concrete definition? Probably not.”

This difficulty is also reflected amongst other professionals and school staff that EPs work with. Participant 5 highlighted the ongoing debate around this within psychology.

“So, I mean the debate around self-harm or what it is goes on in in sort of every area of psychology, I'm sure. I think in learning disabilities it's... maybe feels a bit different because we have to often work differently or harder to unpick, self-harm”

Participant 6 talked about the challenges associated with school staff not recognising behaviour as self-harm, potentially reflecting the conceptual uncertainty surrounding self-harm.

“one member of staff had shared as well that they were, I don't think I'm trying to remember what their words. They weren't like serious that they were going to harm themselves, but some of the behaviours that they're already exhibiting were harming themselves just by not taking their medication and things which would have caused them a lot

of agony. But that it hadn't crossed their minds as well that they would potentially do something more"

Participant 2 further added to this when talking about the need to demystify self-harm and support understanding of what it is amongst EPs.

"But focusing on self-harm, I do think that helping EPs to sort of demystifying it and understanding it. Part of the training that I used to do is about myths and understand some things. And I think there's a lot of myth busting about what self-harm is and isn't what it represents, what you know."

Subtheme 2.5: Training and Professional Support

This subtheme reflects the level of training and professional support received by EPs in relation to self-harm.

EPs consistently highlighted a lack of training within the doctoral training programme which specifically focussed on self-harm. This was highlighted by participant 1.

"I mean... I don't actually. It's awful, but I don't actually remember there being a topic. I'm not sure if it was covered, if it was like that I don't remember it, which is quite telling in and of itself, because if I don't remember it, obviously. You know, maybe it wasn't given, maybe it wasn't given enough time. I don't think we've had... I haven't certainly had any sort of training in in service."

This was reiterated by participant 4, who did not feel that universities were doing enough when it came to self-harm and risk management.

"I don't think all universities train in risk assessment and that kind of approach and understanding or what does it mean and so on. I don't think all universities... will be doing... I want to be very careful here I don't think people are doing a bad job, I just don't think everyone's doing enough."

Participant 5 had a similar experience, finding it difficult to recall if self-harm had a heavy focus within the training programme.

“I don't recall it being it having a heavy focus if I'm being completely honest... and that might be partly my memory, but there are there are bits that I can recall really clearly because the focus was quite heavy on it, no I don't recall, maybe it came up more sort of incidentally in conversations”

Given the lack of training on the doctorate programme, participant 5 wondered whether it was good practice for EPs to engage in work in this area, despite being well placed.

“They're really well placed to do it, but if you and I are both wondering about whether we even had any training in this area, you would have to question whether it would be good practice or safe practice for us to do it.”

Theme 3: Carrying the Emotional Weight of Practice

Theme 3 reflects the emotional factors influencing EPs work when supporting CYP, parents and schools to respond to self-harm. It explores the emotional impact of practice in this area, perceptions of professional responsibility, including consideration of the possible implications of making a mistake, and the influence of language in shaping understanding and responses.

Subtheme 3.1: The Emotional Impact of Practice

This subtheme represents the emotional impact that supporting CYP, parents and schools to respond to self-harm has on EPs, considering how they feel when engaging in work in this area.

Participant 4 compared the impact of engaging in work in this area to other areas of EP practice, highlighting the emotional reaction it can evoke.

“You know if you're in this space, you're coming across some quite... Umm. Visceral things. They evoke emotional reaction. It's not the kind of thing that you know, it's not straightforward. It's very different to kind of just doing an assessment of reading skills and stuff like that.”

Participant 4 illustrated the emotional impact of work in this area when describing how it feels like leaving behind some of your heart and soul.

“...you kind of you leave some of your heart and soul with them when you're sharing kind of either your stories of things you've experienced or the care and attention that they give to these children. You you've got to honour that. You've got to respect what they do and what that means.”

Participant 6 reflected the difficulties in managing the emotional impact of practice and switching off following disclosures of self-harm.

“I think it's like another challenge is that it is really emotionally draining when you're working with that and it, you know, when it comes up by surprise in a meeting and stuff and you've got to completely reframe and yeah. And then I know some people are really good at switching it off and work is work and life is life. But I think for those who struggle with switching it off and we'll carry it with you, particularly when it happens on a Friday night at like 4:59 and then there's just no one around that, that kind of thing is really hard.”

The emotional impact of managing risk was highlighted by participant 7.

“when you feel like you are the only one who is managing the risk so that risk management sometimes sits really heavily on you”

Participant 7 felt that whilst enjoying specialist roles in this area this can be accompanied with feelings of emptiness.

“Another situation when you have a child that actually you're like, I don't know if you're safe. I don't know how being at home is protective or risk factor in terms of where you are and that can be that can deplete you completely. And in those days when I am in those specialist roles, as much as I enjoy them, when I leave the place, I feel empty, I feel totally empty.”

Subtheme 3.2: The Power of Language

This subtheme captures the power that language can have in shaping understanding and responses in relation to self-harm. Language within this context was viewed as laden with judgement and stigma, impacting on how people respond and feel about engaging in work in this area.

Participant 1 reflected on the power of language, recognising how the use of the word self-harm can lead people to interpret things in a different way.

“Because again, the word self-harm, doesn't it? It kind of almost has a... it has more power to it. I think it does have, it's something about it that makes you think it's sort of what it's got a bit of a shock factor to it, hasn't it? And it's a oh, whereas you know, if you frame it as well, they were head banging or they were doing this, you might think, well actually they were in distress, they were communicating this. But actually when you're using the word self-harm, you then think, oh, is it a mental health need. But actually when you then if you're not using that label and you're understanding it's actually what the function of that was that he was distressed and he was communicating XY and Z, whereas the term self-harm instantly makes you think right mental health doesn't it?”

This was further emphasised by participant 2 who felt that the use of the word self-harm on a referral would push some people away and draw some people in.

“And it's interesting that if a referral had self-harm on it, it would push some people away and pull some people in and I would step, I think I would step towards it, whereas some people would step away from it and I think that is that initial barrier that I'm talking about where some someone sort of thinks, yeah, I can maybe make have some impact here, whereas some people will think my impact will be negative, so I'm good, I need to move on. So I think I think that's where what I mean by that first, almost that initial word. You're right that power of the word and and it's those difficult things, you know, the language of mental health and language of difficulty. If people don't feel comfortable, it does set us back, doesn't it?”

Participant 6 wondered about how schools might feel when confronted with language related to self-harm compared to language related to other areas of need and how this might impact on responses.

“And it's not that we don't take it seriously, but it's that we don't then go in all guns blazing well, you know, calling up social services and stuff and so, recognising what's appropriate age wise and obviously contextually is I think that would be really useful because schools as well, the moment you

hear that kind of thing... I just wonder what level of responsibility schools feel when they hear that in comparison to I'm being bullied or something like that. That's a different question."

Participant 6 reflected on the judgement that can be associated with language around self-harm and suicide.

"...even just the language around that people commit suicides that being the incorrect language to use because it's laden with judgement, isn't it?"

Based on the language used and the assumptions that come alongside it, participant 5 felt that this could lead to the wrong frameworks being applied.

"It's like I said about those presuppositions so I think just by using a term like self-harm, it comes with a lot of baggage and understanding or misunderstanding and I suppose if we always start at that point, we could potentially apply the wrong frameworks based upon that"

Subtheme 3.3: Professional Responsibility

This subtheme reflects the level of professional responsibility felt by EPs when supporting CYP, parents and schools to respond to self-harm, considering the consequences of getting something wrong and responsibility to work safely and ethically, within supportive frameworks.

Linked to the previous subtheme on the emotional impact of practice, EPs consistently talked about the potential consequences of getting something wrong when working with CYP who engage in self-harming behaviours, indicating a level of fear. Participant 4 highlighted this, suggesting that death could be a consequence.

"Those sorts of things you have to be on top of. And it's a risk for me because if I forget to make that phone call, if I don't say enough on the phone, the repercussions of that can be substantive.... It could lead to death and. Yeah, putting all of my kind of the risks to my career to one side, this is still a human who has need, is in pain and all of those things and I need to make sure I'm doing everything I can and that requires me to be available outside of the 9:00 to 5:00 or have protocols for someone to be available outside of the 9:00 to 5:00."

This was further emphasised by participant 3 who felt that doing the right thing was paramount.

“I think when you're dealing with something that could have serious consequences, you definitely want to do the right thing. That's kind of paramount.”

As a result of the possible consequences associated with getting something wrong, participant 5 felt this led to trepidation when making recommendations and less creativity in approaches.

“So I think, yeah, for me, like I said, there's quite a lot of trepidation around making recommendations in this area. I suppose if it was maybe a learning need I feel much more comfortable to say, OK, I don't know there's not an evidence base around this, but why don't we try doing this it's a bit wacky, it's a little, it's a little bit left field, but what could go wrong? But when I think we're talking about self-harm, we know what can go wrong and so perhaps we're maybe less creative in our approaches, yeah. Rightly or wrongly.”

Participant 4 emphasised the importance of EPs using their initiative and taking responsibility when it comes to safeguarding.

“Yeah, we all have the responsibility to ask the questions when we're working with children, if the conversation is going in that direction, you know if it's appropriate you don't randomly just ask someone if they've hurt themselves, cut themselves and so on. But you know, if your conversation's leading in that direction. As a psychologist in the room, you need to be sometimes, the word isn't brave, but sometimes the word is take initiative and use your intuition to ask the question because it is a matter of safeguarding and actually, you know, safeguarding is everyone's responsibility.”

Given the potential implications of practice, participant 1 felt it was important to be clear on the remit of EP practice in this area.

“I think that at the heart of it... you want to be clear on where our remit is, making sure we're practising safely and ethically within our remit, that the boundaries are clear and ultimately, we're doing the best that we can for the young person and making sure that they are ultimately that they're safe.”

Participant 1 felt it was particularly important for EPs to reflect on their competence when engaging in work which reflects more of a medical need.

“I think it goes back to my concern about the medical aspects, so with that, you know there's cuts and wounds and they're becoming infected and we're giving advice. You know, I'm becoming implicated into that and I that kind of I guess it's that responsibility, isn't it? And we don't want to be drawn into something that perhaps isn't within our remit and obviously, offering medical advice isn't part of our role, so I guess it's for me. It was that concern about my role slipping into that and then it, yeah. And just going back to our competencies and kind of where our competencies lie and to kind of not to do more harm than good. So I think for me it was getting a little bit uncomfortable because I think some of the conversations were steering towards that and there were questions around that that I didn't feel competent, certainly not competent enough to and certainly didn't feel it was ethically appropriate to be providing advice around the medical side of things. So there was sort of slipping into that which I was a little bit concerned about.”

Participant 7 also highlighted the importance of EPs recognising the limits to their practice.

“I'm like, OK, if somebody is psychotic and I'm like, OK, this is a bit out of my depth. OK. I work with adults who are psychotic but actually this is like what is this like I can't you know and within that recognising what is your limits can be really, really important.”

Further reflecting the need to practise safely and ethically, participant 5 talked about working within the confines of guidelines to support practice.

“...something that was drilled into me in the learning disability team, in the adult LD team, was to always work within the confines of NICE guidelines to protect myself”

Theme 4: Conditions Enabling Practice

Theme 4 captures the factors EPs perceive as supportive to practice when working with CYP, parents and schools to respond to self-harm. Drawing on their professional experiences, it highlights tools which enable effective practice such as resources and evidence-informed approaches and supervision, reflection and containment. It also highlights the role of personal motivation as a driver to engagement in this type of work, as well as the influence of service context in facilitating practice.

Subtheme 4.1: Resources, Guidance and Evidence Informed Practice

This subtheme summarises the ways in which EP practice in relation to self-harm is supported by resources and evidence informed guidance.

Several EPs commented on the availability and usefulness of online resources when supporting CYP, parents and schools to respond to self-harm. Participant 2 reflected on the growth of online resources and the availability of information.

“it seems mad to think of it now but the actually the growth of online, I say it like I'm a dinosaur, but the growth of online resource has come along so you know when you think about Young Minds and various other things, so Young Minds, you know, mental health services online, online papers so actually what really assisted that was an interest then that came alongside sort of some policy research alongside resources, I guess, and the availability of things that we hadn't necessarily seen before. And like I say, it seems crazy to say it now in real time, but that was what was happening. The evolution of availability of information.”

While encouraging professionals to use online resources, participant 4 highlighted the importance of professionals using their discretion to interpret them cautiously.

“I would encourage people to just Google... And when I say people, I mean kind of professionals and I'd expect them to use their professional discretion

to be able to sort the wheat from the chaff... You know, there's tonnes of stuff available online.”

Evidence informed practice appeared to be important to EPs, with several commenting on the legitimacy of information. This was highlighted by participant 3.

“Internet probably, I would have gone on the Internet and Googled whatever was recommended. Places like Young Minds or Anna Freud centre, NHS... I try to stick to those kind of sources because like I can direct parents to those and they're obviously legit.”

This was further emphasised by participant 7, who talked about resources being based on research.

“The Oxford one was kind of one of the key ones that I always share also with people because it's like obviously from research”

In addition to online resources, EPs also talked about drawing upon human resources. Participant 1 reflected on drawing upon other team members with more knowledge.

“obviously like, say, start drawing on [team member] who has she often I mean, she shared some resources with me when all of this, when this case was kind of happening when she was involved in that, there was like a follow up e-mail with a number of resources which you know, it's good to have a bit of an understanding of and she referred to the NICE guidelines as well around how to you know the best practise for schools and things. So that's also useful to draw upon.”

Participant 5 also reflected on drawing on resources within the team.

“There are so many resources within the team, so I would go into that to... So yeah, I think I draw on the resources we've had, but I also draw on the human resources mostly I think so, as you said, one of the privileges I have is being able to formulate with other colleagues...”

EPs also reflected on the usefulness of tools and resources to facilitate discussions with young people about self-harm. This is illustrated by participant 6 who talked about drawing on questionnaires and scales.

“I think initially the questionnaires really helped, so like the resiliency scales and the RCADS, just because the questions are already there and so I've kind of prepped them and said some of the questions might be a bit weird or might make you feel a bit uncomfortable, we can talk through that and there's a few questions I need to check at the end just to make sure that you're OK and you're safe”

“I mean the questionnaires, like I said, were very supportive, just giving me a bit of a structure to asking those questions.”

Subtheme 4.2: Supervision, Reflection and Containment

This subtheme captures the value of supervision, reflection and containment for EPs when supporting CYP, parents and schools to respond to self-harm, considering the emotional impact of practice in this area.

Participant 1 reflected on the value of supervision in unpicking things when you are unsure.

“I think as well having supervision, you know our staff, our team are really great at providing a good package of supervision, so if you're really not sure about something you can ask your supervisor and troubleshoot it and unpick it a little bit more what we you know... what the barriers were in that situation. So I think and that can be really useful as well.”

Participant 5 recognised the value in being part of a multi-disciplinary team and sharing expertise during incidental peer supervision.

“as I said, we're literally situated in the same office, so I can turn around and say you were talking about this, what do you think of this? Or you know I'm working with something similar, but it's different because you know these are the factors as to why it's different... What do you think? And other people you know might join in so that feels so I suppose it's that like incidental supervision, peer supervision, ongoing peer supervision. Yeah, which is which is really useful, it gives you a bit more confidence in what you're doing.”

Participant 2 reflected on the usefulness of reflective spaces to think through responses and consider any gaps in knowledge.

“I think it's been really useful just for me to think through the role and to think through my responses and the gaps, I guess it's the bit that I think it's interesting, the things that I've done, but also the things that I haven't done, all the things that have lapsed, which yeah, will be interesting moving forward.”

As well as using supervision as a space to unpick challenging casework and share ideas, EPs also valued a space that provides psychological safety and containment. This was highlighted by participant 3.

“So maybe it's like that containment, like that must have been that's quite a lot and then sort of like a time to problem solve and what to do next. I think that's probably the most helpful thing about the supervision sessions and equally, when we're all faced with something that we don't want to mess up knowing you've got someone you can just ring and will reassure you that will basically give you, tell you what to do.”

Participant 5 felt that psychological safety within teams was important, so people can express when they are finding something challenging.

“I think a space for colleagues to share their reflections, to share their practice, and perhaps most importantly, to share the areas that they're less confident in, as I said, about head banging. You know, it takes a really confident team, psychologically safe team, to say I don't know where to go with this, I'm baffled and I'm worried because it could potentially show a gap in your practice, but I think we have to be confident enough to say that”

This was reiterated by participant 6 who talked about the importance of a culture of openness within teams.

“And I guess we need that again that culture within our team of being open about it, because otherwise you might not feel comfortable bringing it up into supervision. And if you asked the question and it went terribly to admit that

can be really daunting as well. Yeah, admit it's not that it doesn't feel like the right word, but yeah.”

Subtheme 4.3: Personal Motivation

This subtheme reflects EPs personal interest and motivation to engage in work related to self-harm, considering their personal and professional experiences.

Several EPs reflected on their previous professional experience which led to them feeling more confident when approaching self-harm and therefore more likely to engage in this work. Participant 3 felt that personal and professional experience prior to becoming an EP prepared them to engage in this kind of work more than the doctoral training.

“I also used to volunteer at ChildLine and I also used to be DSL at school. I used to be a SENCo and teacher and I was DSL, so I don't think if I was a EP that had maybe worked had come to this route by, you know by a different path and maybe hadn't had some of the personal experience because I've had family members engage in self-harm too, so I think maybe like by default, yeah, I did feel OK, but would I put that down to [the training provider] and the training I've received? No.”

Participant 4 had a similar experience, reflecting on their experiences prior to becoming an EP and how this led to them feeling more prepared and comfortable.

“So I feel like my experience prior to training opened my... willingness to kind of get into the real extremes might be a bit dramatic, but the kind of upper average outside of the the norms of the work around SEMH presentations. I felt equipped to get involved in it. I took an interest in it. I did the reading, I did the extra work and I'm comfortable working in that space.”

This was also expressed by participant 5, who had experience prior to becoming an EP within clinical settings, where exposure to these kinds of presentations was more common.

“I mean, I suppose because I'd worked in clinical settings as an assistant for over three years that really helped and I think I do reflect on it quite often and I think in particular, I worked in a Tier 3 CAMHS setting and I

think so much of what I do now was learnt from being in that setting full time every day on the ground working with children displaying distressed behaviours so yeah, it's allowed me to feel to sort of sit with that uncomfortableness, I suppose with really distressed behaviours and before that I worked in the short stay school as a teacher so again, I think once you can sit close to the flames in those environments”

In addition to professional experience, EPs also reflected on their personal experiences and how this drew them to work in this area. This was reflected by participant 5.

“And I wonder if it's because if you, even if you've been around it, so if you've had a family member that's self-harmed, I'm sure your interest in that area is going to be much, much higher. If you've self-harmed yourself...”

Participant 7 added to this, suggesting their own experiences of self-harm as a teenager drew them towards this kind of work.

“So it and not many psychologists in my role that they're classified as EPs do any therapeutic stuff or much of that unless they're areas of interest, for me that's essence of my role that I do in terms of mental health is a big one and within the self-harm also because when I was a teenager I also had this self-harming behaviour. So there was also personal reason to be drawn into that I guess. So for me it's like OK, if somebody was there for me to help me when I needed the most I could have managed things better, but it's also I'm kind of an example to also to say that that no matter how difficult this is, is you can get over it”

This was also reflected by participant 6 who felt that their personal experience enabled them to ask the questions they were not asked as a young person.

“I think my personal experience has helped a lot because I know the kind of questions that I wish people had asked like growing up and so that. Yeah, that's kind of given me a bit more impetus to ask those questions as well”

As well as personal and professional experiences, EPs also talked about a general interest in the topic and having the drive to do research and follow this interest. This was highlighted by participant 4.

“And then I think the final thing I'd say is in terms of what would be helpful is just where people take an interest, if it's like an area of personal interest, professional interest. Then just kind of going in on that and saying, well, I'm interested in people who use this as a strategy for these reasons. And so let me do the reading. Let me engage in this space. As you know, just like you're doing with your research here right here. Clearly, there's an interest, which has... it's just brought you to this place.”

Participant 7 also reflected this.

“And self-interest as well. You should be driven to learn and to you know, all of those things as well is not just expect from the procedures to be there.”

Subtheme 4.4: Service Context

While service context and systemic constraints can be a barrier to practice, this subtheme reflects the service contexts that can support EPs to engage in work related to self-harm.

Participant 2 talked about the value of working within a traded service, in terms of being able to be flexible and follow personal interests, without the constraints of the statutory role.

“that comes freedom as well because if a situation arises where someone is happy to do that, we are able to prioritise time and to be flexible around that so I would say that what works well is our flexibility to do something if we need to do something, go somewhere, do a sequence of sessions with someone we can do it as long as the provider... the providee if you like is happy with that so we're we're OK with that. So that's nice that flexibility. We're not necessarily constrained by... an EP role within local authorities typically has a statutory role, has you know has other things that are going on, doesn't it? We're not as constrained by that.”

“Yeah, it's nice. It is that nice bit to, you know, be able to do that and to follow interests I think as well you know if you have an interest you can perhaps put

forward a good argument for following that interest and areas of specialism whereas if you are in a more constrained situation, you might not have the time or the ability to do that.”

Working within a specialist service, participant 5 reflected on the greater depth involved in the work in comparison to the local authority.

“Yeah, really different. It gives me the opportunity to work a lot closer with children and families and systems. So as yeah, as a sort of main grade EP I would as you know do a piece of work, do an assessment, often write a report and send it, and that would often be it. There were other bits to the job, like training and yeah, working in SRBs in the autism SRBs, which gave me greater depth. But, I don't think I've ever worked at this depth since being qualified.”

Adding to this, participant 5 also talked about having more space to be creative in practice.

“I think now there because perhaps with the learning disability community there's a sense that you have to be somewhat more creative but perhaps we're allowed more space to explore that safely and I think there with the people that I work with this, there's a really good understanding of learning disabilities in that you have to work outside of what is typical”

Participant 4 felt that working within private practice made it easier to work collaboratively with other services, reflecting an additional benefit of working within this context.

“it's not always been the case that I've been able to collaborate, build partnership with be in service with services who have similar structures and outcomes and goals and stuff like that, so I guess the quick answer is in private practice it's easier. Or... I mean, it might not be easier. It depends on kind of a very variety of different factors. I have found it easier in private practice”

Discussion

This study explored the perspectives of seven qualified EPs and their perceptions of their role in supporting CYP, parents and schools to respond to self-harm. The aim was to explore how well-equipped EPs feel to carry out work in this area through consideration of the key barriers and facilitators, highlighting implications for practice and training providers. The research attempted to address the following research questions:

- 1) How are EPs currently supporting CYP, parents and schools to respond to self-harm?
- 2) Do EPs feel equipped to support CYP, parents and schools to respond to self-harm?
- 3) What do EPs see as the key barriers and facilitators to their work in supporting CYP, parents and schools with self-harm?

In the present study, EPs perspectives suggest that they engage in a variety of work related to self-harm, across multiple different levels. This is not dissimilar to previous research which recognises EPs as engaging in a variety of work related to SEMH across the five core functions of the role (Scottish Executive, 2002), across multiple system levels and age ranges (Purewal, 2020). EPs in the present study suggested that their work ranged from direct therapeutic intervention with CYP to work with parents and school staff.

Whilst some EPs engaged in therapeutic work with CYP, this appeared to reflect the service context within which they worked, with traded services and private practice appearing to offer more space for flexibility and creative approaches. In contrast, EPs working within local authority services reflected structural demands which constrained their practice, including time, capacity and statutory demand. This aligns with findings from the Scottish Executive (2002), where EPs consistently recognised therapeutic intervention as a core area of practice which was diminished due to workload issues. They suggested that they spent too much time on assessment, limiting their ability to engage in other areas of practice.

Given these constraints, EPs in the present study recognised their role as operating across the systems surrounding CYP, with particular emphasis on building the capacity of those working closely with the CYP. They identified several areas of practice, including delivering staff training, supervision, making onward referrals and

contributing to policy. Although these activities may not always involve direct contact with CYP, they can shape how self-harm is understood and responded to within schools and thereby influence the support and outcomes of CYP who are engaging in self-harm. This role for EPs has been advocated for within the literature, with suggestion that EPs are well placed to offer support at a systems level through the development of policy and staff training (Lewis et al., 2020) and supervision (Lee, 2016).

Whilst EPs in the present study encountered self-harm within their practice, this did not reflect a common area of practice, and they typically tended to engage in this work due to personal interest and motivation. Given that self-harm sits at the intersection of health and education, this may create uncertainty about which professionals are best placed to provide support, with EPs expressing concern about overstepping the boundaries of their roles. They consistently advocated for a joined-up approach to support, recognising the advantages of working with other professionals to develop a shared understanding and ensure CYP receive the best support. However, despite a willingness to work in this way, EPs reflected a number of challenges in practice, including the capacity of other services, combining services who work under different structures and information sharing, with the suggestion that maintaining collaboration is effortful.

This is not a unique challenge, with issues associated with multi-agency working frequently reported within the literature. The introduction of the 'Every Child Matters' (Department for Education and Skills, 2003) agenda placed greater emphasis on multi-agency working and improved communication between services supporting CYP and their families. However, a number of barriers still make effective collaboration difficult. For CAMHS services specifically barriers to effective multi-agency working include the continued domination of the medical model, a lack of understanding between agencies regarding professional culture and roles and difficulties in maintaining clear professional roles whilst working collaboratively (Miller & Ahmad, 2000). Hulme (2017) looked specifically at the barriers to multi-agency working between EPs, CAMHS and schools and highlighted challenges associated with fear of risk, resources and time, communication and ownership, aligning closely with the findings of the present study.

Hulme (2017) suggested that effective multi-agency working was facilitated by a clear understanding of others' roles. Similar findings emerged within the present

study, with EPs consistently highlighting challenges associated with other professionals perceiving and understanding their role in different ways. In particular, EPs identified that they were often positioned as experts in cognition and learning, limiting their ability to engage in work in other areas, simply because others did not recognise this as part of their remit. This is unsurprising, given the challenges EPs face in defining and conceptualising their role in mental health. This is an area which has been widely debated within the profession, with issues raised regarding EPs confidence, training and capacity in this area (Miller, 2016; Wade, 2016). This traditional conceptualisation of the EP role, which does not necessarily recognise mental health as a key area of practice, is reflected at a systemic level, with several EPs reporting a lack of policy guidance and service statement related to self-harm.

Despite self-harm not being viewed as a traditional area of EP practice, EPs in the present study felt that they were well placed to offer support in this area given the skills they have. They highlighted skills in consultation, problem solving, interaction and understanding of psychology which make them different from other professionals and allow them to effectively support CYP, parents and schools. Cameron (2006) reiterated the distinct role of EPs, highlighting the factors which make their perspective different from other professional groups, including their knowledge of psychology and ability to draw on this to understand complex human behaviour and recommend evidence-based strategies. Yusuf (2025) adds to this, recognising the role of EPs in addressing mental health needs by designing inclusive learning environments, equipping teachers with the skills to address mental health challenges and integrating intervention strategies into the curriculum. This aligns with the indirect approach suggested by participants in the current study.

While EPs possess skills that position them well to provide support in this area, all participants in the present study reported a lack of training related to self-harm, suggesting it is not embedded within the doctoral training programme. This raises questions about whether it is ethical for EPs to offer specialised support in this area, given that professional attitudes and approaches to self-harm greatly impact on help seeking behaviour (Waller et al., 2023) and can lead to further harm (Spandler, 1996). Lee (2016) raised similar questions about the preparedness of EPs in undertaking self-harm training for schools, calling for a review into whether self-harm is embedded in the curriculum.

Perhaps reflecting the lack of training in this area, EPs in the present study did not have a clear definition of what constitutes as self-harm and suggested that it is more complex to define than other areas of practice, such as anxiety or addiction. This issue appeared to extend beyond EPs, with participants suggesting that other professionals they encounter in practice also struggle to conceptualise and understand self-harm. Given there is no universally accepted definition of self-harm within the literature and considerable variation in the terminology used to describe self-harm (Silverman & De Leo, 2016), this difficulty appears to reflect a wider issue. Participants in the present study reflected on the power of language used to describe self-harm, noting that this can often be laden with stigma and judgement, shaping understanding and responses to self-harm. They suggested a potential role for themselves in supporting professionals to understand self-harm by unpicking the function of the behaviour and challenging the common misconceptions associated with self-harm. However, given EPs experience uncertainty themselves when it comes to defining self-harm, there is a need for further work in this area to ensure a consistent approach to practice.

Further to this, the language used to describe self-harm appears to impact on EPs willingness to engage in work in this area, with EPs suggesting that the terminology positions self-harm as a mental health need and leads to fear. EPs consistently positioned themselves away from the medical aspect of work in this area, suggesting that this is outside of their competence. This reflected a wider theme related to professional responsibility, with EPs suggesting that the implications of getting something wrong when dealing with self-harm are much greater than other areas of practice and can lead to further harm and even death. Given the possible implications of practice, EPs in the present study consistently reflected the need to recognise the limits of their practice and draw on evidence informed resources, such as the NICE guidelines. This aligns with broader research on the role of the EP in therapeutic practice, which frames therapeutic work as unsafe, dangerous, and frightening, emphasising the importance of self-awareness among EPs (Wade, 2016). It is likely that this lack of confidence amongst EPs stems from the limited training they have received.

When describing their work in relation to self-harm, participants highlighted the emotional impact of practice, describing feelings of emptiness, heaviness and depletion. Given this, they recognised the importance of supervision and

containment to support their emotional wellbeing. In particular, they felt that supervision was useful to share expertise, unpick challenging casework, consider their responses and identify any gaps in their knowledge. Bion's (1962) container theory describes the psychological process where one person (the container) receives and processes the emotional feelings of another (the contained), returning them in a more manageable way, so that the person feels regulated and calm. Participants in the present study recognised the value of supervision as a space where they can feel contained, supporting them to manage the emotional impact of practice. This is particularly important as EPs need to feel safe and contained themselves in order to support others to feel this way, which is a key aspect of their role when working with self-harm.

In addition to this, EPs also recognised the need for psychological safety within teams so they can express when they feel less confident or unsure of something. Psychological safety refers to a shared belief between members of a team that it is safe to take risks, express ideas and concerns, ask questions and admit to mistakes without fear of negative consequences (Edmondson, 1999). This is particularly important in relation to self-harm as this is an area where EPs have already expressed feeling less confident and having less training and knowledge. Psychological safety can lead to individuals within a team feeling more engaged and motivated and ensures a diverse range of perspectives are heard and considered, leading to better decision making (Edmondson, 1999). This culture within teams would support EPs to openly reflect on gaps in their knowledge and identify areas for further development and training, leading to more consistent practice when responding to self-harm.

Further facilitating EP practice in relation to self-harm, EPs identified previous personal and professional experiences which drove their interest and motivation to engage in work in this area. EPs reflected on a number of experiences prior to training to become an EP which facilitated their practice, including more direct work related to self-harm in other service contexts, such as CAMHS and teaching roles, as well as their own personal experiences of engaging in self-harm themselves or experiencing it within their family. EPs felt that this prepared them more for work in this area than the doctoral training, leading to a greater willingness to get involved and more confidence. EPs also reflected on having a personal interest in the topic area, which acted as a driver to them engaging in further research and learning.

Considering motivation more generally, self-determination theory might help to understand why some EPs are driven to engage in certain experiences. Ryan and Deci (2000) suggest that human motivation is largely driven by three needs: autonomy or the desire to feel in control of one's actions and behaviours, competence or the need to feel effective and capable and relatedness or the need to feel connected and supported by others. Dreison et al. (2016) suggested that fulfilment of these core needs reduces burnout amongst mental health professionals, with supervisory support, self-efficacy and staff cohesion reducing burnout even after taking the impact of job demands into account. These findings align closely with the suggestions made by EPs when considering how their practice in relation to self-harm could be supported.

This could be used as a framework to understand the findings from the present study. Themes related to effective training, support and guidance reflect a need for competence in this area, whilst themes related to supervision, containment, psychological safety and the importance of maintaining positive collaborative relationships with other professionals reflect a need for relatedness. Finally, consideration of the structural constraints within services, which limit creative practices and reduce engagement in therapeutic working reflect a need for autonomy. It is possible that meeting these core needs could mediate the emotional impact of practice in this area, encouraging EPs to approach this work with more confidence.

Conclusion

This study explored the perspectives of seven qualified EPs, attempting to further understand their role in relation to supporting CYP, parents and schools to respond to self-harm. Considering the lack of clarity and professional identity surrounding the EP role in mental health more generally, this research was interested in how EPs conceptualised their role in this area, considering how prepared they felt to carry out this work. The findings indicate that EPs are aware of the skills they have to support CYP, parents and schools to respond to self-harm, yet they describe a number of barriers which impact on their ability to carry out work in this area.

The key barriers to practice related to self-harm include the positioning of EPs and their evolving identity in mental health, as well as difficulties associated with multi-agency working, structural constraints within service delivery models, the uncertainty surrounding the conceptualisation of self-harm and a lack of training and professional support related specifically to self-harm. EPs typically positioned self-harm as emotionally demanding, reflecting on the power of language used to describe self-harm and the level of professional responsibility involved when engaging in work in this area.

Overall, the findings suggest that EPs' constructions of their role in responding to self-harm are shaped by the interaction of multiple generative mechanisms operating at the real level. Systemic pressures, emotional experiences, and enabling conditions are collectively influencing how EPs understand their professional identity, negotiate their responsibilities, and realise their distinctive contribution. From a critical realist perspective, these constructions are understood not as individual perceptions alone, but as products of broader structural and contextual influences that both constrain and facilitate practice.

The reported lack of service wide policies and procedures related to self-harm, alongside limited opportunities for multi-agency working and insufficient training, may contribute to reduced confidence and a construction of the role that is more distant. These systemic conditions may heighten fears of making mistakes and feelings of increased professional responsibility, shaping how EPs perceive their competence and define the boundaries of their involvement. Consequently, EPs appear more comfortable working systemically to build capacity in the systems surrounding CYP who self-harm, while expressing greater apprehension about involvement in presentations perceived as more complex, frequently noting the need to work within their competence.

In addition to this, EPs also identified a number of factors which enable their practice in this area, including the availability of online resources and evidence informed guidance, the use of supervision spaces which aid reflection and containment, personal and professional experiences which impact on their willingness and motivation to engage in this work and the service context within which they work, which facilitates creativity and engagement in therapeutic approaches. While some EPs report a willingness and interest to get involved in work in this area, this does not appear to reflect the experiences of all EPs, and the

research highlights that further work is needed to consider how EPs can work more consistently in this area and feel more confident in sharing their unique perspective. Aligned with the findings from the study, some suggestions for developing EP practice in this area are considered at an individual, organisational and course level.

Implications for EPs

In considering the implications for practice, the findings highlight the way in which the existing skills and knowledge of EPs can be utilised to support CYP, parents and schools to respond to self-harm. EPs are equipped with skills in consultation, psychological understanding and have an ability to work at a systemic level to affect change, supporting professional understanding and approaches to self-harm. They are able to build capacity in systems through indirect ways of working, such as offering supervision, delivering training and contributing to policy, highlighting that they are well positioned to offer support in this area. However, there are a number of barriers which impact on their ability to work effectively in this area.

At an individual level, it might be advantageous for EPs to consider and reflect on their own knowledge, confidence and experiences before engaging in work related to self-harm. The HCPC standards of conduct, performance and ethics (2024) reflect the need for EPs to be able to recognise the limits of their practice and work within their competence. This is particularly important when supporting CYP engaging in self-harm as the implications of practice can be great and can impact on future help seeking behaviour (Waller et al., 2023). EPs could also develop their practice in this area by drawing on evidence informed approaches and guidance. The NICE guidelines (2022) in particular, set out a clear definition of self-harm and provide guidance on how to approach self-harm, manage confidentiality, carry out risk assessments and provide support, supporting EPs to develop a consistent approach to practice.

Implications for EP Services

At a service level, it is important that EP services consider their approach to self-harm, with clear policies and procedures in place for staff members who are expected to engage in work in this area. Participants in the current study reflected a

lack of clear service position or approach to self-harm, along with unclear systems for reporting and recording self-harm and advocated for a clearer whole service view. This could include the adoption of a service level definition, as is the case for other areas of practice, such as dyslexia, to ensure EPs are working consistently. Input at a whole service level might help EPs to feel safer when engaging in an area of work where the emotional impact of practice and perceived professional responsibility is great.

In addition to this, it is important for EP services to consider the sense of psychological safety within teams. Participants in the present study reflected the need for a shift in professional culture, to one where they are able to talk openly about areas of practice that are more challenging or where they feel less sure. This could be facilitated by fostering open communication, encouraging active and respectful input from all team members, setting clear team expectations and reframing mistakes as opportunities for learning and growth. Having this kind of team culture and ethos will support EPs to be open about the areas of practice where they feel less confident, identifying areas where further training or development might be required. This can also be facilitated through safe and containing supervision spaces, where EPs are able to reflect on their practice, problem solve challenging casework and manage the emotional demands of work in this area.

Another key implication for EP services highlighted in the present study relates to multi-agency collaboration. Participants consistently advocated for a joined-up approach to work related to self-harm, given its positioning at the intersection between education and health. However, they suggested that collaboration with other services is difficult to maintain and is constrained by professional capacity, structural barriers and difficulties related to information sharing. Further complicating this, EPs reflected the lack of understanding of the EP role amongst other professional groups, limiting their ability to engage in work related to mental health more generally. Given these difficulties, it might be beneficial for EP services to promote awareness of their service offer and professional skillset amongst joint professional groups, aiding understanding of the EP role and unique contribution. Consideration of how EP services could develop their professional relationships with mental services specifically would also be beneficial, allowing for joined up approaches to support and less fragmented support for CYP.

Implications for Training Providers

All EPs in the present study highlighted a lack of training in relation to self-harm on the doctoral training programme, suggesting this is not embedded within the curriculum or covered in any depth. Given this is something EPs are engaging with in practice and report feeling a lack of confidence and increased feelings of professional responsibility, it might be useful for training providers to consider whether this could be addressed on the course. The findings from this study suggest that it would be useful to consider definitions of self-harm, approaches to self-harm and the unique EP contribution, considering the boundaries of the role and when to refer to other professionals. Further emphasising the importance of this, the NICE guidelines (2022) suggest that all staff who work with people who self-harm should have specific training to their role so that they can provide appropriate treatment and care. The guidelines recommend that training should cover the range of behaviours that can be considered self-harm, their treatment and management, and how to communicate compassionately to support engagement. It should also address stigma, cultural competence, the impact of comorbidities, assessing safety, and understanding formal treatment processes.

Limitations

This section considers the potential limitations of the present study, alongside the implications this may have for future research. Firstly, the research sought to specifically explore the perceptions of EPs and so the voice of CYP and families is absent. Given the stigma associated with self-harm and the lack of understanding across various contexts, it is vital that the perspectives of those who have engaged in self-harm are included in research to push against these narratives and highlight their strengths and values (Hasking et al., 2025). In order to meaningfully engage people with lived experience, Hasking et al. (2025) suggest that a shift to more genuine modes of engagement is needed, fostering stigma resistance and moving towards more inclusive practice. The inclusion of CYP's voices in the present study would have helped to understand their experiences when accessing support from professionals, such as EPs, further adding to the understanding of the EP role in this area, including consideration of how this could be developed. Gilmour et al. (2019)

advocate for the views of CYP to be included when delivering care related to self-harm and suicidality, suggesting that they can offer a more nuanced insight into the barriers to help seeking. While there has been considerable research exploring the lived experiences of CYP when seeking help for self-harm more generally there is a lack of research focussing specifically on their experiences of working with EPs and this could present as an interesting area for future research.

Further to this, given EPs in the present study identified a significant area of their work focusses on indirect approaches and building capacity amongst other professionals, such as school staff, there is an argument for the inclusion of their views within the research. While school staff generally report increased knowledge, ability and confidence following EP involvement (Atfield et al., 2023), there is limited research which focusses specifically on their experiences of accessing professional support related to self-harm. Rothi et al. (2008) considers this more generally when working with EPs to support the mental health of pupils and suggest that teachers can identify a number of barriers which constrain service provision. This further reiterates the importance of including their voices as they are able to offer a unique perspective, further highlighting areas of EP practice which could be enhanced. Further exploration into the views of school staff could present as a direction for future research. The inclusion of multiple viewpoints, including school staff, CYP and EPs, would help to triangulate information, strengthening the findings from the present study.

A further limitation of the present study and one which is commonly reflected in qualitative research relates to the sample size and reduced generalisability of the findings to wider populations. The participant sample of the present study included seven EPs, which could be considered as small, thus limiting the generalisability of the findings to wider contexts. While effort was made to seek EPs from a range of service contexts, given the small number of participants it is not possible to say that this sample is representative of the EP profession as a whole and so caution should be taken when considering the findings of the study. Further work is required to understand the views of EPs more widely in this area, which could be achieved through an approach such as a workforce survey. The findings may also be influenced by self-selection bias, as participation was voluntary and those who opted to take part were likely to have a prior interest in the topic area. It is possible that the EPs who took part in the study were already involved in a higher level of work related

to self-harm, given their interest in the topic, meaning this is not a true representation of the profession.

Chapter Three: Reflective Chapter

Introduction

Reflexivity is fundamental in qualitative research given it is inherently shaped by the researcher's identity, values and underlying beliefs about the world. According to Finlay and Gough (2003), reflexivity involves routinely reflecting on your assumptions, expectations and choices throughout the research process, allowing you to consider what your position might make visible or exclude from the research, ultimately shaping the knowledge that is produced. Recognising this as a fundamental aspect of reflexive thematic analysis, Braun and Clarke (2022) suggest that a researcher should thoughtfully question and interrogate their position, values, choices and practices throughout the research process, considering how this influenced the knowledge generated. Given the importance of this, in this chapter I will critically examine my positionality as a researcher, including my personal thoughts, feelings and beliefs, which inevitably shaped my interest in the research topic, approach to the research and overall findings.

Why Focus on This Topic?

Growing up I was aware of self-harm but saw it as a very distant problem, until my sister started to engage in it. I remember there being a lot of fear and uncertainty surrounding this at the time, with my family feeling unsure of where to turn to for support. Whilst not really having any awareness of this at the time, I later realised the impact other people's attitudes had on my sister's willingness and ability to open up to others and access support. She had an overwhelmingly negative experience when engaging with professionals, often facing attitudes laden with judgement and stigma. That was until she met a teacher at school, who she developed a supportive relationship with and was able to trust. She felt safe to talk to this teacher about her difficulties and this had a considerable impact on her life. However, I knew that this was not the case for all young people and certainly hadn't reflected my sisters experiences up until that point.

Later in my life I embarked on a career as a Children's Wellbeing Practitioner, working within a mental health service where I delivered low intensity CBT informed interventions to CYP experiencing anxiety and low mood. Whilst intended as early intervention, the pressures on the system and high thresholds meant that many of the CYP I worked with were beyond 'mild' mental health difficulties and discussion surrounding self-harm reflected a regular area of practice. I felt privileged in this role that I was able to provide CYP with a space where they could be open about the challenges they were experiencing but was struck by the number of stories I heard about CYP having negative experiences when opening up to adults about self-harm. I started to wonder what was driving these responses... Was it fear? Lack of knowledge or awareness? These questions stayed with me as I embarked on the next stage of my career in educational psychology.

During my training on the doctoral course, I started to reflect on how it might feel for professionals who are met with unexpected disclosures of self-harm when this is not routinely part of their practice or an area where they have received training. Given my previous experiences, this is something I felt confident to address in conversations with young people, parents and school staff members. However, when chatting about this informally with colleagues I realised that others did not feel the same way. I then became consciously aware that this was not something that had yet been part of the doctoral training course and wondered whether this reflected EP practice more widely. Whilst self-harm did not represent a common area of my practice as a TEP, it was often part of a bigger picture of need and reflected a growing area of concern within schools, and so I became interested in exploring this further.

Positionality

Considering a researcher's identity and position can significantly influence all aspects of the research process, including the research design, data collection and analysis (Wilson et al., 2022), it feels important for me to reflect on aspects of my own identity and positionality, which are likely impacting on my underlying assumptions and beliefs about the research topic.

Although I have not personally engaged in self-harm and therefore consider myself somewhat of an 'outsider' in this context, I believe my early experiences have

strongly informed my interest in this research topic. As a child I experienced a number of adverse experiences, including witnessing domestic abuse and insecurity within relationships. While the relationship between these experiences and the current topic is complex and difficult for me to fully comprehend, I believe the challenges I faced shaped my ability to connect with others, allowing me to listen with empathy and a genuine curiosity about their experiences. Given I have been privileged to hear many stories from CYP about their experiences of disclosing self-harm, I feel a level of personal and professional responsibility to understand their experiences further and ensure their voices are prioritised.

It would be remiss of me not to reflect on how my sister's experiences of help seeking have impacted on my own beliefs surrounding professional support for self-harm. Given her experiences were overwhelmingly negative, I may hold some biases about professional attitudes and responses to self-harm, leading to a greater focus or emphasis on the barriers to practice in this area. However, having worked in various professional roles myself, I approached this with the view that professionals are doing the best that they can with the resources available to them and was therefore driven to understand the underlying mechanisms driving their responses and experiences. I approached this with a genuine interest and curiosity, informed by my own professional experiences where I have at times felt unsupported and insufficiently prepared for the expectations of my role when working within a mental health service.

Literature Review

Initially I was going to focus my research on understanding the perspectives of school staff in relation to self-harm, considering how they feel about their role in this area and their levels of confidence. However, after an initial search of the literature I found that this had been the focus of several studies already. The research highlighted a lack of confidence, awareness and training amongst school staff, particularly reflecting the emotional impact of practice in this area. This made me think about the sources of support school staff were drawing on, and considering my role as a TEP, I naturally started to think about the role EPs could play in this. I mentioned this informally to some of my colleagues on placement and was struck by the number of responses which indicated a lack of confidence and training in this

area. I began to wonder how this might manifest in practice if indeed schools were drawing on EPs for support. Following this, I decided to shift my literature review to focus more specifically on the EP role in supporting CYP, parents and schools to respond to self-harm.

Initial searches of the literature indicated a lack of research specifically exploring the EP role in responding to self-harm, leading me to extend my search to consider the EP role more broadly in mental health, hoping to contextualise the work of EPs in this area. The vast amount of research on this topic area was overwhelming, and I was unsure of how to make sense of this in a meaningful way. I inevitably decided to undertake a narrative review to allow me to explore the literature flexibly, following interesting insights and perspectives that I might not have accessed if I followed a rigid or systematic methodology. This helped to provide a broad overview of the topic area, guiding my thinking about the factors that may be impacting on the EP role when working with self-harm. Despite believing that this approach was the most suitable, I experienced some uncertainty during the literature review process and was worried that its flexibility might result in me overlooking important research or introducing bias in the selection of studies included. However, I attempted to mitigate this by thoroughly reviewing the relevant studies and carrying out multiple searches until I was finding no new insights or perspectives.

Excluding Child Voice

The decision to not include the voices of CYP with lived experience of self-harm within the research was not an easy one. Given my strong commitment to ensuring CYP voices are heard and prioritised, shaped by my previous experience of working directly with them, this required careful consideration and reflection. I was aware of the importance of CYP voice in this area given the stigma associated with self-harm, and the need to challenge perceptions and offer insight into nuanced experiences (Hasking et al., 2025). However, when reviewing the literature, I established that there was already a significant amount of research which explored the views of CYP when seeking help for self-harm, which highlighted the inconsistencies in this area (Rowe et al., 2014). I therefore thought it would be more useful to explore a different perspective and consider the possible explanations for these challenges. I also felt that exploring the perspectives of EPs added something

unique to the literature base and would have the ability to indirectly impact on the experiences of CYP when help seeking. Finally, this decision was also impacted by a drive towards ethical decision making. CYP who have engaged in self-harming behaviours are vulnerable and I was worried about the potential harm to participants should they have to revisit challenging experiences. It was important for me to balance the desire to include their voices within the research with the possible risks associated with participating (BPS, 2021). I discussed this in supervision, and it was agreed that focussing on EP experience was more appropriate.

Ontology and Epistemology

The concepts of ontology and epistemology were unfamiliar to me at the start of this research journey, and my limited understanding made it difficult for me to really comprehend their importance in practical research. However, I now recognise that they shape the entire research process, including the research design, methodology and interpretation of the findings (Bracken, 2010). Given my uncertainty surrounding this topic, I opted to approach the research from a position of critical realism, believing this was a good ‘middle ground’ which was easier to understand and apply. However, I am aware that this is a very simplistic view. While critical realism is often seen as a bridge between positivist and interpretivist approaches, it is a distinct philosophical position with its own assumptions about reality and framing it as a ‘middle ground’ may risk this being overlooked. Given my limited understanding, I prioritised revisiting ontology and epistemology throughout my research journey, attempting to develop my confidence and understanding in this area.

While realism views reality as independent and observable, and interpretivism views reality as subjective and socially constructed, critical realism argues that whilst our knowledge of the social world is constructed, the structures themselves are real and exist independently of our knowledge. It suggests that while there is an objective reality, our access to this is always partial and fallible, shaped by our perspectives, theories and social contexts. It encourages looking beyond what is directly observed to identify the underlying structures and mechanisms that generate events (Stutchbury, 2021). Ultimately, I believed this was a good fit for my research, as it

would allow me to explore the role of EPs in relation to self-harm, while also considering the broader factors that shape their practice.

Research Design

Given the limited research on the topic area and the desire to explore the underlying mechanisms impacting on EP practice, a qualitative research design was employed. This approach aligned with the exploratory nature of my research questions, allowing the depth and nuance of EP experience to be captured, helping to reveal the underlying structures and tensions impacting on their practice. I did consider using a mixed methods approach, including a questionnaire to collect data, which would allow me to gain a general overview of the EP role in this area from a wide population of EPs. However, my epistemological position seeks to move beyond the empirical level, to understand the real structures and mechanisms that generate events, and a qualitative approach was deemed more suitable for this purpose as it would enable a deeper exploration of these processes.

Following the decision to use a qualitative research design, I next considered which approach to data collection would align best with my research questions and aims. I initially considered using focus groups to identify broad themes related to EP practice in relation to self-harm. However, considering the sensitivity of the topic area I felt that conducting this discussion within a group setting could exacerbate vulnerabilities or anxiety amongst participants, particularly as EPs were being asked to reflect on their own practice experiences. I was also concerned that focus groups would not facilitate the level of depth and nuance of experience that I was seeking to gain, given the complexity of having multiple participants in the same space. I was concerned that some participants may not feel as comfortable to talk honestly in this space and may therefore conform to the majority opinion or speak up less, allowing certain voices to dominate the discussion. As well as this, I was aiming to recruit participants from a variety of contexts, meaning their experiences were likely to differ depending on the service in which they worked, posing challenges for meaningful comparison within a focus group. This led to the decision to conduct semi-structured interviews, which allowed for individual participant experiences to be explored in greater depth.

When deciding how to analyse the data I considered the use of reflexive thematic analysis (RTA) and interpretative phenomenological analysis (IPA), in line with the qualitative research design. IPA initially appealed to me given its focus on in depth exploration of lived experience, which would allow me to understand how EPs make sense of their experiences when working with self-harm, particularly focussing on the emotional aspects of practice and how this makes them feel. However, given the limited research on the EP role in managing self-harm I was more interested in generating broader themes and ideas, which would give an overview of the topic, helping to identify patterns across EP practice and make generalisations regarding future implications. This led itself more to RTA, which looks at patterns across a dataset, rather than going deep into individual cases.

Simplicity of the Research

Throughout the research process I kept returning to the idea that my research was too simple, given it focussed solely on the perspectives of EPs and included a relatively small sample size. This issue was initially raised during the ethics review process, prompting me to consider broadening the scope of the research or adding greater depth. However, when I returned to the purpose of the research and my hopes for the project, I believed it was focused and well defined and addressed a gap in the existing literature. Given the lack of research on the topic area relating to the EP role, it felt more important to develop a foundational overview of the topic, which could be built on or developed over time. Despite this, I still questioned whether this was enough and whether I could really make an impact with a project of this scale. I continued to reflect on this in supervision and recognised that I needed to also consider what would be feasible within the timeframe. Given the other demands of the course and training to become an EP, I felt it was important to balance the desire to do something meaningful with the need for the project to be realistic and manageable. While I agree that the project is simple, I think the rigorous research process has led to the development of a cohesive piece of research with clear implications for practice and future research.

Dual Role as Researcher and TEP

Throughout the research process I was consciously aware of my position as a TEP, as well as a researcher, and what this might bring. I found it difficult to strike the right balance with this dual role, often forgetting myself and slipping into what felt like a discussion with a colleague about the challenges within the profession. This was particularly challenging when interviews were being conducted with EPs that I had existing relationships with from my placement service or through other work opportunities. I felt at times that I was offering too much of my own perspective, rather than asking questions objectively, which potentially could have guided participant responses. I was torn between wanting to develop a relational approach, where participants felt comfortable to talk openly, and a desire to remain neutral and limit the impact of my own biases.

I reflected on this consistently in my reflexive journal following interviews, attempting to bring this into my conscious awareness to mitigate the impact of this in future interviews. As the interviews progressed, I felt I was able to manage this dual role better, only occasionally offering my own thoughts when I felt this would extend or develop the conversation. Despite my fears regarding a lack of objectivity, I recognise that this is a key facet of qualitative research, with Braun and Clarke (2022) suggesting that researcher subjectivity is fundamental to the research process. I am aware that my own positioning has played a role in constructing the findings of the study but feel that my reflexivity surrounding this demonstrates a commitment to carrying out quality research.

Analysing the Data

The analysis process for me was accompanied with huge feelings of responsibility and wanting to get it right. I felt privileged that the participants had shared their reflections and experiences with me, and I wanted to do them justice during the analysis process. My own lack of confidence, driven by my inexperience in conducting research, meant that the idea of there not being a 'right' answer sat uncomfortably with me and I found that I frequently doubted myself throughout the analysis process. I was worried that I was overidentifying with certain narratives and applying my own biases during the analysis. However, I now recognise that this level of subjectivity is indeed a fundamental part of the process.

Alongside this, there was also the challenge of managing a vast amount of data. Upon completion of the interviews, I started the lengthy task of reviewing the transcripts, amending any mistakes and immersing myself in the data. I was overwhelmed at this stage by the amount of information I had to work through and wondered if I ever would feel truly familiar with the data. However, I broke this down into individual interviews, focussing on one transcript at a time, listening and making notes several times, before moving onto the next one. I did this over a period of time, recognising the need to approach each transcript with fresh ears and eyes. Breaking it down in this way made the task much more manageable and as I got into it, I found that I was really enjoying the process.

The process of coding and generating themes was iterative and developed over time, following much back and forth. I attempted to use digital methods to organise the data but found that it was much easier to engage with when I used a hands-on approach, where I could scribble my thoughts down, draw arrows and physically move pieces of paper around. I continued to struggle with the concept of not having a 'right' answer during this process, relying solely on my interpretation and understanding of what the participants were saying. I was uncertain about the 'ideal' number of themes and was concerned that my initial themes were too broad. When I took this to supervision, I quickly realised that there was no 'ideal' and that the focus should be on developing comprehensive themes that reflect the depth of the data, rather than on quantity.

During the process of reviewing and refining my themes, I modified my initial themes to include a separate theme which captured professional responsibility and the emotional impact of practice, acknowledging the importance of this as a standalone concept reflecting many EPs experiences. I also distilled and renamed some of my subthemes. However, I was conscious that I did not want to do this too much and lose the true meaning of the data. It felt like there was a fine balance between ensuring the themes were coherent and easy to understand but also captured the nuance and richness of participant experience. To achieve this balance, I revisited my coded data multiple times to check that the themes reflected the data set, highlighting possible quotes which helped to illustrate each theme. I also created a thematic map at this stage to represent my themes visually.

During the analysis, I followed the steps of reflexive thematic analysis, outlined by Braun and Clarke (2022). However, upon reflection I question whether

this approach enabled me to truly achieve critical realist ambitions. The five-stage process outlined by Fryer (2022) may have been more appropriate to delve into the causal mechanisms generating EP experiences. Although the two approaches are very similar in terms of their procedures, they differ in their analytic aims. Where reflexive thematic analysis seeks to develop interpretative stories about the data, Fryer's approach is more explicitly interested in generating causal explanations of the mechanisms that produce observed events. Nevertheless, reflexive thematic analysis remained valuable in this study, given the limited existing research into EP's experiences of responding to self-harm. Listening to participant accounts enabled their perspectives to be represented and provided a foundation for understanding in this area. However, adopting an approach specifically designed for critical realist research would have made it easier to theorise the underlying mechanisms generating experiences, aligning more closely with the study's aims.

Writing Up

Despite enjoying the process of carrying out the research, the thought of writing this up presented as a significant barrier. I felt unsure of how to approach this, and the enormity of the task meant I held back from getting started. I felt pressure to get this right and to accurately reflect participant experience and this led to a lot of fear surrounding the writing process. I reflected on this during research supervision and considered how I could make this more manageable by breaking it down into smaller steps. I initially started with a section that felt more manageable, where I could achieve an 'easy win'. This helped to overcome this initial block and motivate me to continue. I found that once I started the writing process, this flowed much easier than I had anticipated. Setting myself small, achievable goals each day helped me to see my progress and keep going.

Quality Control

In the Total Quality Framework, Roller and Lavrakas (2015) emphasise the importance of qualitative researchers developing critical thinking skills to apply when designing, conducting and interpreting research to ensure that the data gathered is of a high quality, the interpretations are robust and valid and that the research

generates useful outcomes. The framework provides a structure in which researchers can consider the quality and integrity of their research, through four key components: credibility, analysability, transparency and usefulness. Following completion of the research, I drew on the Total Quality Framework to reflect on the quality and credibility of the findings. Whilst it would have been useful to engage with the framework throughout the research process, the table below summarises the key reflection points identified retrospectively.

Table 5

Total Quality Framework

TQF concept	Description	Research Reflections and Evidence
Credibility	The trustworthiness, completeness and accuracy of the data collected, with a particular focus on scope and data gathering.	To gain an understanding of the EP role in this area, I attempted to recruit participants from a range of service contexts, with diverse experiences. I attempted to achieve this by applying minimal inclusion criteria and recruiting through multiple channels. However, the final sample was relatively small and does not therefore represent EPs across a broad range of service contexts. This means the findings should be interpreted with caution, particularly in relation to their generalisability. Further limitations relating to the participant sample can be seen in the limitations section on page 100. It is also important to acknowledge that some participants were known to me prior to the research through ongoing working relationships. Although I reflected openly on this throughout the research process and took active steps to mitigate any potential impact, I feel it is important to

explicitly recognise this as a possible source of bias. Further reflections on this can be seen on page 108 of the reflective chapter and in appendix E.

The interview schedule was designed with the research questions in mind to ensure it addressed the intended concepts. Although some questions appear to be quite descriptive in nature and may not have fully reflected the ambitions of critical realism, the interview schedule was intended to provide a flexible guide to ensure that relevant areas were explored. However, during the interviews open ended follow up questions were used to explore participants accounts in greater depth and consider the underlying mechanisms that may have shaped their experiences. This is addressed further in the data collection section on page 48 and examples of the questions used can be seen in appendix D.

Analyzability	The completeness and accuracy of the analysis and interpretations, including processing and verification.	The initial transcript of each interview was produced by Microsoft Teams. However, to ensure each transcript was accurate and complete, I carefully listened to the audio recordings of each interview multiple times, making any changes as necessary. The data analysis was an iterative process, supported by regular supervision in which I critically reviewed my developing interpretations and considered whether they aligned accurately with participant accounts. I frequently returned to
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the raw data to check out my thinking and enhance this further. A reflexive journal was used throughout the research process to document any personal assumptions and possible bias, which may have influenced my interpretations. Some examples of my reflections can be seen in the reflective chapter on page 103. Upon reflection I feel the credibility of the analysis process could be enhanced by using a process of peer verification, member checking or triangulation of data from multiple sources to reduce the likelihood of individual bias.

Transparency	The clear and complete disclosure of the research design and analysis process.	In the reporting of the research, I attempted to provide a clear and transparent account of each stage of the analytical process, alongside examples to illustrate the various stages of the process. This can be seen on page 50 and in appendices F-I.
Usefulness	The practical value and ability to do something with the research outcomes.	The research findings informed implications relevant to EPs at an individual, service and training level, as outlined on page 98. These implications should be interpreted within the context of the study's limitations, which are clearly outlined on page 100. In particular, the sample size, scope of the research and potential self-selection bias limit the generalisability of the findings.

Dissemination of Findings

Capili and Anastasi (2024) recognise the importance of communicating research findings to advance a field, change practice and policy and learn from the barriers or challenges associated with the research process. They suggest that researchers should have a clear strategy for dissemination, including consideration of the target audience, the optimal time to share findings, and where information will be communicated. Considering research on the role of EPs in supporting CYP, parents and schools to respond to self-harm is limited, I think it is important to share the findings from the current study to continue to reflect on and develop EP practice in this area. In order to do this, I have developed a dissemination plan to ensure the findings are shared within the relevant contexts.

Initially, I plan to share a short summary of the research findings with the participants who requested this prior to participation in the research study. I would then like to continue to share the findings further, starting with my local authority service upon qualification as an EP. As a service we have regular CPD opportunities throughout the year where colleagues are encouraged to share their research and this would present a good opportunity for me to share my findings. However, I would like to continue this conversation within the service following this, to ensure the implications are meaningfully considered. This could include further consideration of how we as a service can develop our practice in this area through things like additional training, setting up supervision spaces and sharing resources. If opportunities arise to share the findings more widely, such as at the Division of Educational and Child Psychology (DECP) TEP conference or at shared learning events, then I would be keen to utilise these opportunities to continue to promote awareness of the EP role in this area.

Personal Reflections

At the beginning of this research journey, I felt intimidated by the enormity of what was at hand and while it has not been easy, I feel it has helped me to grow, not only as a researcher but as a psychologist and a person. It has challenged me in more ways than one but has showed me that I have the resilience and determination to succeed. At the heart of it I had a desire to want to do justice to my participants but also the CYP who I have been privileged to work with over the years and my sister, whose own experiences drove my interest in this topic. The choice of a topic

which is not only interesting to me but feels important and meaningful has motivated me to continue when it has felt tough. My own confidence and belief in myself have been the biggest barriers throughout this journey and I have found it difficult to trust in myself and accept that there is no 'right' way to do qualitative research. While accompanied with many moments of doubt, I have found the process valuable and rewarding and am keen to continue pursuing my interest in this area.

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Appendices

Appendix A. Email to Principal Educational Psychologist

Dear [Recipient's Name],

I hope this email finds you well.

I am writing to seek your assistance in recruiting participants for my research project, which explores the role of Educational Psychologists (EPs) in supporting children and young people (CYP), parents, and schools in managing self-harm. This project is being carried out as part of my doctoral thesis at the University of East Anglia under the supervision of Dr LeMarra Williamson.

If interested, EPs will be invited to participate in an online interview, where they will be asked to share their experiences of supporting CYP, parents, and schools in this area. The interview will focus on the key barriers and facilitators to this work, as well as how equipped EPs feel to carry out this role.

To participate, EPs must be qualified, currently working in the UK, and have experience supporting CYP, parents, or school staff in managing self-harm. I have attached a recruitment flyer for further details. Please note that participants will be selected on a first come first served basis.

I would be most grateful if you could circulate this information within the team. Should anyone be interested in taking part or require additional information, please have them contact me directly via email at k.felstead@uea.ac.uk. Please note that participation in the project is entirely voluntary.

Thank you for your support.

Kind Regards,

Kayleigh
Trainee Educational Psychologist
UEA EdPsyD

Appendix B. Recruitment Flyer



University of East Anglia

AN EXPLORATION INTO THE ROLE OF EDUCATIONAL PSYCHOLOGISTS (EPS) IN SUPPORTING CHILDREN AND YOUNG PEOPLE (CYP), PARENTS AND SCHOOLS TO MANAGE SELF-HARM

What is the study about?

The research is seeking to explore the role of EPs in supporting CYP, parents and schools to manage self-harm, focussing on how equipped EPs feel to carry out this work by examining the key barriers and facilitators.

Who can participate?

You can participate in the research if you meet the following criteria:

- ✓ You are a Qualified Educational Psychologist working in the United Kingdom
- ✓ You have worked with a child or young person, parent or school in your capacity as an EP related to self-harm

What does participation involve?

You will be invited to attend an online interview to discuss your experiences of working with self-harm. The interview will take up to 60 minutes to complete and will be recorded.

If you would like to participate or find out more please contact the researcher:

Kayleigh Felstead
k.felstead@uea.ac.uk



This project is being supervised by Dr LeMarra Williamson (lamarra.williamson@uea.ac.uk). Ethical approval has been granted by the University of East Anglia EDU Research Ethics Committee (Ref: ETH2425-1548)

Appendix C. Interview Schedule

Introduction:

This interview is seeking to explore how Educational Psychologists (EPs) are currently supporting children and young people (CYP), parents, and schools to respond to self-harm, including whether they feel equipped to do so, and what barriers or facilitators they encounter in their work.

Just a reminder that your participation is voluntary, and you are free to stop the interview at any time. You can choose not to answer any questions that you're not comfortable with. Do you have any questions before we begin?

Do I have your permission to record this interview?

Contextual information:

- Can you describe your role and a bit about the service context in which you work? (e.g local authority, CAMHS, MHST, etc)
- How often are you engaging in work related to self-harm? Is this a common area of practice for you? Is this an area of specialism?

RQ 1: How are EPs currently supporting CYP, parents and schools to respond to self-harm?

- Can you describe the types of support you currently provide to children and young people who engage in self-harm?
- What specific strategies or interventions do you use when working with schools to address self-harm among students?
- How do you collaborate with school staff when managing self-harm cases in the school environment?
- How do you work with parents to support them to manage self-harm effectively?
- What resources or tools (e.g., workshops, training) do you offer to schools and parents to help manage self-harm?
- How is this work commissioned/contracted? Is this something schools are asking for?

RQ 2: How equipped do EPs feel to support CYP, parents and schools to respond to self-harm?

- Do you feel that you have received sufficient training to support CYP, parents, and schools to deal with self-harm? Why or why not?
- What additional training or resources do you feel would better equip you to address self-harm in your role?
- Can you share a recent example where you felt particularly effective (or ineffective) in supporting someone dealing with self-harm?
- How do you stay updated on best practices for supporting CYP who self-harm? (e.g., attending conferences, accessing research, peer supervision, etc)
- What kind of professional development or support would improve your ability to work with self-harm cases?

RQ 3: What do EPs see as the key barriers and facilitators to their work in supporting CYP, parents and schools with self-harm?

- What do you see as the main challenges or barriers to supporting CYP, parents, and schools to manage self-harm?
- Have you encountered any difficulties when trying to engage parents or school staff in self-harm-related interventions?
- What do you consider to be the key factors that facilitate your ability to support CYP, parents, and schools to manage self-harm?
- Can you identify any specific resources, strategies, or supports that make your work easier when addressing self-harm issues?
- Do you feel there is sufficient collaboration between schools, external mental health professionals, and other agencies when managing self-harm?
- What changes or improvements would you like to see to make your work more effective when managing self-harm?

Conclusion:

Is there anything else you would like to add regarding your experience supporting CYP, parents, and schools with self-harm?

Thank you for sharing your insights today. Your input is very valuable to this research. Do you have any questions?

Appendix D. Examples of Additional Prompts and Follow-up Questions Used in Interviews

I just wondered as well like within your role, how do you feel when you come across these cases or when you're asked to have involvement in things like this?

So you said there was that kind of one example of the young person that you'd worked with. Are you able to tell me like a bit more about that? Kind of what happened, how the work came about?

And you said about EP confidence, do you have any thoughts or ideas on why you think EPs might not feel so confident kind of engaging in this sort of work?

So it sounds like a nice mixture between direct work with young people, but also more of that sort of indirect stuff with like school staff or parents helping their understanding, that kind of thing. Are you able to tell me a bit more about the direct work that you would do with young people?

Is there anything else that you think in this area would help you to feel more confident within your role in supporting self-harm?

I was just wondering as well because you said about previously having worked in CAMHS. So I was just wondering about the differences between having worked in a CAMHS service and then now as an EP, what is that like?

I was just kind of interested in what you felt the EP role or remit was in that area?

And you've kind of touched on this already, but I was just wondering what your thoughts were around the barriers for EPs kind of working in this space?

And you said before about doing work with parents and also work with school staff, are you able to tell me a little bit more about that and what kind of work you're doing with parents and school staff?

So just before we finished did you have any other like reflections or thoughts about EP work in this area related to self-harm?

Do you have any sense just going back to one of the things you said just there in the reflections as to why EPs maybe don't feel so confident to work with self-harm?

And you said as well at the beginning about like training being a barrier for EPs, are you able to say a little bit more about that?

But I guess if that work was coming through, if the school said, can you work with this young person who's self-harming, how would you feel about being involved in that piece of work?

Are there any other thoughts or reflections that you've had kind of engaging with this work sort of related to self-harm?

Are you able to tell me a little bit more about your role and the kind of service context that you work in?

So you're saying that sometimes the young people you're working with, there's other people that are involved that are kind of supporting with that area. So I'm interested in what your role has been as an EP working with those young people?

I think you've kind of touched on it a bit already, but is there anything that you think helps with your sort of work in this area? So I think you talked about kind of having other people that you could go to and kind of ask questions and get signposting. Is there anything else that you think kind of makes work easier in this area or that kind of supports work in this area?

What is it about that, that you think would be useful or kind of in an ideal world, how would you kind of foresee that happening?

Were there any other reflections or thoughts you had about kind of your work in this area?

I think there was just one thing I was going to go back to from before, so when we were talking about confidence and you sort of feeling more confident with the sort of lower level self-harm and then perhaps feeling less confident as it became sort of more complex. I just wanted to ask a little bit more about that and why you felt that was... like what you think it is that makes you feel less confident about kind of working with the more... what you would kind of perceive as more complex?

So I just wondered kind of in your experience so far or perhaps in your service is there much collaborative work with other services, so kind of working with mental health teams, things like that?

Is there anything else that you think helped you...?

And you said before about supervision being really good and like, really helpful. Can you tell me a bit more about your supervision, what you think has been useful in these kinds of particular cases?

So before I finish the recording, is there anything else you wanted to add or any other thoughts you had sort of related to the EP role in this area?

I was just wondering as well, so obviously various kind of different bits of work that you're engaging in as an EP in this area. Do you feel EPs are well placed to offer support in this area?

Appendix E. Sample of Reflexive Diary Entries

17.07.25

The first interview was conducted with a participant from my own service, with whom I already had a pre-existing relationship. This familiarity helped establish rapport and allowed the interview to flow more like a natural conversation, deepening the discussion. However, I am aware this dynamic may have introduced some bias, given my role within the same service.

I found myself occasionally offering my own thoughts and reflections while summarising the participant's responses, which may have unintentionally led their answers. This is something I will be more mindful of in future interviews, aiming to adopt a more neutral stance.

At the end of the interview, I asked for feedback on what worked well and what could improve future interviews. The participant shared that the interview felt warm and natural, and appreciated the way I revisited earlier topics to explore them more deeply. They also valued being asked for any final reflections or thoughts, as this created space for discussion that hadn't been prompted by the initial questions.

20.08.25

I conducted another interview with a colleague from within my service today. Once again, I was worried about offering too much of my own perspective, rather than maintaining a neutral stance. I think part of my inclination to share my own thoughts is to encourage richer discussion, but in doing so I may unintentionally shape the direction of the conversation. However, I feel I was able to manage this better today by refining my questioning skills to elicit deeper responses, rather than relying on my own input. This tension highlights the challenge of balancing my dual role as both researcher and trainee EP, where my professional experiences can introduce bias.

Despite these challenges, I found it interesting that similar themes continue to emerge across interviews, particularly around training, time and capacity, and confidence. In this interview, I especially valued the emphasis on the relational aspects of the role and the importance of involving parents in conversations before reports are shared. I also found it useful to consider how service-wide procedures and collective positions influence practice, as this has not featured as strongly in previous discussions.

Appendix F. Example of Initial Coding Process

part of her. I think part of her autism profile and so often her wounds were becoming quite infected. So I think that the main thing that they were concerned about was that they were having to sort of re-bandage her every day, so I think the I think that for the staff it was more around sort of confidence and making sure that they were following, you know, the right procedures and making sure she was being supported in that sense.

→ Following procedures
Professional responsibility?

Researcher (EDU - Postgraduate Researcher)

Right, yeah.

Participant 4

And I think one of the things I noticed as part of this case was I think my what I sort of the picked up on was that she it felt like this young girl from from our discussions this young girl was it sounded like that she was kind of seeking connection with this with this adult, it sounded like she had a really good relationship, so I think for me it was about empowering this member of staff to understand actually this young person is it sounds like they're kind of coming to you for that reassurance and that time, that time bandaging seemed to be a really important time because it also sounded like she was opening up to this member of staff through through the process. So I think I think it was a lot of it was around empowering that member of staff to understand the role that she played, not just in the medical side of things, but also the emotional aspect of it as well. And then I also did signpost because I guess one of the things and we might talk about this later, but one of the things that I was mindful of us that you know the medical aspect is not sort of part of our role, not part of our remit, but obviously that was something that was coming through and that kind of I think they were seeking something around policies and keeping her safe and risk management and that kind of thing. So I did signpost her because in our service we have a critical instant lead. So I felt that she was probably best placed to offer a bit more of a thorough understanding around the the protocols and the procedures and all of that kind of thing. So I signposted to the critical incident lead to to support with that and yeah, and I think they had like a they did. They had a case discussion and then there was some feedback around some of the things that they could do as well to to continue to support her. Yeah.

→ unpicking function

→ Empowering staff

→ FP distance from medical aspect

← FP not positioned as expert

Researcher (EDU - Postgraduate Researcher)

Professional responsibility

complexity / medical need
leading to fear / increased level
of responsibility?

Yeah. OK. So your role was more around kind of reframing that with that staff member and kind of helping her to understand that more. But then the kind of other side of it was signposting to someone else who had more sort of knowledge of.

Yeah.

Participant 4

Yeah, yeah. Yeah, I think we are. It's probably better place to support. Personally I think sort of in that case particularly I'd say it was much more of an indirect role, you know, signposting to the relevant documentation or procedures and things like that or even. It felt like it was getting a bit of a probably more of a complex presentation as well. So so possibly as well referring over to CAMHS or you know a specialist in that in that field more so. But then also you know like you say empowering the staff to understand the emotional role and actually unpicking that a little bit more. It felt like we we could, you know, unpick that a little bit more about what was going on. Why was she, why was she engaging in these behaviours? And it did feel like this relationship with this particular member of staff seemed really important, so it was unpicking the emotional aspect, but also giving the staff the confidence to know that they're they are enough. It felt like they were often asking for more because they were, you know, wanting the best and making sure they were doing everything. I don't know if it is sometimes self-harm can become a bit of a taboo, particularly when it's medical as well, isn't it? It can become and a grey area can't it as to who is best placed and who is going to be... yeah, there to support so. Yeah.

Indirect involvement

Unpicking emotional role

Empowering staff

Building capacity

Taboo

Grey area who is best placed?

Defining EP role

Medical not part of EP remit

FP not positioned as expert

Researcher (EDU - Postgraduate Researcher)

Yeah, I I just wondered as well like kind of within your role, how do you feel when you're kind of come across these cases or when you're asked to have involvement in things like this?

Participant 4

Yeah. I think with that particular case, I'm, I'm going to admit that it was. Umm. I did feel a bit, you know, not very confident in in sort of particularly with it being sort of moving more into that medical side of things. It was, you know, the having to redress and the infections. And I started to think, oh, you know, going back to our competencies and the remit of our role. So it did have to sort of take a step back and think, OK, where where is our our role and it is much more in that sort of

Confidence linked to complexity

Self-harm or medical need

Working within competence → safety?

understanding emotional function → FP role constructed as emotional
 emotional unpicking and understanding the emotional side of it I think or or
 unpicking the function of that behaviour, we definitely have a role to play with that,
 and then it was thinking, OK, well, where do I draw the line? And actually this → Professional boundaries
 becomes much more of a perhaps more of a specialist or a medical, you know.
 So it's sort of working out where we fit in that, but I definitely think we have a role.
 But no I did for that particular case, I would say I do feel with those more complex
 cases, I do feel that you know, not so much of a... not so much confidence there and
 where... I think it is because there is a bit of a grey area, where do we fit with that? → Grey area
 Especially because when it comes to... yeah, when it starts to become a bit more of a
 medical concern you don't want to do more harm than good, do you or say the
 wrong thing? So I think that's probably why I was more inclined also to sort of
 signpost to our critical incident lead or CAMHS because it felt like actually they might
 have more knowledge, expertise or confidence in in sort of supporting that and you
 want to make sure you get it right for the child. So I'd say definitely I didn't feel very
 confident with that particular case, so.
 Fear of causing harm ←
 → Lack of confidence

Researcher (EDU - Postgraduate Researcher)

OK. Yeah. No. And I think like you said, there is that bit of a grey area there, isn't
 there? Like whose role is... whose role is it? Like we might be able to help with that
 bit, but actually is that bit for someone else, so that makes sense.

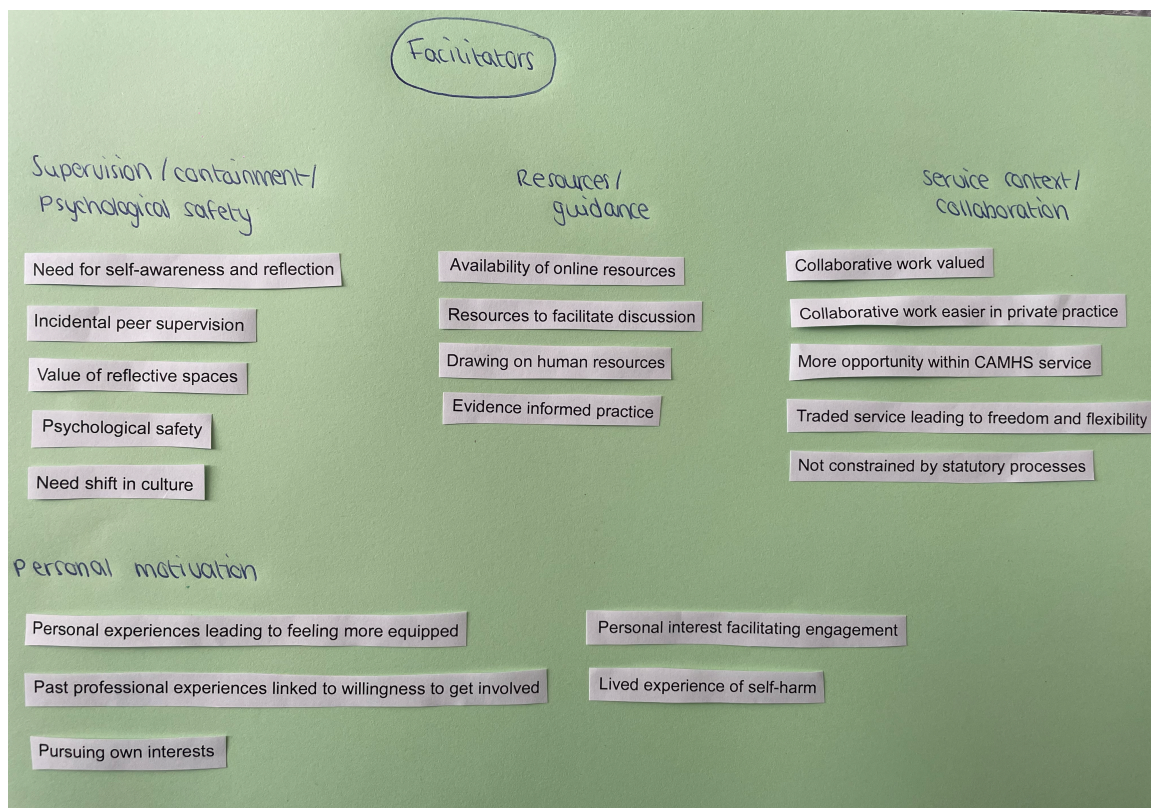
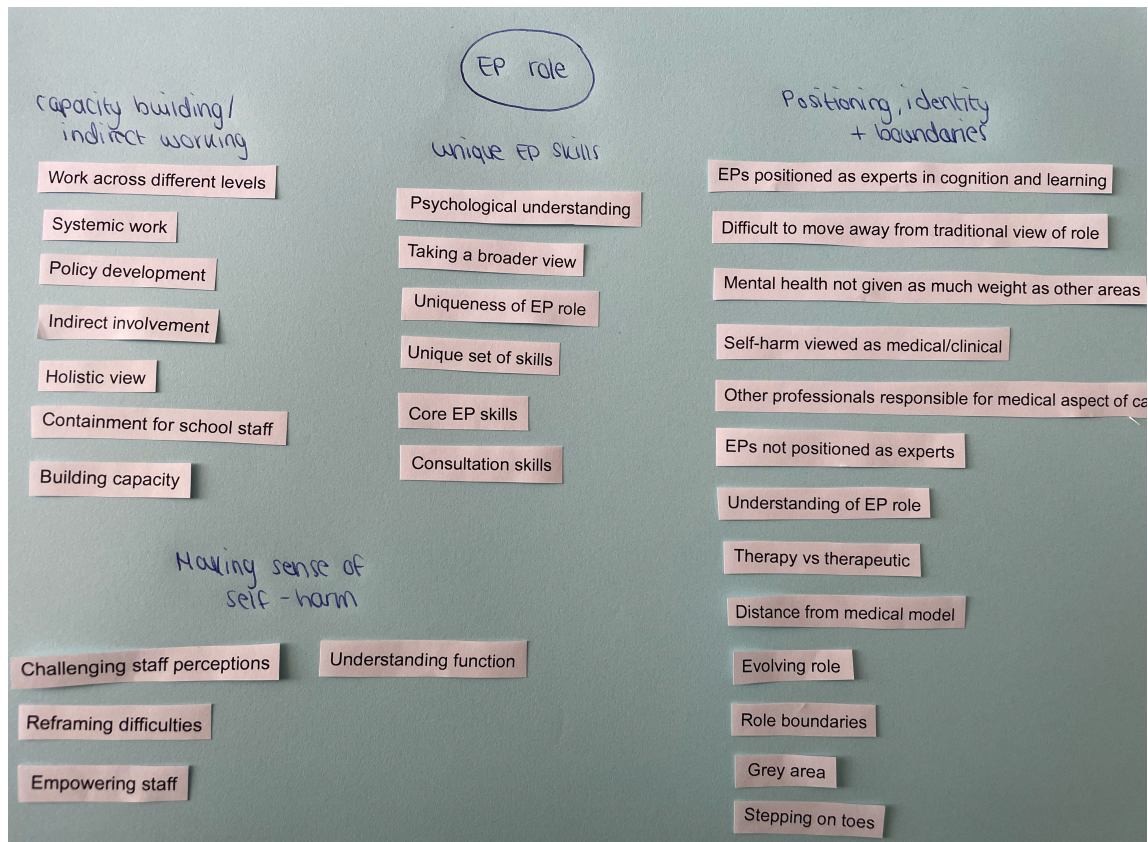
Participant 4

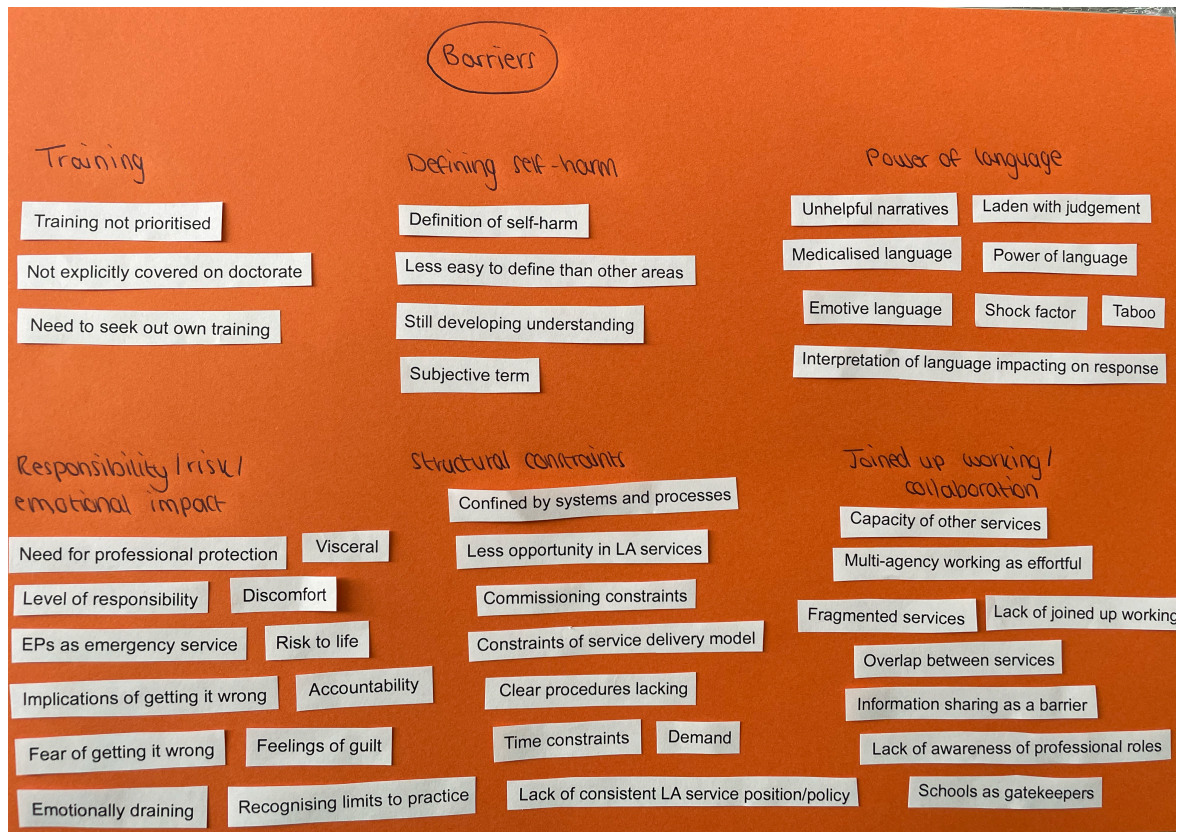
Yeah, yeah. You don't want to tread on people's toes, do you? Either or, you know,
 too many people looking into, you know, too many people in one case, it can. It
 could confuse things. Or you could give the wrong message or different conflicting
 messages and you. Yeah. So there is something around that, but equally I think that
 there there could be a real multidisciplinary role, couldn't there to that because → value of working together
 actually we could support the emotional side of you know the unpicking and the
 developing, the relationship and understanding that. Whereas yeah, the I guess the
 medical side. So it could be it could be a real multidisciplinary approach if we were to
 work in that way definitely. → FP positioned as dealing with emotional aspect, other professionals positioned as medical

Researcher (EDU - Postgraduate Researcher)

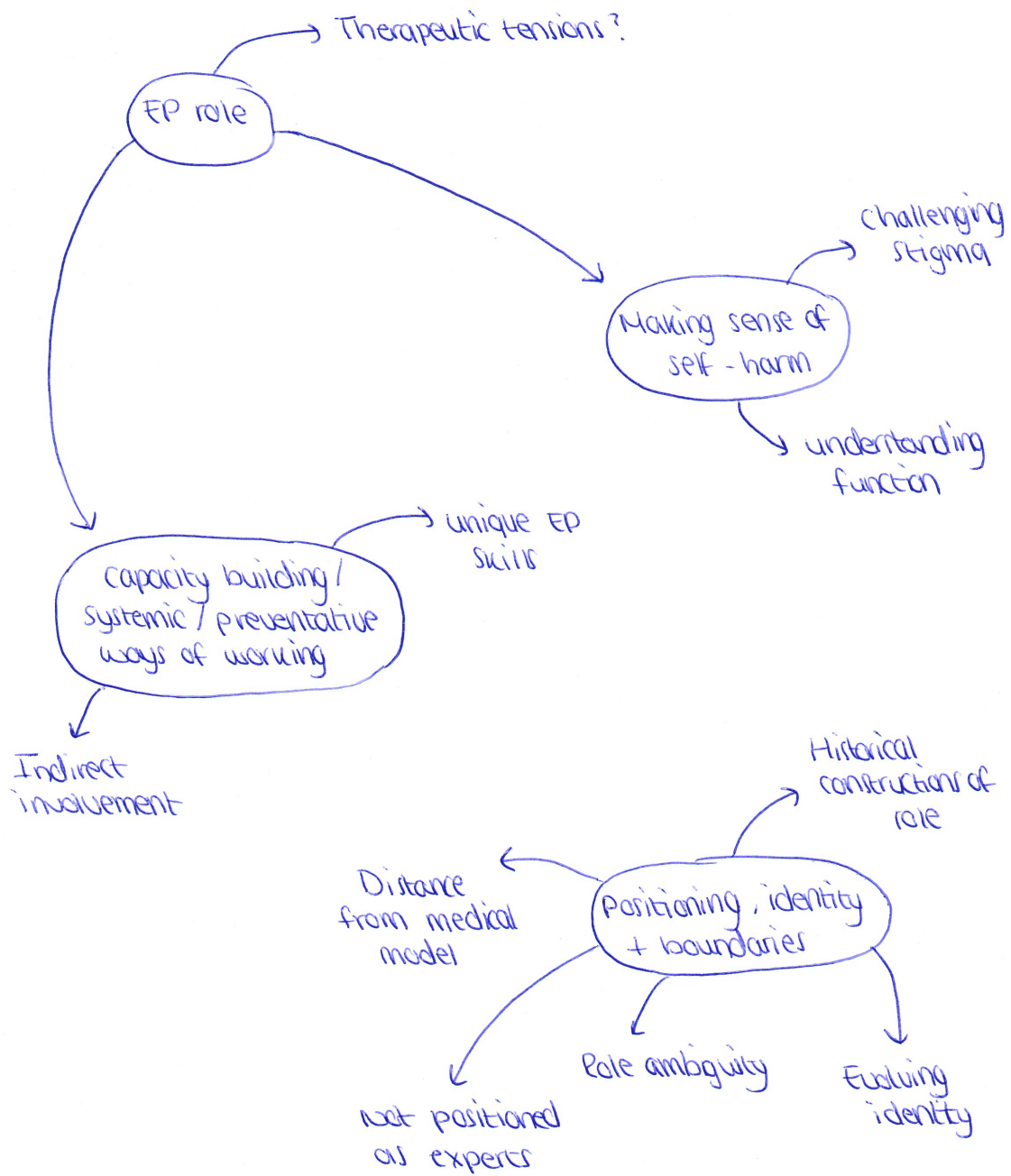
Yeah. Do you feel that that is happening at the moment or it's kind of easy to engage
 with other services to have that more kind of collaborative approach?

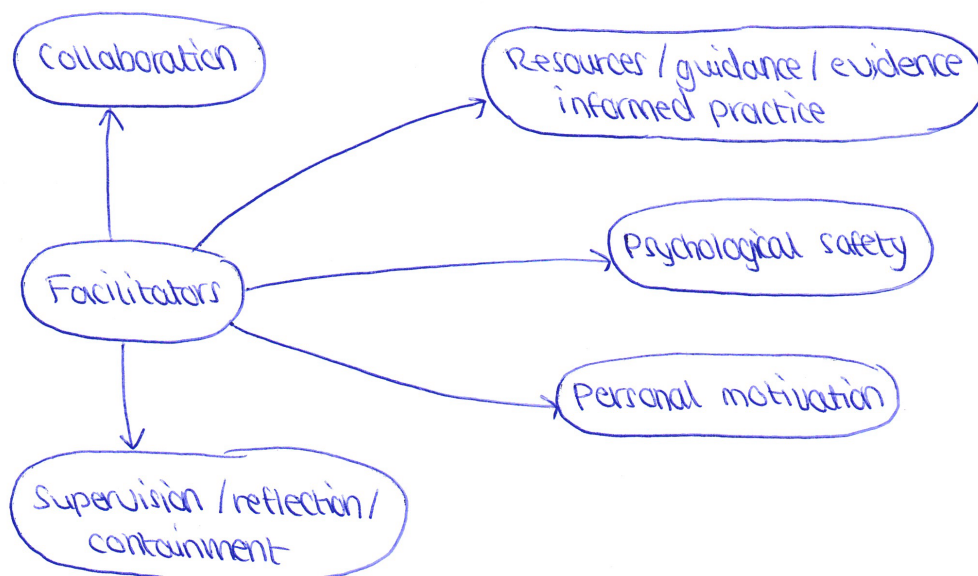
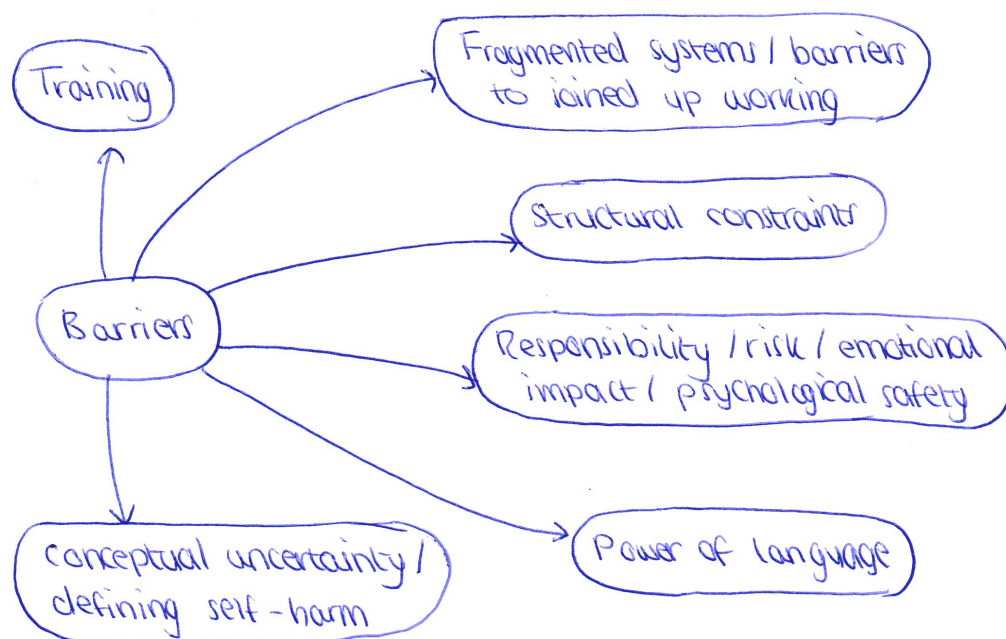
Appendix G. Generating Initial Themes





Appendix H. Developing and Reviewing Themes





Appendix I. Process of Refining Themes



Appendix J. Ethical Approval

University of East Anglia

Study title: An exploration into the role of Educational Psychologists (EPs) in supporting children and young people (CYP), parents and schools to manage self-harm

Application ID: ETH2425-1548

Dear Kayleigh,

Your application was considered on 17th June 2025 by the EDU S-REC (School of Education and Lifelong Learning Research Ethics Subcommittee).

The decision is: **approved**.

You are therefore able to start your project subject to any other necessary approvals being given.

This approval will expire on **1st January 2026**.

Please note that your project is granted ethics approval only for the length of time identified above. Any extension to a project must obtain ethics approval by the EDU S-REC (School of Education and Lifelong Learning Research Ethics Subcommittee) before continuing.

It is a requirement of this ethics approval that you should report any adverse events which occur during your project to the EDU S-REC (School of Education and Lifelong Learning Research Ethics Subcommittee) as soon as possible. An adverse event is one which was not anticipated in the research design, and which could potentially cause risk or harm to the participants or the researcher, or which reveals potential risks in the treatment under evaluation. For research involving animals, it may be the unintended death of an animal after trapping or carrying out a procedure.

Any amendments to your submitted project in terms of design, sample, data collection, focus etc. should be notified to the EDU S-REC (School of Education and Lifelong Learning Research Ethics Subcommittee) in advance to ensure ethical compliance. If the amendments are substantial a new application may be required.

Approval by the EDU S-REC (School of Education and Lifelong Learning Research Ethics Subcommittee) should not be taken as evidence that your study is compliant with the UK General Data Protection Regulation (UK GDPR) and the Data

Protection Act 2018. If you need guidance on how to make your study UK GDPR compliant, please contact the UEA Data Protection Officer (dataprotection@uea.ac.uk).

I would like to wish you every success with your project.

On behalf of the EDU S-REC (School of Education and Lifelong Learning Research Ethics Subcommittee)

Yours sincerely,

Melanie Aplin

Ethics ETH2425-1548 : Miss Kayleigh Felstead

Appendix K. Participant Information Sheet and Consent Form

Miss Kayleigh Felstead
Postgraduate Researcher

06 June 2025

Faculty of Social Sciences
School of Education and Lifelong
Learning

University of East Anglia
Norwich Research Park
Norwich NR4 7TJ
United Kingdom

Email: k.felstead@uea.ac.uk
Web: www.uea.ac.uk

An Exploration into the Role of Educational Psychologists (EPs) in Supporting Children and Young People (CYP), Parents and Schools to Respond to Self-harm

PARTICIPANT INFORMATION SHEET

(1) What is this study about?

You are invited to take part in a research study exploring the role of Educational Psychologists (EPs) in supporting children and young people (CYP), parents and schools to respond to self-harm. This will consider how well equipped EPs feel to carry out work in this area, through exploration of the key barriers and facilitators. You have been invited to participate in this study because you are a qualified Educational Psychologist working in the UK who has had some experience supporting CYP, parents and schools to respond to self-harm in your role. This Participant Information Sheet tells you about the research study. Knowing what is involved will help you decide if you want to take part in the study. Please read this sheet carefully and ask questions about anything that you don't understand or want to know more about.

Participation in this research study is voluntary. By giving consent to take part in this study you are telling us that you:

- ✓ Understand what you have read.
- ✓ Agree to take part in the research study as outlined below.
- ✓ Agree to the use of your personal information as described.
- ✓ You have received a copy of this Participant Information Sheet to keep.

(2) Who is running the study?

The study is being carried out by the following researcher(s): Miss Kayleigh Felstead. This will take place under the supervision of Dr Lemarra Williamson (,).

(3) What will the study involve for me?

You will be invited to attend an online interview to discuss your experiences of working with self-harm. The interview will take up to 60 minutes to complete and will be audio and video recorded to allow the data to be transcribed and analysed. You will be asked some questions about your role and the context in which you work, before being asked more about your experiences of supporting CYP, parents and schools to respond to self-harm. This will include questions related to the resources, tools and training you draw upon in your practice and the key challenges you face. We will also consider the factors that support your practice and make your work more effective in this area.

(4) How much of my time will the study take?

It is anticipated that the interview will take up to 60 minutes to complete. If you decide to review your transcript this may take an additional 30 minutes.

(5) Do I have to be in the study? Can I withdraw from the study once I have started?

Being in this study is completely voluntary and you do not have to take part.

Your decision whether to participate will not affect your current or future relationship with the researchers or anyone else at the University of East Anglia now or in the future.

If you decide to take part in the study, you can withdraw your consent up to the point that your data is fully anonymised. You can do this by contacting the researcher or their supervisor via the email addresses provided.

(6) What are the consequences if I withdraw from the study?

You are free to stop the interview at any time. Unless you say that you want us to keep them, any recordings will be erased and the information you have provided will not be included in the study results. You may also refuse to answer any questions that you do not wish to answer during the interview. If you decide at a later time to withdraw from the study your information will be removed from our records and will not be included in any results, up to the point we have analysed and published the results.

(7) Are there any risks or costs associated with being in the study?

Whilst we don't anticipate that participation will come with considerable risk or cost to participants, we do acknowledge that the topic area is particularly sensitive and may be distressing for some people. We have put in measures to minimise this where possible and will signpost participants to information and support following the study, should this be needed. However, we advise that you carefully consider whether this feels like the appropriate time or topic for you prior to deciding whether you would like to take part.

(8) Are there any benefits associated with being in the study?

It is anticipated that the research will help to shed light on the role of the EP in this area, highlighting the factors that support EPs to support CYP, parents and schools to respond to self-harm and what they need to continue to work effectively in this area. We hope that this will have implications for EP practice, including an improved understanding of the training and supervision needs of EPs in this area. It is possible that the findings from this study will have wider implications for CYP, parents and school staff related to how they are being supported to respond to self-harm. However, it is likely that that this will be minimal considering the small scale and qualitative nature of the project.

(9) What will happen to information provided by me and data collected during the study?

Any personal data provided during the course of the study will be stored securely in password protected files. You will be referred to by a pseudonym (e.g participant 1) throughout the study and any identifiable information within transcripts (such as location, workplace, etc) will be anonymised so you cannot be identified. The data will only be accessible to the researcher and their supervisor throughout. If you wish to access the personal data you have provided you can do so by contacting the researcher or their supervisor via email.

Your personal data and information will only be used as outlined in this Participant Information Sheet, unless you consent otherwise. Data management will follow the Data Protection Act 2018 (DPA 2018) and UK General Data Protection Regulation (UK GDPR), and the University of East Anglia's [Research Data Management Policy](#).

The information you provide will be stored securely and your identity will be kept strictly confidential, except as required by law. Study findings may be published and may also be used for other scholarly and educational purposes such as in teaching, but you will not be

identified if you decide to participate in this study. The data will be kept for at least 10 years beyond the last date the data were used. The study findings may be deposited in a repository to allow it to facilitate its reuse. The deposited data will not include your name or any identifiable information about you.

(10) What if I would like further information about the study?

When you have read this information, Miss Kayleigh Felstead (k.felstead@uea.ac.uk, n/a) will be available to discuss it with you further and answer any questions you may have.

(11) Will I be told the results of the study?

You have a right to receive feedback about the overall results of this study.

You can tell us that you wish to receive feedback by contacting the researcher via email.

This feedback will be in the form of a one page summary.

This feedback will be available following completion of the research project.

(12) What if I have a complaint or any concerns about the study?

If there is a problem please let me know. You can contact me via the University of East Anglia at the following address:

Miss Kayleigh Felstead
School of Education and Lifelong Learning
University of East Anglia
NORWICH NR4 7TJ
k.felstead@uea.ac.uk

You can also contact my research supervisor at the following address:

Dr LeMarra Williamson
School of Education and Lifelong Learning
University of East Anglia
NORWICH NR4 7TJ
lemarra.williamson@uea.ac.uk

If you are concerned about the way this study is being conducted or you wish to make a complaint to someone independent from the study, please contact the Head of School of Education and Lifelong Learning: (,).

(13) How do I know that this study has been approved to take place?

To protect your safety, rights, wellbeing and dignity, all research in the University of East Anglia is reviewed by a Research Ethics Body. This research was approved by the EDU S-REC (School of Education and Lifelong Learning Research Ethics Subcommittee).

(14) What is the general data protection information I need to be informed about?

According to data protection legislation, we are required to inform you that the legal basis for processing your data as listed in Article 6(1) of the UK GDPR is because this allows us to process personal data when it is necessary to perform our public tasks as a University.

In addition to the specific information provided above about why your personal data is required and how it will be used, there is also some general information which needs to be provided for you:

- The data controller is the University of East Anglia.
- For further information, you can contact the University's Data Protection Officer at dataprotection@uea.ac.uk
- You can also find out more about your data protection rights at the [Information Commissioner's Office \(ICO\)](#).

- If you are unhappy with how your personal data has been used, please contact the University's Data Protection Officer at dataprotection@uea.ac.uk in the first instance.

(15) OK, I want to take part – what do I do next?

You need to fill in one copy of the consent form and return this to the researcher via email (k.felstead@uea.ac.uk). Please keep the letter, information sheet and the second copy of the consent form for your information.

(16) Further information

This information was last updated on 20 February 2025.

If there are changes to the information provided, you will be notified by email.

This information sheet is for you to keep

I, [PRINT NAME], **am** willing to participate in this research study.

- I understand the purpose of the study, what I will be asked to do, and any risks/benefits involved.
- I have read the Participant Information Sheet, which I may keep, for my records, and have been able to discuss my involvement in the study with the researchers if I wished to do so.
- The researchers have answered any questions that I had about the study and I am happy with the answers.
- I understand that being in this study is completely voluntary and I do not have to take part. My decision whether to be in the study will not affect my relationship with the researchers or anyone else at the University of East Anglia now or in the future.
- I understand that I may stop the interview at any time if I do not wish to continue, and that unless I indicate otherwise any recordings will then be erased and the information provided will not be included in the study results. I also understand that I may refuse to answer any questions I don't wish to answer.
- I understand that the results of this study will be used in the way described in the information sheet.
- I understand that personal information about me that is collected over the course of this project will be stored securely and will only be used for purposes that I have agreed to. I understand that information about me will only be told to others with my permission, except as required by law.

Audio-recording	YES	☐	NO	☐
Video-recording	YES	☐	NO	☐
Reviewing transcripts	YES	☐	NO	☐

Would you like to receive feedback about the overall results of this study?

YES ☐ NO ☐

If you answered **YES**, please indicate your preferred form of feedback and address:

☐ Postal: _____

☐ Email: _____

.....
Signature

.....
PRINT name

.....
Date

I, _____ [PRINT NAME], am willing to participate in this research study.

- I understand the purpose of the study, what I will be asked to do, and any risks/benefits involved.
- I have read the Participant Information Sheet, which I may keep, for my records, and have been able to discuss my involvement in the study with the researchers if I wished to do so.
- The researchers have answered any questions that I had about the study and I am happy with the answers.
- I understand that being in this study is completely voluntary and I do not have to take part. My decision whether to be in the study will not affect my relationship with the researchers or anyone else at the University of East Anglia now or in the future.
- I understand that I may stop the interview at any time if I do not wish to continue, and that unless I indicate otherwise any recordings will then be erased and the information provided will not be included in the study results. I also understand that I may refuse to answer any questions I don't wish to answer.
- I understand that the results of this study will be used in the way described in the information sheet.
- I understand that personal information about me that is collected over the course of this project will be stored securely and will only be used for purposes that I have agreed to. I understand that information about me will only be told to others with my permission, except as required by law.

Audio-recording YES ☐ NO ☐

Video-recording YES ☐ NO ☐

Reviewing transcripts YES ☐ NO ☐

Would you like to receive feedback about the overall results of this study?

YES ☐ NO ☐

If you answered **YES**, please indicate your preferred form of feedback and address:

☐ Postal: _____

☐ Email: _____

.....
Signature

.....
PRINT name

.....
Date

Appendix L. Participant Debrief Sheet

Miss Kayleigh Felstead
Trainee Educational Psychologist

20 February 2025

Faculty of Social Sciences
School of Education and Lifelong
Learning

University of East Anglia
Norwich Research Park
Norwich NR4 7TJ
United Kingdom

Email: k.felstead@uea.ac.uk
Web: www.uea.ac.uk

An Exploration into the Role of Educational Psychologists (EPs) in Supporting Children and Young People (CYP), Parents and Schools to Respond to Self-harm

PARTICIPANT DEBRIEF SHEET

We appreciate the time and effort you dedicated to participating in this interview. Your insights are invaluable to this research study. If you have any queries about the study or wish to speak with the researcher, please contact: Kayleigh Felstead (k.felstead@uea.ac.uk).

(1) Purpose of the study

The research sought to explore the role of Educational Psychologist's (EPs) in supporting children and young people (CYP), parents and schools to respond to self-harm. Self-harm is a particular area of concern, related to CYP mental health, with an estimated 17% of young people having self-harmed in their lifetime (Gillies et al, 2018). Whilst there is suggestion that school staff are well placed to identify and respond to self-harm, the literature suggests that schools are finding this difficult (Best, 2005; Walshe, 2016).

Considering that EPs are equipped with knowledge of school systems, emotional wellbeing and child development, it is suggested that they are well placed to offer support in this area (Reichardt, 2016). However, issues have been raised in relation to the preparedness of EPs in delivering training on self-harm, and it has been suggested that a review into whether self-harm and mental health are embedded within the educational psychology doctorate training curriculum is needed (Lee, 2016). Whilst EPs are implicated in some of the research exploring educational perspectives on self-harm, there is very little research which directly explores their views in relation to their role in managing self-harm. Considering the evolving role of EPs in CYP mental health, it might be challenging for EPs to define their role when it comes to supporting self-harm.

The present study is aiming to explore the current work of EPs in relation to self-harm, helping to further define their role in this area. It is also seeking to explore how well-equipped EPs feel to carry out this work, through consideration of the key barriers and facilitators.

(2) What happens next?

The information you provided in your interview will be transcribed and analysed using reflexive thematic analysis, following the six-phase framework outlined by Braun and Clarke (2006, 2021). This will help to synthesise the data and extract the key themes and ideas. You will have the opportunity to review your transcript for accuracy prior to analysis, should you wish to do so.

(3) Data

The information you provide will be stored securely and your identity will be kept strictly confidential, except as required by law. Study findings may be published and may also be used for other scholarly and educational purposes such as in teaching, but you will not be identified if you decide to participate in this study. The data will be kept for at least 10 years beyond the last date the data were used. The study findings may be deposited in a repository to allow it to facilitate its reuse. The deposited data will not include your name or any identifiable information about you.

(4) Information and support

If you have found any part of this experience to be distressing, please consider speaking with your clinical supervisor or workplace counselling/employee assistance service. You may also consider seeking further support from one of the organisations below:

- Association of Educational Psychologists (AEP):
<https://www.aep.org.uk/support-members>
- 24/7 support from Samaritans:
<https://www.samaritans.org/how-we-can-help/contact-samaritan/>

If you would like further information and support around managing self-harm you can find this here:

- Charlie Waller Trust:
<https://www.charliewaller.org/>
- Young Minds:
<https://www.mind.org.uk/information-support/types-of-mental-health-problems/self-harm/supporting-someone-who-self-harms/>
- NICE guidelines on self-harm:
<https://www.nice.org.uk/guidance/ng225/resources/selfharm-assessment-management-and-preventing-recurrence-pdf-66143837346757>

(5) Results and follow up

You have a right to receive feedback about the overall results of this study. If you have not already indicated that you would like to receive feedback, then you can do so by emailing the researcher on the email address provided. The feedback will be in the form of a one page summary and will be available following completion of the research project.

Thanks again for your participation 😊