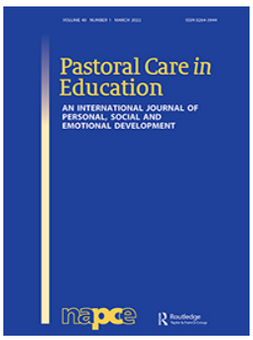

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ARTICLE

Perspectives on what schools and mental health services can do about bullying of adolescents with severe emotional health conditions

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ABSTRACT

Despite evidence identifying bullying as leading to severe distress, few studies have focused on bullied adolescents with existing mental health conditions. With increasing prevalence rates, it is necessary to understand how these adolescents can be better safeguarded. To address the issue, this study reports the rarely conveyed viewpoints of adolescents attending mental health services; clinically diagnosed with severe emotional conditions. To complement these perspectives, the viewpoints of their parents and teachers were also obtained. Thematic analysis identified school bullying as a serious stressor, contributing to and exacerbating their mental health need. They were prone to be trapped in a cycle of victimisation, complicated further by their preference for secrecy. Adolescents and their parents felt bullying problems could be appropriately managed if school staff were better tuned into the subtle signs of bullying, and managed disclosure more sensitively by working collaboratively with them and their assigned mental health practitioner. Recommendations were, a need for staff to better detect bullying distress and strengthen multi-agency links when bullying is suspected, to ensure quick, proactive intervention. Furthermore, schools could consider amalgamating the bullying and mental health whole school approaches, due to the intrinsic links between bullying and mental health.

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Bullying; cyberbullying; school mental health; anti-bullying; emotional difficulties; whole school approach

Introduction

The mental health of adolescents is a global priority, especially as prevalence is increasing. Data obtained in 2005, by the National Office of Statistics (NoS), suggested 10% of 5–15-year-olds in the United Kingdom (UK) had a diagnosable mental health condition (Green et al., 2005). Global statistics in 2011 concurred, suggesting a prevalence of 10–20% (Kieling et al., 2011). A recent survey carried out in the UK illustrates a rising rate of 12.8%, of 5–19-year-olds having at least one diagnosable mental health condition and of these, 9.1% adolescents had a diagnosable emotional disorder, with rates higher in girls (10%) than boys

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(6.2%) (NHS Digital, 2018). Early intervention through a multi-agency approach is thought to be the key to tackling this mental health 'crisis' (DH, 2015). This is because the longer the duration of any mental health difficulty, the more complex the multifactorial aetiology becomes, whereby there is often a complex nexus of integrated biopsychosocial risk factors, i.e., genetic predisposition, poor social status, family and peer relationships difficulties, which can increase an adolescent's risk of developing long-term mental health conditions later in life (Keiling et al., 2011). Conversely, however, if via early intervention their social system is strengthened the adolescent's wellbeing can be promoted (Weare, 2000).

This increased prevalence is therefore likely explained by many factors, including (albeit not limited to) increases in poverty, increased academic pressures on adolescents, social changes in familial structures, and potentially social media (although this remains contentious). One contributing risk factor with a strong evidence-
base is the role of peers in adolescent mental health, and a related consistently highlighted risk factor is that of bullying (Arseneault et al, 2010). This is a social problem affecting millions of adolescents globally (Volk et al., 2006). The nature of this relationship is bi-directional. First in that victimisation of bullying can directly lead to the development of mental health problems, especially emotional conditions, and second those with existing conditions are more likely to be bullied than their peers.

Bullying is not a new phenomenon and over thirty years on from Olweus's (1994) seminal work highlighting its harmful impact, there has been considerable investigation. This evidence has affected the education system as overt school bullying practices, like name calling and physical violence, to some extent, has decreased (Rigby & Smith, 2011). However, while this has been positive, arguably due to the rise of the internet, bullying has transmogrified from overt to more covert bullying whereby the behaviour is more likely to happen surreptitiously with advances in technology allowing it to spread quickly, making it more challenging for schools to tackle (Juvonen & Graham, 2014). Evidence suggests adolescents with Special Educational Needs, are particularly susceptible to experiencing emotional difficulties (Rose et al., 2009). Evidence also suggests they are more vulnerable to all forms of bullying and likely to endure the bullying for longer, refraining from seeking support (MENCAP, 2007). Worryingly, research suggests the longer duration of any form of bullying the more likely the adolescent will experience severe mental health problems (Arseneault et al, 2010), with a higher risk of suicidal ideation (Kim & Leventhal, 2011) Post-Traumatic Stress Disorder (Hong & Espelage, 2012) psychosis (Wolke et al., 2013) and longer-term mental health conditions being sustained in adulthood (Meltzer et al., 2011).

Specifically, in relation to online encounters, it is known that resilient adolescents or those who cope well can tackle adverse situations in adaptive ways, but

those with *psychological problems* tend to be less resilient, which subsequently causes them to experience more intense upset when exposed to negative online behaviour and have greater vulnerability to bullying in all forms (D'Haenens et al., 2013). Due to characteristics associated with their mental health conditions, their ability to be resilient and cope with being bullied is impaired. This often means they tend to revert to silence and commonly use maladaptive behaviours like self-harming (Hay et al., 2010) or restrictive eating (Copeland et al., 2015). Alternatively, they may cope by becoming a bully themselves (Swearer & Hymel, 2015).

Clearly, schools have an important role to play where bullying and mental health overlap. Indeed, the role of schools is increasingly recognised by governments in Western Countries. For example, in the UK, Education Practitioners are considered well placed to support positive mental health (DH, 2015) and have a role in tackling bullying (Department for Education, 2018). Schools have generally embraced this role in tackling bullying, although a more complex challenge for managing cyberbullying as much occurs away from school grounds (Livingstone et al., 2016). Schools in the UK have a range of prevention and intervention methods used to address the problem, typically with a zero-tolerance approach, and using strategies such as mediation and restorative justice (Augustine et al., 2018). Most anti-bullying advocates argue schools should adopt a whole-school approach to the issue (Cowie & Myers, 2018) because this can successfully reduce the problem by 27% and reduce exclusion due to bullying by 45% (Garner, 2008). Global studies suggest schools can support and promote the resiliency of vulnerable adolescents, if they have the time and resource to target populations known to be at risk for being different, i.e., lesbian, gay, bisexual, trans (LGBT) (Mitchell et al., 2014), obese (Bacchini et al., 2015) and those with learning difficulties (Luciano & Savage, 2007). Collectively, the evidence-base demonstrates a need to focus more attention on adolescents with existing mental health conditions as this group constitutes a high-risk of bullying.

Methodology

The challenge of combating bullying in schools, especially in terms of supporting vulnerable groups has mostly been informed by quantitative evidence. Qualitative research is growing, but the voices of seldom-heard groups, like those attending mental health services for emotional conditions, are less promoted. By highlighting the perspectives of adolescents with diagnosed emotional conditions this study aimed to redress this gap. Furthermore, the qualitative design informed by the overarching question *'How can adolescents with emotional mental health conditions be better supported in school?'* acknowledges school experiences change from generation-to-generation, due to the impact of broader societal change, knowledge and thinking. It is

therefore important to revisit this question regularly. The focus on bullying for this paper was iteratively derived from engagement with the data, as the broader research question focusing on school experiences led to participant-driven discussions of bullying. Bullying was not part of the research agenda or interview schedule and yet it became a central and powerful point of discussion raised by all but one of the adolescents and parents. It is this issue that forms our analytic focus.

Design and theory

A qualitative thematic design was utilised due to the exploratory nature of the project and the limited evidence-base with this population. Theoretically, the study was informed by macro-social-constructionism, which centres on how discourse and social structures shape our social world (Lester & O'Reilly, 2018). This is an appropriate design when exploring adolescents' lived experiences as they interpret their social worlds via language and social structure but their interpretation can be different to how adults perceive the same influences (Fraser et al., 2004). Macro-social-constructionism is therefore consistent with a viewpoint that childhood is socially constructed and therefore subject to change (Roy-Chowdhury, 2010). Of note, because the focus of this study was on adolescents with clinically diagnosed mental health conditions, this paper sometimes uses diagnostic terminology, more affiliated with the medical paradigm to contextualise the study. A social constructionist stance has, however, been proactively adopted when conveying and analysing participant perceptions, thus the strong emphasis on quoting participant verbatim to frame analysis and convey transparency.

Sample and recruitment

Adolescents aged 14–16-years-old with a clinical diagnosis of an emotional mental health condition were recruited to explore their school experiences. At least one parent was also invited to participate (*See Table 1*, *outlining Sample Characteristics*). Recruiting 14 young participants and 16 parents (13 mothers and 3 fathers) abided by Francis et al. (2010) sampling adequacy model, which outlines how qualitative researchers may better determine the accomplishment of data saturation. Francis et al. recognised that saturation is typically achieved by 10 participants, but recruiting an additional 3 provides verification; our sampling required 14 to reach the stopping criterion. For Francis et al., the stopping criterion is iteratively achieved and noted to be the point at which there is significant repetition of issues and ideas, with little new information being generated.

A purposive sampling technique ensured the targeted seldom-heard group participated. All adolescents were recruited via Child and Adolescent Mental

Table 1. Sample characteristics.

Young people *interviewed with parent	SexF = FemaleM = Male	Age	Identified mental health problem	Learning difficulty √ = YesX = No	GCSE/A level study	Bullying experience	Parent interviewed M = Mother F = Father	Named teacher participated in study √ = Yes× = No
1	F	14	Anxiety with Obsessive Compulsive Disorder (OCD)	√	GSCE	√	(enduring)	M
√								
2	F	15	Anorexia Nervosa and anxiety disorder	×	GSCE	√	M	√
3	M	16	Anxiety with Post-Traumatic Stress Disorder	√	GCSE	√	M & F	√
4	F	16	Depression and self-harming behaviour	×	GCSE	√	(enduring)	F
√								
5	F	15	Anxiety	×	GSCE	√	M	× (*Family chose not to name a teacher)*
* 6	F	15	Depression	×	GSCE	√	M	√
7	M	16	Depression and self-harming behaviour	×	A Level	√	(enduring)	M
√								
8	M	14	Anxiety	×	GSCE	X	M	× *(School did not respond to communication)*
9	F	15	Depression and self-harming behaviour	×	GSCE	√	M & F	√
10	F	15	Depression and Psychosis	x	GCSE	√	(enduring)	M
√								
11	F	16	Anorexia Nervosa	×	GSCE	√	M	× *(Teacher made redundant)*
12	F	16	Anxiety	×	GCSE	√	M	×*(Head Teacher refused permission)*
*13	F	16	Depression and anxiety	√	GCSE	√	M	√
14	F	16	Depression and self-harming behaviour	×	GSCE	√	(enduring)	M
× *(School did not respond to*	*communication)*							

Health Services (CAMHS) in England, and at the time of participating were receiving outpatient support for emotional problems and comorbidities (*see Table 1*). Those with a primary diagnosis of ADHD or autism were purposefully excluded because those with neurodevelopmental conditions tend to have behaviour that is more visible, easier to detect and possibly challenge (Power et al., 2012). Those that consented to participate were mostly White British, male and female, and represented different socio-economic indices. All adolescents were domiciled with their parents. The young participants identified teachers to participate, which resulted in nine teachers from nine different mainstream schools in England participating (*see Table 1*). Within the teacher sample, the checking recommendation (of +3) from Francis et al. (2010) could not be assured because not all adolescents provided a contact and some teachers were unable to participate; therefore, while there was repetition of issues, saturation could not be verified.

Data collection

Semi-structured interviews were used to gain a richer insight into the participants' worlds and because of the sensitive nature of enquiry into mental health conditions (O'Reilly & Dogra, 2016). Interviews lasted approximately 40 minutes. The adolescents and adults were predominantly interviewed separately; however, two participants chose to be interviewed with their parent (*see Table 1*). Notably, the young participants and their parents spoke extensively about their bullying experiences. All participants were asked the same three broad areas of questioning: what they felt their school did well, what school could do more of and what they felt hampered any needs being addressed.

Data collection for the young participants only was facilitated by participatory techniques in the form of six short film vignettes of approximately three minutes long, that were written and digitally developed in collaboration with a youth drama group. These vignettes depicted different adolescents experiencing various emotional situations in school. For example, Vignette one depicted 'Darren' who arrived late to class looking sad; 'Katy' experiencing escalated anxiety when participating in group work; and 'Jo' having an outburst of emotion when feeling targeted by a teacher. Selected vignettes were used as required by the researcher as a helping tool. They were used in a range of ways; they facilitated the building of rapport, helped to engage participants, aided in maintaining the focus on school experiences, and promoted more in-depth conversation. Furthermore, these vignettes acted as a safe medium when consulting on a sensitive school problem such as their mental health condition, and this enabled the young person to talk in third person rather than about themselves directly.

Analysis

Thematic analysis was utilised due to its meaning-making focus (Braun & Clarke, 2013) and its usefulness when making sense of lived experiences from a macro-social constructionist perspective. Interviews were recorded and subsequently transcribed. Data were coded using the Boyatzis (1998) framework facilitated by NVivo software to organise and map ideas. Initially, data were organised into first order codes whereby each transcript was examined sentence-by-sentence with segments of verbatim assigned to an existing or new code (N = 232 Young people, N = 188 Parent and N = 127 Teacher first order codes). Congruent with the approach, data were collapsed into second order codes meaning they are grouped together into categories (N = 42 Young people, N = 64 Parent and N = 50 Teacher first order codes). Each category was then examined to identify key themes. In total, 16 themes were identified using a macro-social-constructionism lens. All related to different aspects of school mental and emotional wellbeing identified as important to participants. This paper specifically focuses on a core theme reporting the data that relates to a bullying, as this was a pertinent issue derived from a participant-driven analytic scheme.

Ethics

Ethical approval was secured through the National Research Ethics Service (UK). Identified CAMHS professionals acted as gatekeepers which ensured the adolescents and their parents were safely and sensitively recruited. Teachers were only approached with the adolescent's consent. The study was also designed such that identified CAMHS Gatekeepers were available to mitigate in circumstances where the participants may have become distressed. Transcripts were anonymous and parent, teacher and adolescent data reported separately and without association to prevent deductive disclosure.

Findings

Bullying was an issue that most young participants experiencing mental health conditions (n = 13) and parents (n = 13) spoke about and some spoke frankly about experiencing it (n = 11). It was referenced by the adolescents 168 times and their parents 155 times. In contrast, teachers made limited reference to bullying (n = 20). Attention to this issue identified four themes for analysis: vulnerability to serious bullying problems; susceptibility to masking victim distress; school complacency and the need for collaborative management strategy.

Theme 1: vulnerability to serious bullying problems

Young participants and their parents described differing bullying experiences ranging from physical violence (n = 7) to emotional abuse (n = 11) some of which was serious bullying behaviour reported to the police (n = 4), including sexual assault and stalking. The adolescents described how the victimisation exacerbated their already fragile emotional state by describing the consequences as illustrated below:

Young participant 10: *'I was bullied all through year eight and nine, I had to change friendship groups at the beginning of year 10 because in year nine I lost so many friends. I went back in September … year 10 everyone who I used to know just blanked me'.*

Young participant 14: *'Like most of year 11 was terrible because the people that didn't like me, I couldn't even look at them without feeling nervous and having the fear that they would start something with me'.*

The relevance of peer relationships and the importance of friendships were emphasised by the young people as having an impact on their emotions. The lack of friends and the imposed *fear* was described as *terrible* and that constant effect of the bullying was reported. For some, the physical violence was something that governed their lives and that they feared and experienced, as graphically explained by a parent:

Parent E: *'Basically some much older children who must have been either in GSCE year or sixth form, kind of taped him up to a chair like kind of, like something out of Reservoir Dogs and taped up his mouth and his eyes and like drew all over him and poured water all over him and kind of just subjected him to physical abuse and verbal abuse and he, they'd got other people who were watching and like filming it on their phones and all sorts of things like that'.*

These extracts illustrate the complexity of school bullying, in that bullying continued outside the physical spaces of school and was intensified by the influence of digital technology. Indeed, the impact of the *physical abuse* is now captured by the bullies as other adolescents film the violent activities *on their phones* and thus the young person is subject to a recorded reminder of what they experienced via social media.

Notably, this intersection between in-person and online bullying was commonly discussed by about half of young participants (n = 5) and parents (n = 6). Despite the modality of behaviour, however, the narratives focused on the seriousness of incessant bullying and the emotional impact than the means to victimise the young person. For some adolescents, these were reported as very serious consequences, including suicidal ideation and eating problems because of the sustained victimisation:

Young participant 6: *'It went on for quite a long time and I was getting abusive text from it and the police had to get involved with it because it just got so serious. It put my confidence down. I did take attempts on my life thanks to the bullying, but I am happier now that it has stopped'.*

Young Participant 14: *'Yes, because I was being bullied. I was cutting trying to end my life not eating and stuff like that and from not eating I lost a lot of weight and it was quite concerning'.*

Theme 2: susceptibility to mask bullying problems

Participants reported challenges in detecting bullying amongst this group. This was described as a problematic issue because despite bullying problems being severe in terms of impact, they often went unnoticed by school staff. This was hindered further by digital media, which likely played a part in the covertness of the bullying (Rigby & Smith, 2011). Notably, in this specific population, they did report that they were prone to masking or hiding their bullying distress. The excerpts below illustrate this:

Young person 5: *'Yes, I am stronger I don't just cry over nothing I tend to just put on a face and kind of deal with it'.*

Several adolescents (n = 6) and parents (n = 6) spoke about the ways they portrayed an image of themselves where they were coping in school. There is evidence that suggests a significant proportion of distressed adolescents hide or disguise their psychological difficulties, expending considerable energy in keeping their problems a secret (Oliver & Mano, 2007). This complex phenomenon has been linked to low mood, whereby a façade of being well despite emotional distress can be presented (Allan & Dixon, 2009). Parents reported how this masking phenomena hindered their efforts to help their child, resulting in them feeling powerless:

Parent Y: *'Because every time they say to me ((names their child)) always has a smile on her face, but I say yes she has but she puts it on as front, but we don't think so, I say but I know my daughter more than you do and I know she smiles and underneath that she is really upset and she is not happy'.*

Some adolescents (n = 9) gave insights into why they choose to hide their bullying problems. Predominantly this focused on a fear the bullying would get worse or risked being handled insensitively (n = 6) or not being believed (n = 5). Qualitative studies examining the perceptions of a generic populations of school pupils have reported similar complexity and fears (Delara, 2012; Oliver & Mano, 2007). Concealment of problems therefore hampers teacher detection as described below:

Teacher 8: *'I suppose in our school, children are good at saying when something is not right … but it is the quiet ones that worry me, that slip under the net, because nobody picks up anything or they just doesn't tell you or there are no signs and there is nothing to see'*

Teacher 4: *'Most of the time you don't really know to what extent they are having outside support unless it is directly affecting their progress'.*

These teachers' statements convey the reality that despite serious issues school staff are not always aware of a pupils' mental health conditions or the challenges they face or the bullying unless there is academic or behavioural impact. Noteworthy is that most adolescents (n = 11) did not inform their school that they were attending CAMHS unless their mental state had deteriorated to such an extent that they needed specialist inpatient support. It is arguably unsurprising these adolescents were vulnerable to falling under the teacher radar.

Theme 3: School complacency around bullying

The adolescents spoke frequently about how they wanted to fit in at school. When they felt safe and well connected at school this helped to promote their recovery and the management of their mental health symptoms. Bullying however made them feel extremely unsafe, seriously exacerbating their mental health difficulties. Worryingly, despite most young participants (n = 13) and parents (n = 13) explicitly highlighting bullying issues, their teachers frequently said their school did not have bullying problems. This suggests a discordance between the views of teachers and families. This is demonstrated by this teacher:

Teacher 5: *'Yes, definitely I think any bullying we are really hot on it, but we don't have a massive bullying problem'.*

Teacher perspectives of bullying in their schools may be due to the likelihood of these adolescents hiding their difficulties. However, it may also be due to other contributory factors, some of which were voiced by the young participants and their parents:

Parent F: *'They don't deal with it. I know they are caught up with political correctness and some of them are trying to do their jobs with one hand tied behind their back and it is extremely difficult, but those policies are there to adhere to.'*

Young person 6: *'He (a new head of school) came into the school and tuned around grades but he ignored a lot of problems he ignored bullying, racism … .'*

Young person 9: *'I know that somebody has been put on report card for bullying and I think well don't do that take them out of school – yes because what is a card going to do teachers are just going to sign it if they are good in their lesson.'*

These excerpts describe the perceived poor school leadership which they believed does not place enough emphasis on strict behaviour policies, and the need for stricter sanctioning. Young participants spoke about school more frequently reverting to using lenient methods of combating bullying as described by adolescent nine when outlining how a report card system records accumulated behavioural misdemeanours before action is taken. They also described a lack of school process when bravely disclosing bullying:

Young person 14: *'I went to my teacher and said there seems to be a problem with this girl she seems to be getting annoyed with me for some reason and I can't understand why, and they said keep your head down, so I did and out of nowhere the girl came out and attacked me. I had a cut eye and swollen eyes and they didn't do anything about it'.*

Young person 6: *'I felt unsupported much at school because I have been bullied a lot and it's been quite serious bullying. I have had death threats from it and people saying they want to kill me and stuff like that and I told the school, and nothing has really been done about it much, but it has stopped now the older kids have left'.*

It may be argued if the bullying had been managed more effectively and sensitively these adolescents may have been less likely to remain silent. Evidence highlights the importance of handling school bullying disclosures appropriately because it was estimated approximately only 21% of bullying problems are disclosed (Sullivan et al., 2004). It is also well documented that prompt early intervention can prevent an escalation of bullying and further emotional distress (Rivara & Le Menestrel., 2016), which is crucial for those already experiencing high levels of emotional need. It can therefore be argued that it is paramount teachers are tuned into the subtle signs of bullying distress and when it is explicitly disclosed, they deal with it quickly and transparently. The benefits of which were articulated by this young person:

Young Person 11:

YP: *'Um, I've always been a person to keep my emotions to myself a lot of the time, but I know, um, at a point before I had some time out of school I was particularly upset and a teacher sort of, um, kept me back after the lesson and sort of asked me questions, and I think he sort of told my tutor and things like that, so'.*

Researcher: *'And did that help'?*

YP: *'Um, I think so in a way because it, sort of, um … meant that more people sort of knew what I was struggling with, rather than me just keeping it to myself, cos I wouldn't have told anyone else'.*

This story demonstrates the power of teacher intuition, in that the teacher successfully detected the subtle signs of emotional distress and made time to communicate. This interaction appeared to help reduce the complex psychological barrier of self-concealment. Other adolescents (n = 11) gave further insight into the less obvious visible signs of school distress, for example:

Young person 1: *'I lose my concentration a lot at school because I get picked on, people call me names like I turn around, and I get fidgety it is quite hard but I kinda cope with it'.*

Young person 14: *'It did affect my grades a lot when I was getting bullied, they dropped quite a lot'.*

These young participants were describing a bullying chain reaction resulting in anxiety and hyper-vigilance, leading to a loss of concentration and memory, leading to in an inability to learn, an attainment drop and a disengagement from school by truanting or taking more frequent sick absence (n = 8). Many studies now link school bullying with poorer test performance (Bowen, 2011) and higher rates of absenteeism (Juvonen & Graham, 2014). It is clear from the teachers' perspectives that teachers can only detect these subtle signs of distress when they know their students well:

Teacher 4: *'Noticing change where it is slightly out of the ordinary you know if someone is a little bit quiet or a little tearful you know what's their work like? Are they scribbling on pages or are they tearing out pages?'*

This teacher knew their students well, even down to the point of changes in their written work and its tidiness. They had been their form tutor from year seven through to 10. Large comprehensive schools, with fast turnover of staff and compartmentalisation of support services, are at a disadvantage when it comes to knowing their students and a strong emphasis must be placed on nurturing teacher-student connection and teachers having the opportunity to build relationships.

Theme 4: Collaborative management strategy

Additional to the need for zero-tolerance anti-bullying management programmes in schools, the adolescents also reported that they needed more help from CAMHS in terms of bullying, especially as the bullying exacerbated their mental health condition:

Young Person 2: *'I do think it is really complex but I think if CAMHS told the school more exactly the things you are feeling, you would not have to do it which would make it less daunting, and I suppose they would be more aware that you are feeling those kind of emotions. So, more communication between them might help'.*

This young participant suggested that her CAMHS practitioner could step in to arbitrate and provide advice when school problems were being experienced. Adolescents suggested this would be helpful when they were feeling overwhelmed and finding it difficult to articulate difficulty or cope with their emotions. Many adolescents (n = 10) felt their teachers were unlikely to understand the effect of bullying on their already fragile mental state and felt their CAMHS practitioner would be able to better explain. Others spoke about how their CAMHS practitioner was ideally situated to provide more proactive one-to-one support at CAMHS appointments when they were experiencing school problems such as bullying (n = 9).

Parents in many cases did try to help by trying to voice concerns to teachers. However, in most cases, they conveyed stories whereby they had become frustrated, angry and felt unheard.

Parent X: *'Yes, at one time or another I was up at the school nearly every day because there was bullying … it got to the state before I refused to remove from reception until I say a teacher and they kept saying they would ring me back … they haven't I have written letters. No reply'.*

This parent was aware of her child's mental health vulnerabilities. All parents interviewed (n = 13) worried most about their child being bullied as they knew this would compound their child's mental health difficulties. They often felt helpless in that the school regime sometimes silenced them, as was the case of the above parent, or their own children silenced them by asking them not to disclose mental health conditions or discouraged them from having any school involvement. Some parents reverted to condoned absenteeism to safeguard their child from the bullies.

Interestingly, some adolescents (n = 9) spoke about how teachers could better support them when disclosing bullying problems. What they wanted was to have a say in how the bullying should be tackled. Yet in all cases where they described disclosure, they were not encouraged to do this.

Young person 5: *'I don't think it's best to force support on them because sometimes that can just sort of make things worse'.*

Teacher 9: *'We had a situation where her mother came in and she wasn't happy because her daughter was being picked on and her daughter had special needs and problems and we talked about it but in the end you know she didn't like the way I was doing things but the school said we had to carry on so we carried on and over the course of about 18 months this was when the girl left us and she went to another school'.*

The young person was describing feeling coerced to do what her teachers felt was best and yet she felt it would exacerbate the situation. The teacher's statement demonstrates the lack of collaboration when trying to manage

bullying as neither the parents nor the young person felt listened to. The participants suggested that to manage these adolescent's complex difficulties, a multi-dimensional approach needs to be taken. One where the adolescent, teacher and if the young person chooses, their CAMHS practitioner and/or parent should unite to tackle the bullying. Most importantly the adolescent's voice should be central to any decisions made as without this they feel unsafe and are likely to continue to hide their bullying difficulties.

Discussion

The voices of adolescents diagnosed with emotional mental health conditions are rarely represented in research. Respecting a seldom-heard group is central to educational decision-making and for tailoring or modifying generic policies to better meet their needs (Dolton et al., 2019). The aim of this research was to provide a space for adolescents with diagnosed emotional mental health conditions to describe their school experiences. This was achieved, it is important to note, however, two of the 14 adolescent participants choose to speak about their experiences in the company of their parents. Refusing their request would have been unethical due to not being all inclusive; however, it is important to acknowledge their parent's presence may have influenced the dynamics of the interview and their free expression. The adolescents recruited also primarily conveyed a Caucasian viewpoint, as recruitment of BAME populations proved difficult (3 BAME adolescents were invited to participate but refused). The adolescents who did participate very movingly responded, however, to this broad school-based enquiry; communicating very specifically about their bullying concerns, which highlighted the urgent need to modify generic policies around mental health and bullying, therefore likely not only benefiting Caucasian adolescents but those from BAME populations also.

This study provides strong evidence supporting Sims-Schouten (2017) viewpoint that childhood distress predominantly emanates from school, with bullying causing severe harm.

This is because the characteristics of their mental health condition make them less resilient and more susceptible to severe bullying and concealment of difficulties. Figure 1 depicts visually how the environmental stressor of bullying gives rise to a vicious, de-motivating cycle of negative thoughts, feelings, emotions and behaviours. This cycle is wholly supported by the bullying activity and, if no action is taken, risks the young person alienating themselves from their education, an escalation in risky damaging behaviours like self-harm or restricted eating, which consequently leads to a serious deterioration in mental health.

Findings suggested this group of adolescents require anti-bullying philosophy that recognises their vulnerability and a whole school approach that includes more tailored, bespoke anti-bullying intervention than those that presently exist. Currently, whole-school anti-bullying practices often include

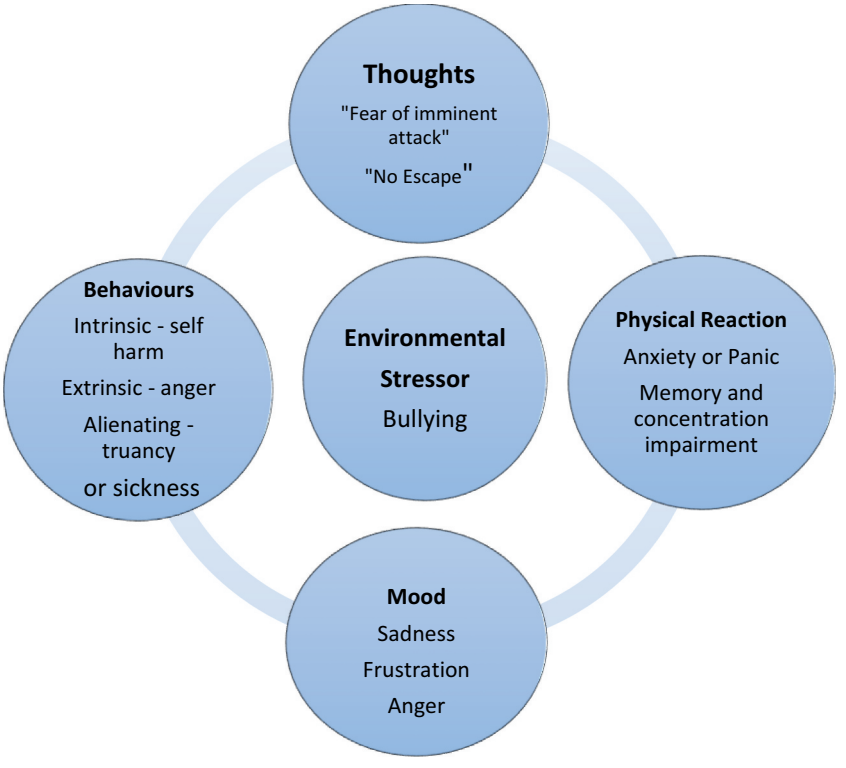

Figure 1. Bullying victimisation – the reaction cycle.

a zero-tolerance approach; strong behaviour policies and direct sanctioning. There is, however, a growing body of evidence suggesting zero tolerance policies have very little impact on school safety, with some arguing they can do more harm. For instance, they risk discrimination and punishing the well intended because they leave little room for teachers to autonomously manage complex problems (Graham et al., 2019). It is therefore clear that the way in which policies are written in education requires some modification and clarity. Conceptualising the bullying behaviour and the profile of victims as well as the *process* of victimisation needs to better account for the diversity and variability in the student body and recognise the specific vulnerabilities of those with emotional health conditions. In so doing, prevention, intervention and management of bullying must be adaptive to the nature of the victimisation and provide stronger, clearer definitions and differences. This research, for example, supports evidence suggesting some appropriate strict sanctioning does have a place alongside alternative evidenced methods such as, mediation and restorative justice methods. Restorative justice approaches, for example, are known to, improve school culture by promoting institutional empathy, and have when successfully implemented reduced exclusions, promoted attendance and improved attainment (Augustine et al., 2018). The introduction to these type of

anti-bullying practices does nonetheless present schools with challenges in that good staff training is paramount, especially when managing the sensitive issue of bullying and the vulnerabilities of the victim (Fronius et al., 2019).

The more covert nature of contemporary school bullying makes tackling the issue even more problematic. This was illustrated by the adolescents and their parents who reported that their bullying problems often fell beneath the radar for complex reasons. Consequently, they felt an important part of the whole-school anti-bullying approach should be equipping teachers with knowledge to spot the subtler signs of bullying distress, as well as ensuring they possess the communication skills needed to sensitively approach a young person when thought to be hiding difficulties. This would require teachers to have a better awareness of emotional and mental health difficulties and overlaps with some of the whole-school approach to mental health recommendations which seek to promote mental health awareness, and early detection of distress as well as increases pastoral support in schools. Presently, however, the whole school approaches to bullying and mental health are segregated, which notably is also mirrored in government policy. For example, the DH (2015) *Future in Mind* report and the House of Commons Health and Education Committee (2017) *Children and young people's mental health – role of education inquiry*, are two influential government documents that both neglect to place any emphasis on the importance of tackling bullying in schools in order to promote better mental health.

Presently in the UK, as is the case for many nations, government policy places an emphasis on schools playing their part in promoting better youth mental health (Department of Health and Social Care and Department of Education, 2018). Schools are acting on recommendations to increase their school counselling resources, as well as ensure teachers receive mental health training (Public Health England, 2017). For instance, investing in training like 'Youth Mental Health First Aid' which has an international status. A criticism of the training however is that it has a generic focus, providing a summary of mental health conditions, whereby course content has not been explicitly developed for teachers and does not place an emphasis on school-based problems like bullying or cyberbullying distress. Furthermore, there is a misguided assumption that training will immediately translate into effective practical implementation but does not consider the complexity of detecting mental health difficulties in the school context or tackling complex school phenomena like covert bullying (O'Reilly et al., 2018).

There is now a window of opportunity in the UK for those developing their own Mental Health Support Team (MHST's) as laid out in the NHS Mental Health Implementation Plan (2019/20 – 2023/24) that outlines how MHST's can play an important part in strengthening mental health support in schools by promoting early intervention via, specially trained Designated Senior Leads for mental health and school mental health teams consisting of school counsellors and

psychotherapists. It will be their business to play an active role in developing and embedding in school working practice more school focussed teaching training packages that amalgamate mental health awareness with anti-bullying evidence-based resiliency promotion, mediation and restorative practices. This is alongside developing supportive one-to-one therapeutic support of those directly involved in bullying and supporting teachers to handle bullying issues more sensitively.

A clear message deriving from this research was that once bullying was disclosed by a young person experiencing a mental health condition, it must be managed by the means of more proactive collaborative intervention, which ideally threaded into school safeguarding protocol if any form of victimisation from bullying is experienced or witnessed. This type of intervention should involve adolescent, parent, any school staff or CAMHS practitioners. Interestingly, they spoke very little about peer support or resiliency building regarding their coping strategies for bullying. What they felt was important is having adult assistance from professionals who knew them well like their CAMHS professionals or school counsellors and psychotherapists. Dialogue between the different professionals needs to place an emphasis on sharing of 'need-to-know' information, which is especially important when a young person with complex mental health needs finds it hard to trust their teachers and may not wish to highlight problems like bullying for fear of drawing negative attention to themselves (Hart & O'Reilly, 2018). Schools and mental health services must therefore develop new communication processes to support vulnerable adolescents experiencing school distress, as it is widely and internationally agreed that to meet their mental health needs, the different children's services need to work together (O'Reilly et al., 2018).

The reality of working together, is not entirely straightforward, though. Education and health services are different types of organisation, and there are multi-agency working challenges (Salmon & Kirby, 2008). Yet despite these challenges what is known is that school staff need multi-agency support. This is because they report feeling under resourced and overwhelmed by complex pastoral difficulties; especially because of the limited opportunity for support, supervision or debriefing (O'Reilly et al., 2018). A simplistic, time efficient, multi-professional anti-bullying communication process is therefore needed. This would aim to promote quick supportive intervention when school distress such as bullying is initially detected or reported. Such a collaborative process should be sensitive, ideally include and be led by the young person and when practical their parents, in identifying ways of managing the bullying. The recommendation being that this should be a step before any intervention involving the victim and perpetrator, i.e., mediation or restorative justice intervention, thus safeguarding a more vulnerable pupil with existing mental health conditions. This is because a meeting with their bully might not always be wholly appropriate and risk doing more harm than good.

In summary, bullying challenges are strongly linked to poor adolescent mental health, not only in terms of potentially leading to the development of such conditions but also in terms of exacerbating existing conditions. If bullying is ignored, then the educational environment becomes a potential contributor to poor mental health outcomes. Schools clearly play an important role in protecting mental health. To achieve this teachers, school counselling teams and external mental health practitioners must work in partnership; sharing skills and experiences so that bullying can be better prevented, detected and managed. Likewise, clarity regarding differentiations from mere normative peer conflict and bullying behaviour needs to be taught to adolescents and their teachers, along with formal policy definitions to facilitate teachers and parents in their understanding of bullying and its impact. Central to this endeavour, and especially important when supporting adolescents with existing mental health difficulties, is managing any bullying problems in collaboration with the adolescent themselves and (when appropriate) their parents and any key professionals involved in their care. This is so as to ensure a sensitive adolescent-centred, tailored approach is taken when working towards resolving any bullying problems, therefore ensuring the young person feels safe knowing their unique differences have had special consideration.

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References

Allan, J., & Dixon, A. (2009). Older women's experiences of depression: A hermeneutic phenomenological study. *Journal of Psychiatry Mental Health Nursing*, *16*(10), 865–873. https://doi.org/10.1111/j.1365-2850.2009.01465.x

Arseneault, L., Bowes, L., & Shakoor, S. (2010). Bullying victimization in youths and mental health problems: 'much ado about nothing? *Psychological Medicine*, *40*(5), 717–729. https://doi.org/10.1017/S0033291709991383

Augustine, C. H., Engberg, J., Grimm, G. E., Lee, E., Wang, E. L., Christianson, K., & Joseph, A. A. (2018). *Can restorative practices improve school climate and curb suspensions? An evaluation of the impact of restorative practices in a mid-sized urban school district*. RAND Corporation. UHL https://www.rand.org/pubs/research_reports/RR2840.html

Bacchini, D., Licenziati, M. R., Affuso, G., Garrasi, A., Corciulo, N., Driul, D., Fiumani, G., Di Pietro, E., Pesce, S., Crinò, A., Maltoni, G., Iughetti, L., Sartorio, A., Deiana, M., Lombardi, F., Valerio, G., & Valerio, R. (2015). The interplay among BMI z-score, peer Victimization, and self-concept in outpatient children and adolescents with overweight or obesity. *Child Obesity*, *13*(3), 242–249. https://doi.org/10.1089/chi.2016.0139

Bowen, L. (2011). Bullying may contribute to lower test scores. *Upfront Monitor on Psychology*, *42*(9), 19. https://www.apa.org/monitor/2011/10/bullying

Boyatzis, R. (1998). *Transforming qualitative information: Thematic analysis and code development*. Sage.

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. Sage.

Copeland, W. E., Bulik, C. M., Zucker, N., Wolke, D., Lereya, S., & Costello, E. (2015). Does childhood bullying predict eating disorder symptoms? A prospective, longitudinal analysis. *The International Journal of Eating Disorders*, *48*(8), 1141–1149. https://doi.org/10.1002/eat.22459

Cowie, H., & Myers, C. A. (2018). *School bullying and mental health: Risks, intervention and prevention*. Routledge.

D'Haenens, L., Vandonink, S., & Donoso, V. (2013). *How to cope and build resilience*. LSE. http://eprints.lse.ac.uk/48115/

Delara, E. (2012). Why adolescents don't disclose incidents of bullying and harassment. *Journal of School Violence*, *11*(4), 288–305. https://doi.org/10.1080/15388220.2012.705931

Department for Education. (2018). *Mental health and behaviour in schools: Departmental advice for school staff* (Ref: DFE-00327-2018). Department of Education.

Department of Health and Social Care and Department of Education. (2018) *Government response to the consultation on transforming children and young people's mental health provision: A green paper and next steps* (Cm 9626).

DH. (2015). *Future in mind: Promoting, protecting and improving our children and young people's mental health and well-being* (Gateway Ref: No 02939). NHS England Publication.

Dolton, A., Adams, S., & O'Reilly, M. (2019). In the child's voice: The experiences of primary school children with social, emotional and mental health difficulties. *Clinical Child Psychology and Psychiatry*, *25*(2), 419–434. https://doi.org/10.1177/1359104519859923

Francis, J., Johnston, M., Robertson, C., Glidewell, L., Entwistle, V., Eccles, M., & Grimshaw, J. (2010). What is adequate sample size? Operationalizing data saturation for theory-based interview studies. *Psychology and Health*, *25*(10), 1229–1245. https://doi.org/10.1080/08870440903194015

Fraser, S., Lewis, V., Ding, S., Kellett, M., & Robinson, C. (2004). *Doing research with children and young people*. Open University Press.

Fronius, T., Darling-Hammond, S., Persson, H., Guckenburg, S., Hurley, N., & Petrosino, A. (2019). *Restorative justice in U.S. schools: An updated research review*. https://files.eric.ed.gov/fulltext/ED595733.pdf

Garner, R. (2008). *Restorative justice cuts exclusions*. The Independent. http://www.independent.co.uk/news/education/eduction-news/restorative-justice-cuts-exclsuions-948595.html

Graham, B., White, C., Edwards, A., Potter, S., & Street, C. (2019). *School exclusion: A literature review on the continued disproportionate exclusion of certain children*. Department of Education. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/800028/Timpson_review_of_school_exclusion_literature_review.pdf

Green, H., McGinnity, A., Meltzer, H., Ford, T., & Goodman, R. 2005. *The mental health of children and young people in Great Britain*. Palgrave Macmillan. Office for National Statistics Mental health of children and adolescents in Great Britain London: The Stationery Office.

Hart, T., & O'Reilly, M. (2018). The challenges of sharing information when a young person is experiencing severe emotional difficulties: Implications for schools and CAMHS. *Child Adolescent Mental Health*, *23*(3), 235–242. https://doi.org/org//full/10.1111/camh.12245

Hay, C., Meldrum, R., & Mann, K. (2010). Traditional bullying, cyber bullying, and deviance: A general strain theory approach. *Journal of Contemporary Criminal Justice*, *26*(2), 130–147. https://doi.org/10.1177/1043986209359557

Hong, J. S., & Espelage, D. L. (2012). A review of research on bullying and peer victimization in school: An ecological system analysis. *Aggression and Violent Behavior*, *17*(4), 311–322. https://doi.org/10.1016/j.avb.2012.03.003

House of Commons Health and Education Committee. (2017). *Children and young people's mental health—The role of education. First joint report of the Education and Health Committees of Session 2016–2017 (HC 849)*. House of Commons London. The Stationary Office Limited.

Juvonen, J., & Graham, S. (2014). Bullying in schools: The power of bullies and the plight of victims. *Annual Review of Psychology*, *65*(1), 159–185. https://doi.org/10.1146/annurev-psych-010213-115030

Keiling, C., Baker-Henningham, H., Belfer, M., Conti, G., Ertem, I., Omigbodun, O., Rohde L. A., Srinath S., Ulkuer N., Rahman, A. (2011). Child and adolescent mental health worldwide: Evidence for action. *Lancet*, (9801), 378–1515. https://doi.org/10.1016/S0140-6736(11)60827-1

Kim, Y., & Leventhal, B. (2011). Bullying and suicide. A review. *International Journal of Adolescent Medicine and Health*, *20* (2), 133–154. Retrieved 22 Jan. 2020, from. https://doi.org/10.1515/IJAMH.2008.20.2.133 .

Lester, J. N., & O'Reilly, M. (2018). *Examining mental health through social constructionism: The language of mental health*. Sage.

Livingstone, S., Stoilova, M., & Kelly, A. (2016). Cyberbullying: Incidence, trends and consequences. In *Ending the torment: Tackling bullying from the schoolyard to cyberspace*. United Nations Office of the Special Representative of the Secretary-General on Violence against Children, New York, USA, pp. 115- 120. ISBN 9789211013443.

Luciano, S., & Savage, R. S. (2007). Bullying risk in children with learning difficulties in inclusive educational settings. *Canadian Journal of School Psychology*, *22*(1), 14–31. https://doi.org/10.1007/s10566-012-9183-9

Meltzer, H., Ford, T., Goodman, R., & Vostanis., P. (2011). The burden of caring for children with emotional or conduct disorders. *International Journal of Family Medicine*, *2011*(1-8), 1–8. Article ID 801203. https://doi.org/10.1155/2011/801203

MENCAP. (2007). *Bullying wrecks lives: The experiences of children and young people with a learning disability*. https://www.mencap.org.uk/sites/default/files/2016-07/Bullying%20wrecks%20lives.pdf

Mitchell, M., Gray, M., Green, K., & Beninger, K. (2014). *What works in tackling homophobic, biphobic and transphobic (HBT) bullying among school-age children and young people?* Government Equalities Office. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/570490/Tackling_homophobic__biphobic_and_transphobic_bullying_evidence_review.pdf

NHS Digital. (2018). *Mental health of children and young people in England, 2017 [PAS]*. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017

NHS Mental Health Implementation Plan 2019/20 – 2023/24. NHS England. https://www.longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf

O'Reilly, M., Adams, S., Whiteman, N., Hughes, J., Reilly, P., & Dogra, N. (2018). Whose responsibility is adolescent mental health in the UK? The perspectives of key stakeholders. *School Mental Health*, *10*(4), 450–461. https://doi.org/10.1007/s12310-018-9263-6

O'Reilly, M., & Dogra, N. (2016). *Interviewing children and young people for research*. Sage.
Oliver, C., & Mano, C. (2007). Bullying and the politics of 'telling'. *Oxford Review of Education*, *33* (1), 71–86. https://doi.org/10.1080/03054980601094594
Olweus, D. (1994). Bullying at school: Basic facts and effects of a school-based intervention program. *Journal of Child Psychological and Psychiatrics*, *7*(7), 1171–1190. https://doi.org/10.1111/j.1469-7610.1994.tb01229.x
Power, T. J., Jawad, A. F., Mautone, J. A., Soffer, S. L., Clarke, A. T., Marhsall, S. A., Sharman, J., Blum, N. J., Glanzman, M., & Elia, J. (2012). A family-school intervention for children with ADHD: Results of a randomized clinical trial. *Journal of Consulting and Clinical Psychology*, *80*(4), 611–623. https://doi.org/10.1037/a0028188
Public Health England. (2017). *Secondary school staff get mental health 'first aid' training*. Gov. UK. https://www.gov.uk/government/news/secondary-school-staff-get-mental-health-first-aid-training. Accessed 18 Aug 2017.
Rigby, K., & Smith, P. K. (2011). Is school bullying really on the rise? *Social Psychology of Education*, *14*(4), 441–455. https://doi.org/10.1007/s11218-011-9158-y
Rivara, F., & Le Menestrel., S. (2016). *Preventing bullying through science, policy, and practice*. The National Academies Press.
Rose, R., Howley, M., Fergusson, A., & Johnson, J. (2009). Mental health and special educational needs: Exploring a complex relationship. *British Journal of Special Education*, *36*(1), 3-8. https://doi.org/10.1111/j.1467-8578.2008.00409.x
Roy-Chowdhury, S. (2010). Is there a place for individual subjectivity within a social constructionist epistemology? *Journal of Family Therapy*, *32*(4), 342–357. https://doi.org/10.1111/j.1467-6427.2010.00496.x
Salmon, G., & Kirby, A. (2008). Schools: Central to providing comprehensive CAMH services in the future? *Child and Adolescent Mental Health*, *13*(3), 107–114. https://doi.org/10.1111/j.1475-3588.2007.00468.x
Sims-Schouten, W. (2017). *Mental health first aid training' in schools is a sticking-plaster solution*. The Conversation. https://theconversation.com/mental-health-first-aid-training-in-schools-is-a-sticking-plaster-solution-80166
Sullivan, K., Cleary, M., & Sullivan, G. (2004). *Bullying in secondary schools. What it looks like and how to manage it*. Sage.
Swearer, S., & Hymel, S. (2015). Understanding the psychology of bullying moving toward a social-ecological diathesis–stress model. *American Psychologist*, *70*(4), 344–353. https://doi.org/apa.org/getdoi.cfm?doi=10.1037/a0038929
Volk, A., Craig, W., Boyce, W., & King, M. (2006). Adolescent risk correlates of bullying and different types of victimization. *International Journal of Adolescent Medicine and Health*, *18* (4), 575–586. https://doi.org/10.1515/IJAMH.2006.18.4.575
Weare, K. (2000). *Promoting mental, emotional and social health a whole school approach*. Routledge.
Wolke, D., Lerey, S., Fisher, H., Lewis, G., & Zammit, S. (2013). Bullying in elementary school and psychotic experiences at 18 years: A longitudinal, population-based cohort study. *Psychological Medicine*, *10*(1017), 1–13. https://doi.org/10.1017/S0033291713002912