



**The Hopeful Minds programme: a mixed method evaluation of 10 school curriculum based, theoretically framed lessons to promote mental health and coping skills in 8-14 year olds.**

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## Background literature

The rise in adolescent mental ill health has become a major worldwide concern and is a leading global cause of disability in those under 25 years (Erskine et al., 2015). It has been reported that mental health problems affect 10–20% of children and adolescents worldwide (Keiling et al., 2011), with 50% developing by age 14 and 75% by age 24 (Kessler et al., 2005), with demand outweighing resources (Belfer, 2008). WHO (2014) state that over 50% of young people remain untreated into their adult life.

Keiling et al., (2011) recommends that '*early intervention and prevention offer the hope to avoid later adult mental health problems and improve personal wellbeing and productivity*' (p.1515). For example, many of the interventions that have been developed are aimed at promoting positive mental health, emotional-regulation and helpful coping strategies in young people (Collins, Marks Woolfson, & Durkin, 2013). Schools are a very suitable context for the delivery of such interventions (Frydenberg, 2008), where resilience-building and trauma focused interventions have been adapted and implemented via schools (Fazel, Patel, Thomas, & Tol, 2014). Meta-analyses suggest interventions developed for depression, through the promotion of resilience and protective factors are effective (Durlack, Weissberg, Dymnicki, Taylor, & Schellinger, 2011; Stice, Shaw, Bohon, Marti, & Rohde, 2009; Werner-Seidler, Perry, Callear, Newby, & Christensen, 2017). Further meta-analyses highlight the benefits of school-based prevention strategies, appraising ability to improve skills, resilience, pro-social behaviour and academic performance (Taylor, Oberle, Durlak, & Weissberg, 2017) and potential to reduce symptoms of anxiety and depression (Werner-Seidler et al., 2017). Programmes such as the 'SPARK Resilience Programme' (Pluess, Boniwell, Hefferon, & Tunariu, 2017) showed reduced symptoms of depression for at least 6 months following participation (Brunwasser et al., 2009) although a reported limitation of such studies has been the over focus on reducing symptoms of depression rather than increasing resilience (Pluess et al., 2017).

A systematic review of early intervention programmes in schools for anxiety indicated that most universal, selective prevention programmes are effective in reducing symptoms (Neil & Christensen, 2009). Whilst many programmes have been evaluated there are no conclusive findings on the most effective techniques to achieve these outcomes. A longitudinal study by Horwitz, Berona, Czyz, Yeguez, and King (2017), recommended building hope and optimism as a critical intervention target for suicidal adolescents. However, introducing hope to pre-adolescents to target the potential precursors to suicidal ideation has not been carried out before. Furthermore, hopelessness is the most negative state of mind, before the onset of suicidal

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3 ideation (Horwitz, et al., 2017), and is the opposite of hope.  
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5 Snyder and colleagues (1994, 2000) pioneered the development of hope in terms of promoting  
6 goal-directed thinking, whereby the individual can find routes to goals (pathways thinking), and  
7 motivation to use them (agency thinking) (Snyder et al., 2002). As individuals learn to be more  
8 hopeful, they may be more able to make commitments, set goals, and work towards attaining  
9 them (Shorey et al., 2003). Research shows that hope exists uniquely beyond optimism and  
10 positive thinking (Feldman & Kubota, 2015).  
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15 Since the creation of hope theory, there has been a growing body of research evaluating its  
16 role in wellbeing. Low hope is significantly related to negative outcomes: psychological  
17 distress (Snyder, LaPointe, Crowson, & Early, 1998); depressive symptoms (Kwon, 2000),  
18 poorer academic achievement; disengaged coping styles (Folkman, 2010) and tendencies to  
19 engage in self-doubt and negative rumination (Snyder, 1999). Low-hope and negative  
20 rumination has been linked to anxiety (Michael, 2000), low emotional regulation (ER), low self-  
21 esteem and low social support satisfaction in children and adolescents (Merkaš & Brajša-  
22 Žganec, 2011). Those higher in hopeful thinking show positive associations with perceived  
23 competence and self-efficacy (Davidson, Feldman, Margalit & 2012), increased confidence  
24 (Snyder, 2000), lower emotional distress (Gilman, Dooley, & Florell, 2006), greater use of  
25 engaged coping styles (Chang & DeSimone, 2001), and positive coping abilities such as  
26 problem solving (Snyder, 2000).  
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35 Nevertheless, there remains some mixed reports, as a meta-analysis by Weis and Speridakos  
36 (2011) found no conclusive evidence that hope enhancement strategies alleviate  
37 psychological distress, although Klausner and colleagues (2002) found a hope-based  
38 intervention for older adults diagnosed with depression resulted in significant improvements  
39 on all measured outcomes (hope, anxiety, and family interactions). Using college students,  
40 Brown and colleagues (1999), found they experienced increases in levels of hope, academic  
41 performances and self-esteem on completion of a hope-based programme. There is a lack of  
42 longitudinal research on the impact of hope interventions (Ciarrochi, Heaven, & Davies, 2007),  
43 however one post-primary school study showed that students who had received a hope  
44 intervention showed significant increases in levels of hope, self-worth and life satisfaction up  
45 to 18 months after completion (Marques, Lopez, & Pais-Ribeiro, 2011).  
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55 Considering relatively weak evidence base on the effectiveness of hope-based interventions  
56 in pre and early adolescent children (not just those at risk), a purposeful theoretically sound  
57 intervention was considered necessary. Further there are no curriculum-based programmes  
58 which explicitly teach children to develop an innate conceptualisation of hope and goal setting  
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3 alongside the development of lifelong skills. Finally, no such pilot has assessed how these  
4 hope factors (agency & pathway thinking, Snyder et al., 2002) combined contribute to what  
5 may constitute building levels of resilience, coping, problem solving and confidence building,  
6 and ultimately develop a mastery over future feelings of hopelessness in children.  
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10 The purpose of the current study therefore was to evaluate a unique programme which  
11 incorporates all these elements. *Hopeful Minds* (www.hopefulminds.org) was developed in  
12 the US by www.iFred.org (Goetzke, Tate, Patel, & Lewis, 2014) and it endorses the concept  
13 that hope is a teachable skill (Rand & Cheavens, 2008), thereby equipping children with tools  
14 to develop and maintain hope. It was originally designed to prevent hopelessness, a key  
15 predictor of suicide in youth (Horwitz, Hill, & King, 2011), whilst improving mental wellbeing in  
16 young people. It is a universal prevention programme, suitable for both low and higher risk  
17 groups.  
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25 More specifically, the purpose of *Hopeful Minds* is to prevent the development of negative  
26 states of mind *and* the precursors to hopelessness which is a key predictor of suicide. To  
27 support this, literature suggests that anxiety, emotional dysregulation and low mood precede  
28 a state of hopelessness, as Miranda, et al. (2013) suggest that '*perceived inability to access*  
29 *emotion regulation strategies may increase vulnerability to suicidal ideation through its effects*  
30 *on rumination and hopelessness*' (pp. 786). It is these precursors which the programme  
31 attempts to prevent. This is supported by Horowitz et al. (2017) who suggest that a lack of  
32 positive expectations, rather than presence of negative expectations, accounts for the  
33 relationship between hopelessness, future depression and suicidal behaviour among  
34 adolescents. There are no known studies on the effectiveness of the programme in promoting  
35 mental health outcomes outside the US (Goetske et al., 2014).  
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44 As recommended by Kieling et al. (2011), when designing interventions to prevent child and  
45 adolescent mental health problems in a new setting, the pilot study should collect and utilise  
46 data from both quantitative and qualitative methods to inform any required modifications to the  
47 intervention before wider implementation. Hence, using a one group pre-test post-test pilot  
48 design, it was hypothesised that participation in the programme would result in reduced levels  
49 of hopelessness, anxiety, and increases in reported ER, positive coping strategies and  
50 resilience. The study also aimed to explore participants' experiences of the programme by  
51 incorporating a qualitative focus group evaluation.  
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## ***Method***

### ***Design***

A convergent mixed methodology design was used over two phases. Phase 1 consisted of a pre-post intervention pilot. Phase 2 consisted of focus group interviews conducted with pupils partaking in the pilot programme.

### ***Phase 1 Quantitative Study***

#### ***Sample***

The sample consisted of 88 primary and secondary school students who completed the *Hopeful Minds* programme, four primary school groups ( $n = 63$ ) and three post-primary school groups ( $n = 25$ ) (44 males and 44 females). Both primary and post primary school samples were obtained using opportunity sampling technique from P7 and Year 8/9 children who volunteered and consented (both parent & child) to participate in the *Hopeful Minds* programme.

Primary school participants were 26 females and 37 males between the ages of 8 and 11. Post-primary school participants were 18 females and 7 males between 11 and 13 years. All pupils with full parental consent, who had agreed and signed assent form, and who participated in the programme were eligible for inclusion, as per the agreed ethics protocol, approved by Ulster Research Ethics Committee (UREC). The sample size was lower in the post primary group due to timing issues with securing parent consent.

#### ***Measures***

To secure ethical approval, age appropriate measures of anxiety, emotional regulation, resilience and coping were selected for each age group (8-11 primary schools; and 11-13 post-primary schools). All measures are shown in Table 1.

Table 1 near here

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3 *Primary school measures:*  
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5 The Generalised Anxiety Disorder (GAD) 6-item sub-scale from the 44-item Spence Children's  
6 Anxiety Scale (SCAS; Spence, 1998), is a self-report measure of anxiety developed for  
7 children aged 8–12 years. Participants indicate frequency of occurrence of symptoms such as  
8 “*When I have a problem, my heart beats very fast*”, on a four-point Likert scale from Never to  
9 Always. Higher scores reflect higher levels of symptomatology. Previous studies demonstrate  
10 high internal consistency, high concurrent validity with other measures of child and adolescent  
11 anxiety, and adequate test–retest reliability (Méndez et al., 2014). Internal consistency of the  
12 sub-scales has been found to be acceptable (Spence, et al., 2002).  
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21 The How I Feel Scale (Walden, Harris, & Carton, 2003) is designed for children between 8  
22 and 12 years of age and measures emotional arousal and regulation using three sub-scales -  
23 positive emotion (8 items), negative emotion (12 items) and emotion control (10 items). Items  
24 concern the frequency, intensity and control of positive and negative emotions. Participants  
25 rate on a five-point Likert scale the extent to which statements describe their emotional  
26 experience over the previous three months. The Control Scale measures control over the  
27 same set of positive and negative emotions. Walden et al. (2003) found that the HIF has  
28 demonstrated reliability, stability, and validity and is particularly helpful in understanding the  
29 interplay between arousal and control in emotional development. Children who have excesses  
30 in emotion arousal may find it difficult to develop strategies to control it. This may contribute  
31 to the development of psychopathology and dysfunction. Lower scores on the emotion control  
32 scale indicate less arousal indicating better control and regulation. Ciucci et al. (2016)  
33 supported the reliability and validity of the scale and found good internal constancy of the sub-  
34 scales (Table 1).  
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47 *Post-Primary measures:*  
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49 The GAD-7 (Spritzer et al., 2006) measures anxiety levels over the previous two weeks. Items  
50 such as “*how often, over the past two weeks, have you felt nervous, anxious or on edge?*”  
51 range from 0 (not at all) to 3 (nearly every day). Item scores are summated and range from 0  
52 to 21. Scores in the range of 5-9, 10-14, and 15-21 represent mild, moderate, and severe  
53 anxiety symptoms respectively (Spritzer et al., 2006). Studies indicate excellent internal  
54 reliability (Daig et al., 2009).  
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3 The Difficulties in Emotional Regulation Scale-Short Form (Kaufman, Xia, Fosco, Yaptangco,  
4 Skidmore, & Crowell; 2015), developed from the original 36-item scale (DERS; Gratz &  
5 Roemer, 2004), assesses deficits in ER. Items such as, "*I pay attention to how I feel*" with  
6 items rated on a five-point Likert scale (1= almost never to 5 = almost always). Items scores  
7 are summated to provide an overall score and six sub-scale scores: non-acceptance (? Items);  
8 difficulties with goal directed behaviour (? items); impulse control (?); lack of emotional  
9 awareness(?); clarity and limited access to ER strategies(?). DERS-SF has been shown to  
10 have excellent psychometric properties within an adolescent sample. Cronbach's alpha values  
11 for both the DERS-SF total scale and sub-scales exceed .70, ranging from .78 to .91. Kaufman  
12 et al. (2015) indicated correlations between the DERS and DERS-SF ranged from .90 to .97  
13 and indicated that the DERS and the DERS-SF shared 81–94% of their variance.  
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17 The Measure of Adolescent Coping Strategies (Sveinbjornsdottir & Thorsteinsson, 2012)  
18 measures coping strategies using 34 items. Participants think of a stressful situation from the  
19 recent past and answer questions relating to how often they used different methods of coping.  
20 Participants circled numbers in response to statements like "I tried to be or stay happy" and "I  
21 tried to harm myself", rated on a four-point Likert scale ranging from 0 "I did not use" to 3 "I  
22 used almost all the time. The scale measures 3 'adaptive' (self-care-7 items, distraction-8  
23 items & seeking social support-7 items) and 2 "maladaptive" (rumination-6 items & acting out-6  
24 items) strategies. Higher total scores indicate greater use. Good internal consistency for each  
25 of the sub-scales is reported, ranging from .70 - .81 (Sveinbjornsdottir & Thorsteinsson, 2014).  
26 One study reported Cronbach's Alpha was satisfactory for distraction (.67), seeking social  
27 support (.75), and self-care (.69). Internal consistency was low for rumination (.55) and acting  
28 out (.62) though, which may reduce confidence in results related to rumination and acting out  
29 (Thorsteinsson, Sveinbjornsdottir, Dintsi, & Rooke, 2013).  
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33 The Adolescent Resilient Questionnaire (Gartland, Bond, Olsson, Buzwell & Sawyer, 2011)  
34 measures individual and environmental factors relating to resilience. Items such as "*I take it*  
35 *easy on myself when I am not feeling well*", are rated on the extent to which they are true on  
36 a five-point scale from 'almost never' to 'almost always'. Items are grouped into five resilience  
37 domains: 1) self (40 items); 2) family (11 items); 3) friends (15 items); 4) school (16 items);  
38 and 5) community (6 items). Minimum and maximum scores range between 1 and 5. The  
39 original version (Gartland et al., 2011) and the Spanish/Catalan version (Guilera, Pereda,  
40 Paños, & Abad, 2015) have both shown adequate psychometric properties. Cronbach's  
41 alphas in this study were .61 for self, .87 for family, .73 for peers, .77 for school, and .84 for  
42 community.  
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### *The Intervention*

Hopeful Minds is a universal-based preventative mental health programme designed for children and adolescents ([www.hopefulminds.org](http://www.hopefulminds.org)). The programme at the time of the pilot contained ten core lessons based on the theoretical foundations of hope theory (Snyder, 2000). The programme is divided into two curricula; 'fall' and 'spring' and focuses on teaching children social and emotional learning tools to develop and maintain 'hope'. The winter (or fall) curriculum focuses on developing understanding of the meaning of hope, and why it is important for the individual. It teaches children how to develop a 'hopeful mind'. An array of evidence-based tools are used including cognitive behavioural techniques, meditation, visualisation and journaling, to achieve these outcomes. In the spring curriculum, focus is on hopeful goals and pathways (based on Snyder's hope theory; 1994, 2000), overcoming challenges in the path to reaching goals, and giving hope.

### *Procedure*

Ethical approval was given by the Ulster Research Ethics Committee (UREC). All participants, their parents/guardians and the relevant school principals were given an information pack containing an information sheet, frequently asked question sheet and consent form. Each school principal, and parents/guardians and child were asked to read, sign and return to the school. The study adopted an 'opt in' approach whereby parental consent was necessary for the child to participate. Those who provided written consent were brought into a separate classroom during a pre-arranged time slot. Participants were given details of the study using a standardised script, with additional verbal and written instructions on how to complete the questionnaires. Questionnaires were distributed before the programme commenced (time 1) and within one week of completion (time 2). Researchers, class teachers and programme facilitators were on site to provide additional support for participants. On completing the questionnaires, each participant was given a debriefing sheet containing the principal investigators contact information, local counselling services (inside and outside the school) should they or their parents wish to discuss anything, seek advice or learn more about the study or its findings.



### *Phase 2 Qualitative Study: focus group interviews*

Horner (2000) found children between 11 and 14 years old tend to be more hesitant when talking to adult strangers and suggests this age group are more relaxed and willing to share perceptions when discussions are with a group of peers. This reason contributed to the decision of using focus groups for the qualitative analysis.

### *Sample*

Three focus groups were conducted from two post-primary school groups who had completed the programme, limiting bias that might be seen in a single group or site and allow examination of themes across groups (Castel et al., 2008). Two of the groups were from two classes in an all-female school (School 1 A, School 1 B) with the third group from a mixed-gender school (School 2 C). Inclusion criteria were based on completion of the programme and written parental consent. Interviews were conducted within a two-week period post-programme in the participants' own school during allocated times. Table 2 outlines focus groups sample characteristics. Thirty-nine students took part in focus groups (females = 32; males = 7; age ranged from 11-13 years).

Table 2 near here

### *Data Collection*

Face-to-face, semi-structured focus group interviews were conducted and video-recorded. The interview schedule was designed to facilitate exploration using questions such as: "*What did you think of the Hopeful Minds programme?*". Follow-up and probing questions were used to encourage discussion, exploring concepts that emerged during interviews. Interviewers aimed to adhere to a naturalistic method, creating a relaxed and comfortable environment for a conversation to take place. Interviews were conducted by a moderator team comprising of two researchers to improve outcomes and the validity of findings (Krueger, 1994). The moderator led the interview process, an assistant moderator video-recorded the session and contributed to verifying, analysing and interpreting the data (Krueger & Casey, 2000).

### *Data Analysis Procedure*

On completion of the focus group, data was transcribed verbatim and analysed by the author and a second researcher. The transcribed data was read several times, and videos were re-

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3 watched to ensure accuracy of the transcription. Transcripts were thematically analysed by  
4 the two researchers (the author and a second researcher) following the guidelines of Braun  
5 and Clarke (2006). Researchers became familiar with data, then generated initial codes,  
6 identified and reviewed themes, then defined and named them. A broad and descriptive coding  
7 framework for generation of initial codes was used. Coding was conducted on a semantic  
8 (explicit) and a latent level (from underlying ideas or references to semantic content). It began  
9 immediately after the first transcription was complete. To establish validity and reliability both  
10 researchers analysed all transcripts separately, generating initial codes and themes, before  
11 reviewing the transcripts together and redefining themes.

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14 A Thematic Network Analysis (Attride-Stirling, 2001) was used to organise the themes on three  
15 levels: (i) Basic Themes, or the lowest-order themes in the text; (ii) Organising Themes, which  
16 groups the basic themes together in clusters; and (iii) Global Themes, which are the super-  
17 ordinate themes encapsulating the principal metaphors in the whole data set. This tool created  
18 web-like network structure of themes (see figure 1). Tables of each 'organising theme' with  
19 brief data extracts were then created. The analysis was written up in a narrative account.  
20 Themes not relevant to the aims of this evaluation were discarded. Through the collection of  
21 qualitative focus group data and quantitative data, the researcher hoped to identify patterns of  
22 convergence to develop and corroborate an overall interpretation. This triangulation ensures  
23 comprehensiveness and encourages reflexive analysis of the data (Mays & Pope, 2000).

## 34 35 36 **Results**

### 37 38 *Phase 1 Quantitative Study*

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40 This section outlines comparisons between primary and post-primary school pre- and post-  
41 programme outcome measures. Statistical analyses were conducted using SPSS-23. The  
42 distribution of variables was examined, data was found to be approximately normally  
43 distributed with no significant outliers, and so no transformations were made to any of the  
44 scale variables for the prior to the substantive statistical analyses.

### 45 46 47 *Primary school findings*

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49 Paired-samples *t*-tests were conducted on time 1 (pre- programme) and time 2 (post-  
50 programme) scores to evaluate the average change in participant scores on anxiety, emotional  
51 arousal and regulation scores. Results are summarised in table 3.

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8 There was a statistically significant decrease in anxiety scores from time 1 ( $M = 8.20$ ,  $SD =$   
9  $5.16$ ) to time 2 ( $M = 6.28$ ,  $SD = 3.02$ ),  $t(45) = 3.30$ ,  $p < 0.01$  (two-tailed), mean decrease was  
10 1.91 with a 95% confidence interval ranging from .74 to 3.08,  $r = .35$ . Cohens' D indicates a  
11 medium effect size (Cohen, 1988, pp.284-7). Lower scores indicate lower GAD  
12 symptomatology following completion.  
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16 Emotional arousal and regulation was measured through the sub scales, Negative Emotion,  
17 Positive Emotion and Emotional Control. A significant decrease was noted in Negative  
18 Emotions from time 1 ( $M = 29.00$ ,  $SD = 8.33$ ) to time 2 ( $M = 26.37$ ,  $SD = 7.94$ ),  $t(48) = 2.19$ ,  
19  $p = 0.03$  (two-tailed) and in Emotional Control ( $M = 31.65$ ,  $SD = 7.75$ ) to time 2 ( $M = 28.56$ ,  
20  $SD = 7.28$ ),  $t(47) = 3.07$ ,  $p = 0.004$  (two-tailed). There were no changes in levels of Positive  
21 Emotion from time 1 ( $M = 31.04$ ,  $SD = 5.88$ ) to time 2 ( $M = 29.03$ ,  $SD = 6.55$ ),  $t(47) = 1.39$ ,  $p$   
22  $= 0.17$  (two-tailed). Children who participated reported reductions in negative emotions, with  
23 simultaneous reductions in emotional arousal (emotional control), indicating improved  
24 emotional regulation skills, and demonstrated stable positive emotions throughout. The mean  
25 decrease in Negative Emotion and Emotional Control scores were 2.63, 3.08 respectively with  
26 a 95% confidence interval ranging from .22 to 5.05 (negative emotions), 1.06 to 5.10  
27 (emotional arousal & control). Cohen's D indicates a medium effect size for Emotional Control,  
28 and small to medium effect size for changes in Negative Emotions.  
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### 39 *Post Primary school findings*

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41 Paired-samples  $t$ -tests were also conducted on time 1 (pre- programme) and time 2 (post-  
42 programme) scores to evaluate the impact on participant's scores for measures outlined in  
43 Table 2 (anxiety, ER, coping and resilience) and results are summarised in See Table 4.  
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48 There were no changes were observed in anxiety scores between time 1 ( $M = 5.25$ ,  $SD =$   
49  $6.27$ ) to time 2 ( $M = 6.60$ ,  $SD = 6.29$ ),  $t(19) = -1.23$ ,  $p = .232$  (two-tailed).  
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52 For ER scores, an increase was found between time 1 ( $M = 44.85$ ,  $SD = 20.74$ ) and time 2 ( $M$   
53  $= 46.92$ ,  $SD = 16.38$ ),  $t(13) = -.48$ ,  $p = 0.642$  (two-tailed). Higher scores indicate greater ER  
54 although the increase did not reach statistical significance. The mean increase in ER scores  
55 was 2.08 with a 95% confidence interval ranging from 11.61 to 7.45,  $r = .62$ . Cohen's D  
56 indicates a small effect size.  
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3 There were statistically significant increases recorded in the coping scale scores from time 1  
4 ( $M = 50.67$ ,  $SD = 7.50$ ) to time 2 ( $M = 57.00$ ,  $SD = 7.62$ ),  $t(6) = 2.96$ ,  $p < 0.05$  (two-tailed),  
5 and the emotional resilience scores between time 1 ( $M = 129.24$ ,  $SD = 22.26$ ) to time 2 ( $M =$   
6  $138.38$ ,  $SD = 20.06$ ),  $t(20) = -2.06$ ,  $p = 0.05$  (two-tailed). Both findings support the hypotheses  
7 that post-primary participants' coping, and resilience scores would increase. The mean  
8 increase in coping scores was 6.33 with a 95% confidence interval ranging from 11.83 to .83,  
9  $r = .76$ . Cohen's D indicates a very large effect size. The mean increase in resilience scores  
10 was 20.38 with a 95% confidence interval ranging from 18.42, .13,  $r = .74$ . Cohen's D indicates  
11 a medium effect size.  
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18 Examining the sub-scales of the MAC coping scale shows that self-care increased significantly  
19 between time 1 ( $M = 12.11$ ,  $SD = 3.62$ ) to time 2 ( $M = 13.56$ ,  $SD = 3.78$ ),  $t(8) = 2.49$ ,  $p = 0.038$   
20 (two-tailed), suggesting post primary pupils independently engaged in attending to their own  
21 self-care needs by the end of the programme. The remaining sub-scales noted some changes  
22 (rumination, seeking social support, acting out and stoicism). However, these did not reach  
23 significance ( $p > .05$ ).  
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29 On closer analyses of post-primary resilience sub-scales (ARQ-R), findings show significant  
30 positive improvements in three sub-scales relating to resilience. These are confidence (in self  
31 and future), time 1 ( $M = 26.22$ ,  $SD = 6.33$ ) time 2 ( $M = 30.52$ ,  $SD = 6.39$ ),  $t(22) = -2.97$ ,  $p =$   
32  $0.007$  (two-tailed), emotional insight, time 1 ( $M = 26.37$ ,  $SD = 5.68$ ) time 2 ( $M = 30.79$ ,  $SD =$   
33  $5.11$ ),  $t(18) = -3.00$ ,  $p = 0.008$  (two-tailed), and negative cognitions which improved from time  
34 1 ( $M = 28.65$ ,  $SD = 6.67$ ) to time 2 ( $M = 23.78$ ,  $SD = 5.22$ ),  $t(22) = -5.77$ ,  $p < 0.001$  (two-tailed).  
35 Post-primary school pupils reported experiencing higher levels of confidence in themselves  
36 and their future, greater emotional insight and less negative thoughts. No significant changes  
37 were reported in the remaining resilience sub-scales (family, friends, school connectedness,  
38 social environment in school, or neighbourhood/ community connectedness,  $p > 0.05$ ).  
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### 49 *Phase 2 Qualitative Study*

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51 Participants' experiences of the programme were organised into themes based on the  
52 Thematic Network Analysis model (Attride-Stirling, 2001). The global theme 'Learning Hope'  
53 was established; from that 4 organising themes were identified: what hope means, skills  
54 gained, sharing hope, and future recommendations. Each theme had a range of clustered  
55 lowest-order basic themes (See figure 1).  
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## 15 **Discussion**

### 16 *Phase 1 Quantitative Study*

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18 This preliminary pilot has shown some evidence of effective change, when comparing  
19 children's' responses to a range of measures before and after the delivery of *Hopeful Minds*  
20 (10 weekly lessons). The findings are mixed for primary and post primary participants.  
21 Potential reasons are documented in the limitations section.  
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25 Primary school sample findings indicated statistically significant positive changes in anxiety  
26 and emotional arousal scores. The large effect sizes reported in the primary school samples  
27 are like that found by similarly higher-powered studies such as a meta-analysis conducted by  
28 Neil and Christensen (2009) which reported that most universal-school based mental health  
29 prevention programmes are effective in reducing symptoms of anxiety in young people. A  
30 further explanation for this may be related to the teaching of hope as Michael (2000), found  
31 high-hope individuals are less susceptible to anxiety provoking behaviours such as negative  
32 rumination and self-doubt.  
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38 Supporting this reduction may be the significant positive changes observed in negative  
39 emotions and emotional arousal of the pupils. These may have contributed to the positive  
40 reduction in anxiety in the 8-11 years old group. Literature supports that high emotional arousal  
41 is associated with anxiety (Bilek, 2015). Findings are comparable to those by Gilman et al.  
42 (2006), who suggest individuals with higher levels of hope experience lower emotional  
43 distress.  
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51 For the post primary group, whilst there were no changes reported in the levels of anxiety, the  
52 programme was able to show that overall levels of coping and resilience improved significantly  
53 despite the smaller sample size. This is consistent with previous findings that suggest those  
54 with higher hope adopt a greater use of positive coping strategies (Snyder, 2000). Whilst  
55 overall resilience had improved significantly, it was raised confidence in the pupils' themselves  
56 and their future, greater emotional insight and less negative thoughts on completion of the  
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3 programme which contributed to this raised resilience. This is reassuring considering  
4 Horowitzs' et al. (2017) emphasis on how lack of positive expectations contributes to  
5 hopelessness and suicidal behaviour. Raising confidence is a very encouraging indicator of  
6 being able to increase positive expectations. No changes were noted for rumination or acting  
7 out, however, Thorsteinsson, et al. (2013) reported that the internal consistency for these  
8 subscales were poor to start with. Hence future studies may wish to adapt the programme to  
9 include additional lessons on rumination, and the measurement of it, as rumination is a strong  
10 precursor to depression and suicidal ideation (Miranda et al., 2013).  
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19 Work is needed to develop external resilience within the child's school, family and friends, and  
20 a general sense of hope within their own social environment. The programme is delivered to  
21 the pupils directly in one class, not to every class in each school, and not with every teacher  
22 in the school. Parents, community groups and the general social school environment need to  
23 also be introduced to the concept of developing hopeful conceptualisations and skills. *Hopeful*  
24 *Minds* may need to become a whole school, systemically embedded programme, as evidence  
25 suggests that for school based mental health promotion programmes to have the greatest  
26 impact, the whole school approach is necessary, thereby creating a culture of coping (Weisz,  
27 Sandler, Durlak & Anton 2005). Stigma can also be reduced, where pupils together build skills  
28 that increase mental wellbeing, decrease susceptibility to anxiety, depression, and suicide  
29 (Protecting Life in Schools, 2016).  
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### 39 *Phase 2 Qualitative Study*

#### 40 *Gaining Hope*

41 This theme explores the participants' understanding of hope, and their development of hope-  
42 based qualities on completion (see table 5). Hope was difficult to define with one interviewee  
43 (A2) describing hope as "...believing in yourself mostly and believing in others and say if  
44 someone was sick you would hope they get better". Snyder et al. (2002) defines hope as the  
45 belief that one can find pathways to desired goals and become motivated to use those  
46 pathways. While many respondents struggled with a definition, a plethora of examples were  
47 provided to demonstrate the hope gained by individuals on completion. The sub-themes  
48 explore how participants described their increase in self-efficacy and self-belief, self-  
49 confidence, and learned ability to set goals and engage in positive thinking, all key features of  
50 a hopeful individual (Gilman Dooley, & Florell, 2006).  
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7 Members of each focus group emphasised how the programme taught them to believe in  
8 themselves and to “*never give up*” on their aims and goals regardless of the barriers they may  
9 face. A1 stated that “*You have an aim for yourself, and even if you find it hard you always try*  
10 *to reach your aim*”; such goal-directed thinking is a necessary quality for a hopeful mind  
11 (Snyder, 1994, 2000). Establishing techniques such as goal setting and positive thinking  
12 contributed to an individual’s belief that “*...I could do anything I put my mind too*” (A3). Such  
13 examples of self-efficacy are fundamental in the success of a high hope individual (Davidson  
14 et al., 2012; Snyder 1994, 2000). Similarly, positive thinking was established by one  
15 respondent who stated “*... there is always a way around thing*” (B8); this example of ‘pathway  
16 thinking’, defined by Snyder (2000) as the perceived ability to find routes to goals, is a key  
17 characteristic of a high-hopes individual (Snyder et al., 2002). An improvement in self-  
18 confidence was a gain described across all focus groups. Confidence was established by the  
19 safe environment within the programme where individuals described feeling “not judged” and  
20 felt they could talk openly about their feelings. The “boost in confidence” described by B10 is  
21 supported by research by Snyder (2000) who found that having high-hopes is positively  
22 associated with increased confidence.  
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### 33 *Learning new skills*

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35 This theme explores the development of skills such as communication, positive coping  
36 strategies, resilience and the ability to identify and regulate emotions (see table 6). Members  
37 from each group described how they have developed skills that allow them to manage  
38 stressors such as exams, bullying and relationships.  
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49 Being able to cope with daily life events made some participants feel reduced levels of stress,  
50 such findings are supported by O’Connor and O’Connor (2003), and Machmutow, Perren,  
51 Sticca, and Alsaker (2012). Participants learned about ER through the ‘upstairs and  
52 downstairs brain’ which was a highlight of the programme for many. Throughout, all focus  
53 groups participants described a better ability to overcome stressful situations at home, school  
54 and with friends. Many described being more resilient after completing the programme. One  
55 participant states, “*There are always going to be obstacles in life, but there are always going*  
56 *to be ways to overcome them*” (A2). Being confident in your ability to ‘bounce back’ from  
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3 stressful situations may prevent students from slipping into downwards spirals and reduce  
4 negative mental health outcomes (Furlong, Gilman & Huebner, 2014).  
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7 Several respondents described how they learned to “*understand your feelings*” (C4), and each  
8 group provided examples of techniques used to manage emotions, “*I would count back from*  
9 *10 to 1, but if that didn’t work then I would tell my mummy*” (A6) or “*If I was feeling nervous I*  
10 *would learn to cope with it by breathing in through my nose and taking big deep breaths*” (A4).  
11 Seeking social support and relaxation techniques are adaptive coping strategies  
12 (Sveinbjornsdottir & Thorsteinsson, 2012) and effective ways of regulating emotions (Arch &  
13 Craske, 2006).  
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18 One respondent discussed the negative effects of internalising situations, an example of a  
19 maladaptive ‘emotion-focused’ coping (Lazarus & Folkman, 1984), “*Now I would tell*  
20 *somebody instead of keeping it inside because then it could do damage*” (A3). Whilst research  
21 indicated that emotional stability is low during early adolescent years (Zimmermann & Iwanski,  
22 2014), many participants described learning skills to allow them to control or regulate how they  
23 feel in stressful situations (Folk, Zeman, Poon, & Dallaire, 2014). Such skills predict better  
24 academic outcomes in youth (Folk et al., 2014). Some respondents remarked that they helped  
25 them manage the stress and worry around their examinations, suggesting transferability and  
26 relevance to the skills they have learnt. Such examples of enhanced ability to cope have been  
27 found to reduce feelings of stress and helplessness (O’Connor & O’Connor, 2003), and are  
28 consistent with high-hope individuals (Onwuegbuzie & Snyder, 2000; Snyder, 1999).  
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### 39 *Sharing Hope*

40 This theme reflected on how the adolescents used their new knowledge and understanding to  
41 help and support others, and their recommendations for the future of the programme (see  
42 Table 7). They describe feeling greater confidence utilising the hope and skills they acquired  
43 to not only help themselves, but others.  
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55 One participant described how the planting of the sunflower seeds as “*The circle of hope*”  
56 (C4), was a symbol of hope to be passed on to future groups starting the programme. Others  
57 described how they would encourage other participants to continue using the skills they learnt.  
58 Positive social behaviours exhibited may contribute to ability to regulate positive emotions  
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3 experienced from partaking in the programme (Langton, 1994). Another reoccurring thread  
4 was that participants would use new skills to identify distress in others, encourage them to  
5 seek help, and encourage them use coping skills or techniques such as positive thinking.  
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8 When asked what age they believe *Hopeful Minds* was most suited, some suggested it would  
9 suit a post-primary population, as it helps with examination stress, and “*If you were younger*  
10 *you might not know what they are talking about*” (B13). However, an overwhelming majority  
11 of all focus groups suggested it would be beneficial from a younger age. Explanations why  
12 offer an insight into difficulties adolescents face. Some said the programme would prepare  
13 children for post-primary school, with one participant describing this change as “*scary*” (B8),  
14 another suggests it will boost confidence as they transition into their “*world*” (B2).  
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### 23 Limitations, Strengths and Recommendations

24 Whilst the study had limited funding to resource a controlled trial and had an inadequately  
25 powered sample size for the post primary group, compared to the primary school group (36%  
26 and 54% respectively), it did have an adequate focus group size (N 39). Reasons suggested  
27 are the parental ‘*opt in*’ consent requirements, and the data collection coincided with the post-  
28 primary student’s exam period. Missing data in participant’s questionnaire responses may also  
29 have had an impact on statistical power. Future research with a larger sample size would allow  
30 firm statistical conclusions. Restricted resources and busy school curriculums meant it was  
31 not feasible to include a whole school approach at this time, rather a whole class approach  
32 was utilised instead. However, the whole school approach has been recommended throughout  
33 the literature, and the findings within this study referring to no changes in school, family, and  
34 community resilience would reflect this need.  
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### 45 **Conclusion**

46 Whilst the present study has limitations in terms of power and the use of non-controlled  
47 methods, it nevertheless provides preliminary evidence of effectiveness for this novel hope-  
48 based intervention. By combining the quantitative and qualitative findings, the study can  
49 prepare for the wider implementation of *Hopeful Minds* and testing using full RCT methods.  
50 Overall findings suggest that this theoretically framed hope-based programme was able to  
51 significantly improve anxiety and emotional regulation levels for primary school pupils and  
52 improve adaptive coping strategies and resilience (specifically self-care, confidence in self and  
53 future, emotional insight and less negative thoughts) in the post primary pupils. Findings from  
54 focus-groups complimented the quantitative findings with key themes reporting gaining a  
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3 hopeful mind, improved self-belief, confidence, emotional awareness and management, and  
4 improved coping skills. Future recommendations would refer to implementing a 'whole school'  
5 approach, as the study also found that resilience levels in family, friends, social and school  
6 environment, neighbourhood and community connectedness requires more attention, and  
7 including additional lessons on dealing with rumination and school stressors. Finally, all the  
8 young focus group participants recommended that this programme be provided to all primary  
9 school children transitioning to post primary school.  
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35 and pupil assent was given for each child participant involved in this study.  
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47

## 48 References

49 Arch, J. J., & Craske, M. G. (2006). Mechanisms of mindfulness: Emotion regulation  
50 following a focused breathing induction. *Behaviour research and therapy*, 44(12), 1849-  
51 1858.  
52  
53

54  
55 Attride-Stirling, J. (2001). Thematic networks: an analytic tool for qualitative research.  
56 *Qualitative research*, 1(3), 385-405.  
57  
58  
59  
60

1  
2  
3 Belfer, M.L. (2008). Child and adolescent mental disorders: the magnitude of the problem  
4 across the globe. *J Child Psychol Psychiatry*, 49 (2008), pp. 226-236  
5  
6

7  
8 Berking, M., & Wupperman, P. (2012). Emotion regulation and mental health: recent  
9 findings, current challenges, and future directions. *Current opinion in psychiatry*, 25(2), 128-  
10 134.  
11

12  
13 Bilek, E. L. (2015). A Multimethod Assessment of Emotion Regulation and Associations with  
14 Anxiety Symptoms in a Clinical Sample of School-Age Youth. ProQuest, 3719932.  
15  
16

17  
18 Brammer, L. M. (1992). Coping with life transitions. *International Journal for the*  
19 *Advancement of Counselling*, 15(4), 239-253.  
20  
21

22  
23 Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research*  
24 *in psychology*, 3(2), 77-101.  
25  
26

27  
28 Brodbeck, J., Goodyer, I. M., Abbott, R. A., Dunn, V. J., St Clair, M. C., Owens, M., Jones, P.  
29 B., & Croudace, T. J. (2014). General distress, hopelessness—suicidal ideation and  
30 worrying in adolescence: Concurrent and predictive validity of a symptom-level bifactor  
31 model for clinical diagnoses. *Journal of affective disorders*, 152, 299-305.  
32  
33

34  
35 Brown, M., Curry, L. A., Hagstrom, H., & Sandstedt, S. (1999). Female teenage athletes,  
36 sport participation, self-esteem, and hope. Association for the Advancement of Applied Sport  
37 Psychology, Banff, Alberta, Canada.  
38  
39

40  
41 Carr, A. (2015). *The handbook of child and adolescent clinical psychology: A contextual*  
42 *approach*. Routledge.  
43  
44

45  
46 Castel, L. D., Williams, K. A., Bosworth, H. B., Eisen, S. V., Hahn, E. A., Irwin, D. E., Kelly,  
47 M. A. R., Morse, J., Stover, A., DeWalt, D. A., & DeVellis, R. F. (2008). Content validity in the  
48 PROMIS social-health domain: a qualitative analysis of focus-group data. *Quality of Life*  
49 *Research*, 17(5), 737.  
50  
51

52  
53 Chang, E. C., & DeSimone, S. L. (2001). The influence of hope on appraisals, coping, and  
54 dysphoria: A test of hope theory. *Journal of Social and Clinical Psychology*, 20(2), 117-129.  
55  
56

57  
58 Children's Society (2008) *The Good Childhood Inquiry: health research evidence*. London:  
59 Children's Society.  
60

1  
2  
3 Ciarrochi, J., Heaven, P. C., & Davies, F. (2007). The impact of hope, self-esteem, and  
4 attributional style on adolescents' school grades and emotional well-being: A longitudinal  
5 study. *Journal of Research in Personality*, 41(6), 1161-1178.  
6  
7

8  
9 Ciucci, E., Baroncelli, A., Grazzani, I., Ornaghi, V., & Caprin, C. (2016). Emotional Arousal  
10 and Regulation: Further Evidence of the Validity of the "How I Feel" Questionnaire for Use  
11 With School-Age Children. *Journal of School Health*, 86(3), 195-203.  
12  
13

14  
15 Cohen, J. (1988). The effect size index: d. *Statistical power analysis for the behavioral*  
16 *sciences*, 2, 284-288.  
17

18  
19 Collins, S., Woolfson, L. M., & Durkin, K. (2014). Effects on coping skills and anxiety of a  
20 universal school-based mental health intervention delivered in Scottish primary schools.  
21 *School Psychology International*, 35(1), 85-100.  
22  
23

24  
25 Connolly, P., Miller, S., Mooney, J., Sloan, S., & Hanratty, J. (2016). Universal School-Based  
26 Programmes for Improving Social and Emotional Outcomes in Children Aged 3-11 years: A  
27 Systematic Review and Meta-Analysis. Campbell Collaboration.  
28  
29

30  
31 Daig, I., Herschbach, P., Lehmann, A., Knoll, N., & Decker, O. (2009). Gender and age  
32 differences in domain-specific life satisfaction and the impact of depressive and anxiety  
33 symptoms: a general population survey from Germany. *Quality of Life Research*, 18(6), 669-  
34 678.  
35  
36

37  
38 Davidson, O. B., Feldman, D. B., & Margalit, M. (2012). A focused intervention for 1st-year  
39 college students: Promoting hope, sense of coherence, and self-efficacy. *The Journal of*  
40 *psychology*, 146(3), 333-352.  
41  
42

43  
44 Department of Health, Social Services and Public Safety (Northern Ireland) (2006). Protect  
45 life. Northern Ireland suicide prevention strategy. Belfast, Northern Ireland.  
46  
47

48  
49 Department of Health, Social Services and Public Safety (Northern Ireland) (2015).  
50 Delivering Excellence, Achieving Recovery, A professional framework for the mental health  
51 nursing profession in Northern Ireland. Belfast, UK; DHSSP (NI).  
52  
53

54  
55 Department of Health, Social Services and Public Safety (Northern Ireland) (2016). Protect  
56 life 2. Northern Ireland suicide prevention strategy. Belfast, Northern Ireland.  
57  
58  
59  
60

1  
2  
3 Department of Health, Social Services and Public Safety (Northern Ireland) (2016).  
4 Protecting life in schools. Helping protect against suicide by supporting pupils' emotional  
5 health and wellbeing. Belfast, Northern Ireland.  
6  
7

8  
9 Durlak, J. A., Weissberg, R. P., Dymnicki, A. B., Taylor, R. D., & Schellinger, K. B. (2011).  
10 The impact of enhancing students' social and emotional learning: A meta-analysis of  
11 school-based universal interventions. *Child development*, 82(1), 405-432.  
12  
13

14  
15 Erskine, H. E., Baxter, A. J., Patton, G., Moffitt, T. E., Patel, V., Whiteford, H. A., & Scott, J.  
16 G. (2017). The global coverage of prevalence data for mental disorders in children and  
17 adolescents. *Epidemiology and psychiatric sciences*, 26(4), 395-402.  
18  
19

20  
21 Erskine, H. E., Moffitt, T. E., Copeland, W. E., Costello, E. J., Ferrari, A. J., Patton, G., ... &  
22 Scott, J. G. (2015). A heavy burden on young minds: the global burden of mental and  
23 substance use disorders in children and youth. *Psychological medicine*, 45(7), 1551-1563.  
24

25 Fazel, M., Patel, V., Thomas, S., & Tol, W. (2014). School mental health interventions in low-  
26 income and middle-income countries. *The Lancet Psychiatry*, 1, 388-398.  
27  
28

29  
30 Feldman, D. B., & Kubota, M. (2015). Hope, self-efficacy, optimism, and academic  
31 achievement: Distinguishing constructs and levels of specificity in predicting college grade-  
32 point average. *Learning and Individual Differences*, 37, 210-216.  
33  
34

35  
36 Folk, J. B., Zeman, J. L., Poon, J. A., & Dallaire, D. H. (2014). A longitudinal examination of  
37 emotion regulation: Pathways to anxiety and depressive symptoms in urban minority youth.  
38 *Child and Adolescent Mental Health*, 19(4), 243-250.  
39  
40

41  
42 Folkman, S. (2010). Stress, coping, and hope. *Psycho-Oncology*, 19(9), 901-908.  
43  
44

45  
46 Frydenberg, E. (2008). *Adolescent coping: Advances in theory, research and practice*.  
47 Routledge.  
48  
49

50  
51 Furlong, M. J., Gilman, R., & Huebner, E. S. (2014). *Handbook of positive psychology in  
52 schools 2nd edition*. Routledge.  
53  
54

55  
56 Gartland, D., Bond, L., Olsson, C. A., Buzwell, S., & Sawyer, S. M. (2011). Development of a  
57 multi-dimensional measure of resilience in adolescents: the Adolescent Resilience  
58 Questionnaire. *BMC medical research methodology*, 11(1), 134.  
59  
60

1  
2  
3 Gillham, J. E., Reivich, K. J., Jaycox, L. H., & Seligman, M. E. (1995). Prevention of  
4 depressive symptoms in schoolchildren: Two-year follow-up. *Psychological science*, 6(6),  
5 343-351.  
6  
7

8  
9 Gilman, R., Dooley, J., & Florell, D. (2006). Relative levels of hope and their relationship with  
10 academic and psychological indicators among adolescents. *Journal of Social and Clinical*  
11 *Psychology*, 25(2), 166-178.  
12  
13

14  
15 Goetzke, K., Tate. P., Patel., H., & Lewis., K. (2014). Schools for hope: implementation with  
16 late elementary students at the fifth-grade level international foundation for research and  
17 education on depression. [www.schoolsforhope.org](http://www.schoolsforhope.org).  
18  
19

20  
21 Gratz, K. L., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and  
22 dysregulation: Development, factor structure, and initial validation of the difficulties in  
23 emotion regulation scale. *Journal of psychopathology and behavioral assessment*, 26(1), 41-  
24 54.  
25  
26

27  
28 Greenberg, M. T., Weissberg, R. P., O'brien, M. U., Zins, J. E., Fredericks, L., Resnik, H., &  
29 Elias, M. J. (2003). Enhancing school-based prevention and youth development through  
30 coordinated social, emotional, and academic learning. *American psychologist*, 58(6-7), 466.  
31  
32

33  
34 Guilera, G., Pereda, N., Paños, A., & Abad, J. (2015). Assessing resilience in adolescence:  
35 The Spanish adaptation of the Adolescent Resilience Questionnaire. *Health and quality of*  
36 *life outcomes*, 13(1), 100.  
37  
38

39  
40 Horner, S. D. (2000). Using focus group methods with middle school children. *Research in*  
41 *Nursing & Health*, 23(6), 510-517.  
42  
43

44  
45 Horwitz, A. G., Hill, R. M., & King, C. A. (2011). Specific coping behaviors in relation to  
46 adolescent depression and suicidal ideation. *Journal of adolescence*, 34(5), 1077-1085.  
47  
48

49  
50 Horwitz, A. G., Berona, J., Czyz, E. K., Yeguez, C. E. and King, C. A. (2017), Positive and  
51 Negative Expectations of Hopelessness as Longitudinal Predictors of Depression, Suicidal  
52 Ideation, and Suicidal Behavior in High-Risk Adolescents. *Suicide Life Threat Behav*, 47:  
53 168–176. doi:10.1111/sltb.12273  
54  
55

56  
57 Kaufman, E. A., Xia, M., Fosco, G., Yaptangco, M., Skidmore, C. R., & Crowell, S. E. (2016).  
58 The Difficulties in Emotion Regulation Scale Short Form (DERS-SF): validation and  
59 replication in adolescent and adult samples. *Journal of Psychopathology and Behavioral*  
60 *Assessment*, 38(3), 443-455.

1  
2  
3  
4  
5 Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. (2005). Lifetime  
6 Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity  
7 Survey Replication. *Archives of General Psychiatry*, 62 (6) pp. 593-602.  
8 doi:10.1001/archpsyc.62.6.593.  
9

10  
11  
12 Kieling, C., Baker-Henningham, H., Belfer, M., Conti, G., Ertem,I., Omigbodun, Rohde, L.A.,  
13 Srinath, S., Ulkuer, N., Rahman, A. (2011). Child and adolescent mental health worldwide:  
14 evidence for action. *The Lancet*, Volume 378, Issue 9801,Pages 1515-1525, ISSN 0140-  
15 6736, [https://doi.org/10.1016/S0140-6736\(11\)60827-1](https://doi.org/10.1016/S0140-6736(11)60827-1).  
16

17  
18  
19 Klausner, E. J., Snyder, C. R., & Cheavens, J. (2002). A hope-based group treatment for  
20 depressed older adult outpatients. In *Physical illness and depression in older adults (pp.*  
21 *295-310)*. Springer US.  
22

23  
24  
25 Krueger, R. (1994). *Focus groups: a practical guide for applied research* 2nd Ed. Sage.  
26 Thousand Oaks CA.  
27

28  
29  
30 Krueger, R. A., & Casey, M. A. (2000). *A practical guide for applied research. A practical*  
31 *guide for applied research*.  
32

33  
34  
35 Kwon, P. (2000). Hope and dysphoria: The moderating role of defence mechanisms. *Journal*  
36 *of personality*, 68(2), 199-223.  
37

38  
39  
40 Lazarus, R. S., & Folkman, S. (1984). Coping and adaptation. *The handbook of behavioral*  
41 *medicine*, 282-325.  
42

43  
44  
45 Lerner, R. M., & Steinberg, L. (Eds.). (2009). *Handbook of adolescent psychology, volume 1:*  
46 *Individual bases of adolescent development (Vol. 1)*. John Wiley & Sons.  
47

48  
49  
50 Lopez, S. J., Rose, S., Robinson, C., Marques, S. C., & Pais-Ribeiro, J. O. S. E. (2009).  
51 Measuring and promoting hope in school children. *Handbook of positive psychology in the*  
52 *schools*, 37-51.  
53

54  
55  
56 Machmutow, K., Perren, S., Sticca, F., & Alsaker, F. D. (2012). Peer victimisation and  
57 depressive symptoms: can specific coping strategies buffer the negative impact of  
58 cybervictimisation?. *Emotional and Behavioural Difficulties*, 17(3-4), 403-420.  
59  
60

1  
2  
3 Marques, S. C., Pais-Ribeiro, J. L., & Lopez, S. J. (2011). The role of positive psychology  
4 constructs in predicting mental health and academic achievement in children and  
5 adolescents: A two-year longitudinal study. *Journal of Happiness Studies*, 12(6), 1049-1062.  
6  
7

8  
9 Mays, N., & Pope, C. (2000). Qualitative research in health care: Assessing quality in  
10 qualitative research. *BMJ: British Medical Journal*, 320(7226), 50.  
11

12 Méndez, X., Espada, J. P., Orgilés, M., Llavona, L. M., & García-Fernández, J. M. (2014).  
13 Children's separation anxiety scale (CSAS): psychometric properties. *PloS one*, 9(7),  
14 e103212.  
15

16  
17  
18 Merkaš, M., & Brajša-Žganec, A. (2011). Children with different levels of hope: Are there  
19 differences in their self-esteem, life satisfaction, social support, and family cohesion? *Child*  
20 *Indicators Research*, 4(3), 499-514.  
21

22  
23  
24 Michael, S. T. (2000). Hope conquers fear: Overcoming anxiety and panic attacks. In C. R.  
25 Snyder (Ed.), *Handbook of hope: Theory, measures, and applications* (pp. 355–378). San  
26 Diego, CA: Academic.  
27

28  
29  
30 Miranda, R., Tsypes, A., Gallagher, M. et al. (2013). Rumination and Hopelessness as  
31 Mediators of the Relation Between Perceived Emotion Dysregulation and Suicidal Ideation  
32 *Cogn Ther Res* (2013) 37: 786. <https://doi.org/10.1007/s10608-013-9524-5>  
33

34  
35  
36 Neil, A. L., & Christensen, H. (2009). Efficacy and effectiveness of school-based prevention  
37 and early intervention programs for anxiety. *Clinical psychology review*, 29(3), 208-215.  
38

39  
40 O'Connor, R., & O'Connor, D. B. (2003). Predicting hopelessness and psychological  
41 distress: The role of perfectionism and coping. *Journal of counseling psychology*, 50(3), 362-  
42 372.  
43

44  
45  
46 Onwuegbuzie, A. J. (1998). Role of hope in predicting anxiety about statistics. *Psychological*  
47 *Reports*, 82, 1315–1320.  
48

49  
50  
51 Onwuegbuzie, A. J., & Snyder, C. R. (2000). Relations between hope and graduate  
52 students' coping strategies for studying and examination-taking. *Psychological Reports*,  
53 86(3), 803-806.  
54

55  
56  
57 Pluess, M., Boniwell, I., Hefferon, K., & Tunariu, A. (2017). Preliminary evaluation of a  
58 school-based resilience-promoting intervention in a high-risk population: Application of an  
59 exploratory two-cohort treatment/control design. *PloS one*, 12(5), e0177191.  
60



1  
2  
3  
4  
5 Richards, M. H., Crowe, P. A., Larson, R., & Swarr, A. (1998). Developmental patterns and  
6 gender differences in the experience of peer companionship during adolescence. *Child*  
7 *development*, 69(1), 154-163.  
8  
9

10  
11 Shorey, H. S., Little, T. D., Snyder, C. R., Kluck, B., & Robitschek, C. (2007). Hope and  
12 personal growth initiative: A comparison of positive, future-oriented constructs. *Personality*  
13 *and Individual Differences*, 43(7), 1917-1926.  
14  
15

16  
17 Snyder, C. R. (1994). *The psychology of hope: You can get there from here*. Simon and  
18 Schuster.  
19

20  
21 Snyder, C. R. (1999). Hope, goal-blocking thoughts, and test-related anxieties.  
22 *Psychological reports*, 84(1), 206-208.  
23  
24

25  
26 Snyder, C. R. (Ed.). (2000). *Handbook of hope: Theory, measures, and applications*.  
27 Academic press.  
28  
29

30  
31 Snyder, C. R., Hoza, B., Pelham, W. E., Rapoff, M., Ware, L., Danovsky, M., Highberger, L.,  
32 Ribinstein, H., & Stahl, K. J. (1997). The development and validation of the Children's Hope  
33 Scale. *Journal of pediatric psychology*, 22(3), 399-421.  
34  
35

36  
37 Snyder, C. R., LaPointe, A. B., Jeffrey Crowson, J., & Early, S. (1998). Preferences of high-  
38 and low-hope people for self-referential input. *Cognition & Emotion*, 12(6), 807-823.  
39  
40

41  
42 Snyder, C. R., Rand, K. L., & Sigmon, D. R. (2002). Hope theory. *Handbook of positive*  
43 *psychology*, 257-276.  
44  
45

46  
47 Spence, S. H. (1998). A measure of anxiety symptoms among children. *Behaviour research*  
48 *and therapy*, 36(5), 545-566.  
49  
50

51  
52 Spence, S. H., Barrett, P. M., & Turner, C. M. (2003). Psychometric properties of the Spence  
53 *Children's Anxiety Scale* with young adolescents. *Journal of anxiety disorders*, 17(6), 605-  
54 625.  
55  
56

57  
58 Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing  
59 generalized anxiety disorder: the GAD-7. *Archives of internal medicine*, 166(10), 1092-1097.  
60

1  
2  
3 Stice, E., Shaw, H., Bohon, C., Marti, C. N., & Rohde, P. (2009). A meta-analytic review of  
4 depression prevention programs for children and adolescents: factors that predict magnitude  
5 of intervention effects. *Journal of consulting and clinical psychology*, 77(3), 486.  
6  
7

8  
9 Sveinbjornsdottir, S., & Thorsteinsson, E. B. (2012). A psychometrically derived theory on  
10 adolescent coping: Development of the Measure of Adolescent Coping Strategies (MACS).  
11 Manuscript submitted for publication.  
12  
13

14  
15 Sveinbjornsdottir, S., & Thorsteinsson, E. B. (2014). Psychometric properties of the measure  
16 of adolescent coping strategies (MACS). *Psychology*, 5(02), 142.  
17  
18

19  
20 Taylor, R. D., Oberle, E., Durlak, J. A., & Weissberg, R. P. (2017). Promoting Positive Youth  
21 Development Through School-Based Social and Emotional Learning Interventions: A  
22 Meta-Analysis of Follow-Up Effects. *Child Development*, 88(4), 1156-1171.  
23  
24

25  
26 Thomassin, K., Marion, C. G., Venasse, M., & Shaffer, A. (2017). Specific coping strategies  
27 moderate the link between emotion expression deficits and non-suicidal self-injury in an  
28 inpatient sample of adolescents. *Child and adolescent psychiatry and mental health*, 11(1),  
29 21.  
30

31  
32 Thorsteinsson, E.B., Sveinbjornsdottir, S., Dintsi, M., and Rooke, S.E. (2013). Negative life  
33 events, distress, and coping among adolescents in Botswana. *Australian Journal of*  
34 *Educational & Developmental Psychology*. Vol 13, 2013, pp. 75-86.  
35  
36

37  
38 Walden, T. A., Harris, V. S., & Catron, T. F. (2003). How I feel: a self-report measure of  
39 emotional arousal and regulation for children. *Psychological assessment*, 15(3), 399.  
40  
41

42  
43 Weis, R., & Speridakos, E. C. (2011). A meta-analysis of hope enhancement strategies in  
44 clinical and community settings. *Psychology of well-being: Theory, research and Practice*,  
45 1(1), 5.  
46  
47

48  
49 Weisz, J. R., Sandler, I. N., Durlak, J. A., & Anton, B. S. (2005). Promoting and protecting  
50 youth mental health through evidence-based prevention and treatment. *American*  
51 *psychologist*, 60(6), 628.  
52  
53

54  
55 Werner-Seidler, A., Perry, Y., CEAR, A. L., Newby, J. M., & Christensen, H. (2017). School-  
56 based depression and anxiety prevention programs for young people: A systematic review  
57 and meta-analysis. *Clinical psychology review*, 51, 30-47.  
58  
59

60  
World Health Organisation (2014). *Health for the World's Adolescents – A Second Chance in*  
*the Second Decade*. World Health Organisation: Geneva, Switzerland.

1  
2  
3  
4  
5 World Health Organisation (2003). Caring for children and adolescents with mental  
6 disorders: Setting WHO directions. [online] Geneva: World Health Organization. Available at:  
7 [http://www.who.int/mental\\_health/media/en/785.pdf](http://www.who.int/mental_health/media/en/785.pdf) [Accessed 14 Sep. 2015].  
8  
9

10  
11 Zimmermann, P., & Iwanski, A. (2014). Emotion regulation from early adolescence to  
12 emerging adulthood and middle adulthood: Age differences, gender differences, and  
13 emotion-specific developmental variations. *International Journal of Behavioral Development*,  
14 38(2), 182-194.  
15  
16  
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20  
21  
22  
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**Table 1.** Reported reliabilities of scales for primary and post primary school measures

Scale	Number of items	Cronbach's Alpha
<b>Primary School Measures</b>		
Generalised Anxiety Disorder 6 GAD-6 (Spence)	6	.77
How I Feel scale HIF	30	-
Positive Emotion Subscale		.87
Negative Emotion Subscale		.89
Emotion Control		.84
<b>Post Primary School Measures</b>		
Generalised Anxiety Disorder – 7 GAD-7	7	.89
Difficulties in Emotional Regulation Scale Short Form	18	.79 - .91
Measure of Adolescent Coping Scale	34	.70 - .81
Adolescent Resilience Questionnaire Revised	88	
Self	40	.61
Family	11	.87
Friends	15	.73
School	16	.77
Community	6	.84

**Table 2.** Focus groups sample characteristics

Focus Group	Age (years)	Males	Females	Total	Length of Time
School 1 A	11-13	0	9	9	36 mins 21 sec
School 1 B	11-13	0	15	15	28 mins 58 sec
School 2 C	11-13	7	8	15	32 mins 43 sec

**Table 3.** Comparison descriptive statistics and *t*-test results for primary school participant's outcome measures pre- and post-programme (Listwise N= 46-49 matched over time points).

Outcome	Pre		Post		95% CI for Mean Difference		t	df	Cohen's D
	M	SD	M	SD	r				
Anxiety	8.20	3.78	6.28	3.02	.74, 3.08	.35	<b>3.30**</b>	45	0.48
Negative Emotions	29.00	8.33	26.37	7.94	.22, 5.05	.47	<b>2.19*</b>	48	0.31
Positive Emotions	31.04	5.88	29.03	6.55	-.50, 2.71	.61	1.39	47	0.20
Emotional Control (arousal)	31.65	7.75	28.56	7.28	1.06, 5.10	.57	<b>3.07**</b>	47	0.44

*Note:* \*  $p < .05$ ; \*\*  $p < .01$ ; M=Mean. SD=Standard Deviation.  
Cohen's D Effect Size conventions: Small=.2 Medium=.5 Large=.8

**Table 4.** Comparison descriptive statistics and t-test results of post-primary school participant's outcome measures pre- and post-programme (Listwise N= 6-21 matched over time points).

Outcome	Pre		Post		95% CI for Mean Difference	<i>r</i>	<i>t</i>	df	Cohen's D
	M	SD	M	SD					
Anxiety	5.25	6.27	6.60	6.29	-3.64, .94	.70	-1.23	19	0.26
Emotional Regulation	44.85	20.74	46.92	16.38	-11.61, 7.45	.62	-.48	12	0.13
Coping	50.67	7.50	57.00	7.62	-11.83, -.83	.76	<b>-2.96*</b>	5	1.20
Resilience	129.24	22.26	138.38	20.06	-18.42, .13	.54	<b>-2.06*</b>	20	0.44

*Note:* \*  $p < .05$ ; \*\* $p < .01$ ; M=Mean. SD=Standard Deviation  
Cohen's D Effect Size conventions: Small=.2 Medium=.5 Large=.8

**Table 5.** Supporting quotes of basic themes from organising theme 'Gaining hope'

<b>1 Gaining Hope</b>	
<i>a) Self-Efficacy / Self-Belief</i>	
C1:	"I believe I can do anything if I put my mind to it and never give up"
A2:	"It helped me believe in myself too, like I could get good grades in exams, that I could do anything I put my mind to"
A4:	"After the programme, I feel like I can have more confidence to reach my goals and like to really well in school"
B9:	"...but you can keep on going, because it doesn't matter what other people say"
A4:	"...just listening to that story would help you feel confident and you could reach your goals and make you feel happy"
A6:	"Before when we started our tests, we were all worried about the test coming up, and [facilitator] said don't worry and if you believe in yourself then you can achieve it and do good"
A2:	"Hope is believing in yourself mostly, and having hope in others..."
<i>b) Confidence</i>	
A4:	"Before the Hope Programme, I wouldn't be able to speak in front of people, and cause you're recording me now, I wouldn't be able to do that, but now it has taught me to breath and just get on with it and I that I can do it"
A3:	"Since [the facilitator] came in I have felt more confident"
B2:	"It helps people boost their confidence"
A3:	"It has helped me become more confident, I used to struggle with a lot of things, but now after I have more confidence, having this wee group has really helped"
C6:	"To speak up a bit more"
<i>c) Goal Setting</i>	
C9:	" I liked when we were setting out our goals"
A1:	"You have an aim for yourself, and even if you find it hard you always try to reach your aim"
B3:	"You should always set goals for yourself"
<i>d) Positive Thinking</i>	
A5:	"I liked the part where we write down all the hopeful things we had, we are [grateful] for in our lives"
C2:	"That you should never stop, you should try and you will get there in the end"
B9:	"To think about it is gonna get better"

**Table 6.** Supporting quotes of basic themes from organising theme 'Learning new skills'

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## 2. Learning new skills

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### a) *Breaking down communication barriers*

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C10: "To open up"

B3: "To tell somebody instead of keeping it inside [because] then it could do damage"

A2: "It's important to talk to someone about it or it will just get worse"

A2: "Before the programme came... I couldn't say what was on my mind ...I'd be scared to ask for help...[now] I feel like I am better at telling teachers"

B2: "You're not always alone, there's always people you can talk to"

A3: "I think it has given me confidence to like talk to my mammy and like, if I was emotional I would tell my mammy and I would talk to her"

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### b) *Identifying and regulating emotions*

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A6: "I would count back from 10 to 1, but if that didn't work then I would tell my mummy"

B13: "You learn how to cope with your feelings"

A5: "Things that work for me is to go outside, just to go outside even if it's raining and just think to myself"

A4: "If I was feeling nervous I have learned to cope with it by breathing in through my nose and taking big deep breaths"

B6: "Before [the programme] if something happened ... you felt really sad, you felt angry and then you'd just keep doing stuff to make you more sad... it helped you overcome that"

C6: "We talked about the upstairs and downstairs, and how to get around things when you don't feel good at times"

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### c) *Coping Strategies*

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A8: "You became more aware of your problems and how to deal with them"

A5: "Before... I never knew what to do, I would go to a teacher if I was being bullied, but once we started talking about the upstairs and downstairs brain, I became more confident after that"

A4: "Before, I didn't feel quite very confident as I was going through a bit of a hard time... I didn't know what to do, but when [facilitators] came in to show us how to deal with it, it really helped"

B2: "It taught me how to deal with [stresses], and what I have to do to overcome them"

B9: "It's like a great support if you feel like there is something [wrong] you always know what to do after the programme"

A7: "I feel like before the programme I wasn't able to overcome problems but I feel more able now"

A4: "...before I was worried about exams, how I was gonna do and how I was gonna revise, now it's just got all better"

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### d) *Resilience*

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- B15: "If you tried to do something, and something might stop you or get in the way just try your best to overcome it or work around it"
- A2: "There are always going to be obstacles in life, but there are always going to be ways to overcome them"
- B2: "People are going to say things, that are going to try to prevent you from doing the things you want to do, so you should just ignore them, you should not listen".

**Table 7.** Supporting quotes of basic themes from second organising theme 'Sharing Hope'.

<b>4 Sharing Hope</b>	
<i>a) Helping Others</i>	
B9:	"If it was someone who done the programme with us, you can sorta say to them, remember what [the facilitator] said, remember about all the stuff we learnt"
B6:	"Because maybe they didn't learn about hope and maybe we could tell them what to do if they feel down or they feel sad"
A2:	"And it doesn't only work on yourself, it works on other people too, say like they are stressed, the stress advice you were given, to think positive, and you are passing on your stress advice to your friend that is stressed"
A4:	"...Cause like say, [a friend] is thinking negative and you are thinking positive and you know it's gonna get better, you tell her it's gonna get better to help cheer her up."
C2:	"... you'd be there to say, there is no need to get stressed cause you're gonna get through it!"
<i>b) Teaching hope to younger people</i>	
C13:	"Younger age because when they go to secondary school they will be able to cope with stuff"
C5:	"So maybe they can have it in their heads when they are younger so it'll stay with them"
B6:	"Because P7's are going into big school so it could help them"
B14:	"Because they'll be coming into a school where they don't really know anyone, it will help them cope and to make new friends and what not"
B2:	"Especially when they're growing up, as well as going into our world, it will boost their confidence and [they will] know not to give up"
B2:	"I think it should be P6 you should get it, because you're gonna go through ... your transfer test in P6, you're gonna be going through stress and then in P7 you're gonna be going through stress for going to secondary school. I think it should start from the age of 10"
B8:	"Because it's scary going into big school, it would help them prepare"
A1:	"A lot of things happen in secondary school, and the programme will help you get through them"

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**Figure 1.** Thematic network of themes derived from focus group interviews